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‘Selling it as a holistic health provision and not just about condoms…’

Sexual health services in school settings: current models and their relationship with SRE policy and provision

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In this article we discuss the findings from a recent study of UK policy and practice in relation to sexual health services for young people, based in - or closely linked with - schools. This study formed part of a larger project, completed in 2009, which also included a systematic review of international research. The findings discussed in this paper are based on analyses of interviews with 51 service managers and questionnaire returns from 205 school nurses. Four themes are discussed. First, we found three main service permutations, in a context of very diverse and uneven implementation. Second, we identified factors within the school context that shaped and often constrained service provision; some of these also have implications for SRE. Third, we found contrasting approaches to the relationship between SRE input and sexual health provision. Fourth, we identified some specific barriers that need to be addressed in order to develop ‘young people friendly’ services in the school context. The relative autonomy available to school head teachers and governors can represent an obstacle to service provision - and inter-professional collaboration - in a climate where, in many schools, there is still considerable ambivalence about discussing ‘sex’ openly. In conclusion, we identify areas worthy of further research and development, in order to address some obstacles to sexual health service and SRE provision in schools.

Running head: Sexual health services in school settings

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Introduction

This article examines recent developments in policy and practice concerning sexual health services based in, or closely linked to, schools, for young people aged between 11 and 18 years. Recent UK Government initiatives have encouraged an expansion of such services as a means of reducing rates of conceptions, births, and sexually transmitted infections (STIs) among young people (DfES, 2007a; 2007b). However, just as there is still no statutory requirement to provide sex and relationships education (SRE) in British schools, nor is there a requirement to provide sexual health services at school level. Therefore, developments have been uneven, reflecting differing local priorities and funding sources.

Following the definition used in a recent survey of schools by the Sex Education Forum in England, we define sexual health services as 'the provision of something tangible, if the young person needs it, for example, condoms and pregnancy testing' (Emmerson, 2008, p.10). That is, they offer more extensive advice than that traditionally available via the school curriculum (in the form of SRE), and a wider range of services than those provided on an individual basis in many (but not all) schools by school nurses. *School-based* sexual health services (SBSHS) are those located on school premises; *school-linked* sexual health services (SLSHS) are based elsewhere (for example, youth centres), but are connected to local schools through staffing and/or funding arrangements, or other explicit and sustained forms of collaboration.

Whilst policy initiatives discussed in this article are specific to the UK, our findings have wider relevance, especially regarding the ways in which young people's sexual health needs and preferences are understood and addressed in policy and in practice. Space prevents detailed discussion of international trends in policy here. However, there is evidence of related initiatives to improve access for young people

to appropriate sexual health services, and to optimise skills, knowledge and uptake of services through SRE and through school-linked provision. The European Commission, for example, convenes a Sexual Health Forum with this remit, which has representatives from all European Union (EU) countries, and collaborates with the World Health Organisation and the United Nations Educational, Scientific and Cultural Organisation (Clarke, 2010). The SAFE project is another European partnership concerned with promoting the sexual and reproductive health rights of young people, and with improving access to sexual health services, making explicit links to SRE (IPPF, 2007). There are similar initiatives in some African states, in parts of Asia and of the USA (UNFPA, 2010).

A majority of initiatives appear embryonic; they also reflect national differences in the age of consent, in attitudes to young people's sexuality and in patterns of access to education. In countries where SRE is mandatory, such as Germany, Finland and the Netherlands, there are also sexual health services in the school context. In Berlin, for instance, a network of female doctors deliver both education and services in schools, and across Finland, emergency hormonal contraception (EHC) and condoms are available from school nurses (Clarke, 2010). The findings presented in this article are not claimed to be generalisable to non-UK contexts; however, they do offer insights that might be useful to anyone with interests in the ways in which school-based or school-linked sexual health service provision can complement SRE.

We turn now to summarising the background to our study. Government concern about teenage pregnancy rates, particularly in disadvantaged communities, became pronounced during the 1990s in England, and in other Anglophone countries. The impetus for action in England came from the Government's Social Exclusion Unit report on teenage pregnancy (SEU, 1999). This stimulated the introduction of a national strategy and a range of interventions intended to reduce under-18

conception rates by half by 2010 and to reduce social exclusion among young parents by offering greater support. More recently, there has been increasing concern about young people's sexual health, and more specifically about the rising levels of STIs, particularly Chlamydia (Clarke, 2010). Estimates suggest that one in ten young people may be infected with Chlamydia in the UK (HPA, 2006), with an 'ongoing Chlamydia epidemic' reported in other EU states (Clarke, 2010, p.1). In this context, the importance of making connections between SRE and sexual health services has been reiterated. In 2004, the Health Development Agency asserted: 'There is good evidence that school-based sex and relationship education (SRE), particularly when linked to contraceptive services, can have an impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates' (HDA, 2004, p.1). English Government guidance (DfES, 2007a; 2007b) went on to highlight further education (FE) and school-based service provision as pivotal in reducing rates of both STIs and teenage conceptions.

Studies with young people have found that many anticipate and/or experience dismissive, punitive or judgemental attitudes in their encounters with mainstream health service providers (Higginbottom *et al.*, 2005; Hirst *et al.*, 2006; Stapleton, forthcoming); barriers to seeking sexual health care include a lack of knowledge about, or access to, services, embarrassment, and worries about confidentiality (Wilson and Williams, 2000; Coleman, 2001; Garside *et al.*, 2002; Graham *et al.*, 2002). The Department of Health developed the *You're Welcome* guidance (DH, 2007) to assist health service providers in becoming more sensitive and responsive to the needs of young people. While this is a positive development, research consistently reveals that many young people prefer dedicated young people's sexual health services (Donovan *et al.*, 1997; Hardon and Ogden, 1999; Hayter, 2005). Schools, therefore, are one of the main sites through which this might be achieved. To date, however, few studies have examined the development of SBSHS/SLSHS in

the UK, and none has addressed the long-term impact in relation to indicators such as rates of STIs and teenage conceptions/births. That said, the recent Sex Education Forum survey of secondary schools in England revealed that between a quarter and a third had already established SBSHS/SLSHS, with others indicating intentions to do so (Emmerson, 2008). An evaluation of a pilot scheme in Bristol (Salmon and Ingram, 2008) reported substantial up-take and acceptability of services, particularly amongst young men. However, the study was not designed to address longer term outcomes such as patterns of sexual decision-making or STI/conception rates.

The systematic review carried out as part of our study (Owen *et al.*, 2010) established that almost all of the small number of published studies on SBSHS/SLSHS have been undertaken in the USA; our analysis also exposed considerable variation in methodological quality. Nevertheless, our review found some evidence to suggest that both types of services may be associated with a reduction in the proportion of teenagers reporting recent sexual activity and multiple sexual partners; there is some evidence to indicate an association with a reduction in live births to teenage girls and a reduction in Chlamydia prevalence in male students. However, the absence of robust, published evaluations indicates the need for more large-scale studies designed to examine the long-term impact of SBSHS/SLSHS.

Methods and participants

This article discusses findings from two aspects of the study - a postal survey of school nurses, and a set of in-depth telephone interviews with service managers and coordinators. Both aimed to enable us to define existing service models and configurations, and to identify barriers and facilitating factors regarding implementation. The study was not designed to quantify levels of implementation across the UK, however. The survey questionnaire was circulated to 1400 school nurses via the Community Practitioners and Health Visitors Association and 205

responded. This relatively low response rate (15%) was offset somewhat by the fact that returns were received from all parts of the UK, increasing the chance that we could address the aim of identifying service models. Survey findings also converged closely with those from the telephone interviews (n=51) with individuals who had a lead role in promoting and/or implementing adolescent sexual health strategies and services. Telephone interviews were digitally recorded, transcribed verbatim, and subsequently anonymised.

Quantitative data were analysed using SPSS to produce descriptive statistics on skill mix, services provided and funding arrangements. We also examined whether or not distinct service models and staffing patterns were associated with specific levels and types of provision. Qualitative data analysis was informed by 'framework analysis' (Ritchie and Spencer, 1994); free text comments were analysed thematically. Data from telephone interviewees were entered into a grid based on the interview question categories; key themes within categories were identified by the research team and subsequently circulated amongst paired team members who identified sub-themes and drafted preliminary analyses for validity checks by all team members. Finally, team members discussed the draft analysis, resolved outstanding interpretative differences, and checked for consistency.

Study findings

We identified four key themes from our analyses of interview and questionnaire data, two of which directly concern the development and sustainability of services in the school context, and two of which concern wider issues. First, we found three main service permutations, in a context of very diverse and uneven implementation. Second, we identified factors within the school context that shaped and often constrained service provision; some of these also have implications for SRE. Third, we found contrasting approaches to the relationship between SRE input and sexual

health provision. Fourth, we identified some specific barriers that need to be addressed in order to develop 'young people friendly' services in the school context. These are discussed in turn below.

Current services: three models

There was considerable variation in the type of provision and means of delivery of SBSHS/SLSHS. This may reflect the rapid pace of policy and practice change and guidance (for example, see DfES, 2007a, 2007b; Mullinar and Martinez, 2007), as well as the fact that there is no standard national requirement for local services to meet. We found three broad models, each with differences within and between them, primarily relating to staffing mix: (i) school-based services staffed entirely by school nurses; (ii) school-based and school-linked services staffed by multi-professional teams, but excluding medical practitioners, and (iii) school-based and school-linked services staffed by multi-professional teams, including medical practitioners. These three models incorporated six modes of service delivery identified by research participants (see Table 1).

Insert Table 1 about here please

In effect, young people could access three levels of service. This echoes evidence from the Sex Education Forum in their survey (Emmerson, 2008). *Basic* services offered information, referrals and/or condom access, primarily based on Model 1 in Table 1. *Intermediate* provision offered these and some additional services, such as Chlamydia screening and pregnancy testing (more likely to emanate from Model 2). Finally, *comprehensive* provision (primarily originating from Model 3) tended to offer the services already mentioned, as well as a wider variety of services, including long acting reversible contraception (LARC), EHC, and a range of STI screening and/or treatment. A common element in all levels and models of service was the use of

(specialist) referral pathways; effective signposting was often described as integral to provision.

Respondents described the range and type of provision as linked to shortages of staff and specialist skills:

> *What they can offer is very much dependent on how qualified the nurse is to deliver a particular service.* (Interview participant 36)

> *School nurse drop-ins only happen monthly due to staff shortages.* (Survey participant 1030)

Whilst school-based health services have a high profile in national policy, this is not necessarily matched in funding for school sexual health services. Participants cited a variety of funding sources and concerns for the medium- to long-term sustainability of services, issues about staffing availability, and resources for training:

> *At the moment we can't think… too far ahead because without more funding there's no chance anyway.* (Interview participant 50)

Sometimes funding difficulties were attributed to problems in sustaining partnerships or collaborative arrangements between health organisations and schools or local authorities, rather than to an overall lack of money:

> *Services were stopped as joint funding was not agreed. Currently the school nurse has stopped delivery because 'training' and 'time' was not jointly paid and funded.* (Survey participant 793)

The ability to guarantee only short-term provision was not unusual, with added strain on sustaining sexual health services brought about changing public health agendas. The introduction of the HPV vaccination programme in schools was the most commonly reported example, with many arguing that there were insufficient numbers of school nurses to sustain school-based services alongside this new initiative or other competing demands:

> *Due to lack of school nurses I have to offer drop-ins on inappropriate days, e.g. Thursday - not good for emergency contraception after weekend sex.* (Survey participant 598)

In this context, many services had relied heavily on the temporary support available through funding devolved to local areas from the national teenage pregnancy strategy budget. This was commonly described as having enabled services to be initiated; however, the disadvantages were obvious:

> *…teenage pregnancy money is not always going to be around and we don't want people relying on it.* (Interview participant 7)

Our analyses suggest that funding issues can act as barriers to the development, and longevity, of school sexual health services; it also clearly affects staff recruitment and training.

Sex and young people

Whilst our research highlighted strong support for school-based sexual health services at the level of formal, national policy, it also identified a range of potential difficulties that made themselves evident within the local school context. Sexual health is a subject that remains stigmatised (MedFASH, 2008), and sexuality is still

widely regarded as ‘private’ (Carabine, 1996; Fish, 2006). Bring young people into the frame and there is additional ambivalence, discomfort or a desire to protect ‘innocence’ in many quarters (Jackson, 1996; Woodiwiss, 2009). This discomfort underlies much of the difficulties described below, paradoxical given the sexualised imagery and discourses which pervade all aspects of life in the UK (Attwood, 2006; Roscow *et al.*, 2009; Smith, 2009). Furthermore, sexual health and SRE policy recommendations and guidance contrast with a social context in Britain that does not appear comfortable with open, confident, and unembarrassed discussion of sex (Hirst *et al.*, 2006; FPA, 2007; Formby, 2009).

These tensions were evident in the ways in which respondents described how their local services were promoted or categorised. On the basis of previous research and of consultations with experts in the field, we had anticipated that respondents might distinguish between *generic* health and *sexual* health services at local school level. Respondents recognised this distinction, and many expressed a preference for a generic approach in service advertising. One reason for this was related to concerns about confidentiality among young people themselves:

> *In a small school, anonymity is a problem, therefore best to have general drop-in so people don't know it is a sexual health issue being dealt with.* (Survey participant 607)

Some service providers referred to feedback from young people which supported their view that a general health service protected young people’s confidentiality and any taboos associated with sexual health. Other research participants, however, emphasised their belief that generic health services did not provide sufficient specialist input regarding sexual health. There was some evidence from the school nurse survey to support this view, with school-based services identified as *sexual*

health specific tending to provide a fuller range of (sexual health) services than those marketed as *general health*. This may be partly explained by the fact that the services described as *sexual health specific* involved medical practitioners (with prescribing rights) more commonly than did the services described as *generic*. Staff training and availability are key to influencing (uneven) levels and forms of provision, again paralleling issues within SRE, where research has identified teachers lacking in confidence and specialist skills (Formby *et al.*, 2009).

However, this distinction between *generic* and *sexual* health services bears further examination; sometimes it reflected the ways in which actual or potential opposition from school head teachers, governors or parents was being managed, rather than a robust difference in staffing or provision:

> *They're pitched as a health drop-in because that's what schools were comfortable with.* (Interview participant 2)

This suggests that, in future research, careful attention needs to be paid to the ways in which services are categorised. Adopting a service identity that was not specific to sexual health often reflected ambivalent or conflicting attitudes, rather than necessarily reflecting young people's needs, perceptions or preferences. Some interviewees illustrated the balancing act that they felt obliged to perform:

> *I think it is recognised as a sexual health service. When we're putting some of that information into schools we don't make the sexual health element of it as explicit, so we've got different levels of marketing, but young people themselves recognise it as a sexual health service.* (Interview participant 27)

We weren't allowed to say that emergency contraception was available, and pregnancy testing. (Interview participant 45)

The risk is, of course, that this approach could potentially increase, rather than effectively challenge, any stigma or mystification associated with *sexual* health.

School management can set the tone for a school's approach in relation to SRE (DfEE, 2000), and this also extends to the provision of health services. Clearly, implicit and explicit messages from school staff and governors can influence the quality of sexual health provision. Schools' relative autonomy was an issue raised in both the survey and interviews, with many participants providing examples where schools attempted to shape or restrict their services, with varying degrees of success.

Some schools, they won't even let you put the posters up. It has to be inside the office, where the nurse works… It can't be in a corridor, presumably in case anyone reads it! (Interview participant 29)

Here, the schools actually employ their nurses direct and they're not provided by the NHS… and the school nurse they employed was very keen to expand her remit around sexual health, but she was… slapped down and basically her role was to stick plasters on and look after the headaches, and she got very frustrated and in the end she left. (Interview participant 50)

[One] *head teacher has banned pupils coming into school at break time so the children could not access the room.* (Survey participant 462)

Many respondents spoke about “having to get this past the governors” in initial service development stages. Whilst some staff clearly had come to accept that this was an inevitable procedure, others were clearly immensely frustrated by the time and energy used in the process.

> *We always have to go through the governors… it’s awful, and we’ve had some really difficult meetings. What they do is they bring the parents in… It’s been really tough.* (Interview participant 10)

Many participants believed that the quality of the built environment allocated to school-based services reflected the status the school attached to the service. Venues varied from new, purpose-built structures, to temporary locations (including portacabins). If no dedicated space was provided, staff rotated around available rooms or portacabins, which were frequently described as dirty, noisy, and lacking in privacy and essential amenities such as toilet facilities (for urine sampling purposes).

> *Facilities adapted and shared so not ideal. We need a purpose-built room which will allow a pleasant environment in which we can offer a professional service.* (Survey participant 382)

The majority of respondents reported working hard to engage and appease school teachers, management and governors before they became an insurmountable barrier to service provision, with additional issues raised in relation to faith schools:

> *I know that* [the school nurse] *finds it difficult to… cover a lot of basic stuff within some of the faith schools and we’ve had so many other things to deal with that we’ve never gone down that road.* (Interview participant 45)

Similarly, geographic and regional sensitivities were evident in relation to the greater influence of religion in Scotland and Northern Ireland, where condoms and EHC were far less available than in England, increasing the inequality of access for young people.

> *It's mainly the Catholic schools that don't provide* [advice or services]. *It's been identified there's a need* [there] *as well.* (Interview participant 16)

Whilst parental opposition was less commonly reported than school or governor opposition, it nevertheless provided a clear backdrop to staff planning in relation to service development.

> *It's the condom bit that they're more worried about. It's bizarre. They'll let you do emergency contraception actually in the school… because there's no packets of condoms involved in it… what they're worried about is kids then playing with the condoms and parents seeing it.* (Interview participant 7)

Condom distribution was seen as difficult or impossible in many schools in England - sometimes referred to as *condom-phobia* - where the physical presence of condoms (or their packaging) appeared to be symbolic of (problematic) youth sexuality, often related to a concern for school 'reputation'.

> *The issue that schools always have is… that there'll be condoms all round the school and blown up and left on cars, which again is never really seen.* (Interview participant 25)

> *…some of the teachers… they'll say "Could you put those condoms in a bag please? We don't want you walking round school with them".* (Interview participant 10)

The most prominent external factor cited as a barrier to service development or provision was fear of the media. High-profile cases of schools and individuals being targeted by a sensationalistic or antagonistic press appeared to have left the majority of service providers with feelings of fear or trepidation in relation to potential negative media coverage.

Areas where there had been local media involvement were particularly susceptible to anxiety in relation to public perceptions of the service, and were often initially reluctant to take part in our research as a result. These examples of press interest were frequently cited as fuelling school ambivalence or hostility, and directly influencing the approach towards service marketing, which often had to walk a fine line between 'discretion' and 'promotion'.

> *They did get a bit of press and the schools got a little bit of a hounding, so our schools asked us if for the pilot we could… keep it fairly… not secret, but discreet.* (Interview participant 12)

Blurred boundaries: SRE and sexual health

Whilst the distinction between sexual health care and SRE is often blurred and/or misunderstood (Emmerson, 2008; Formby *et al.*, 2009), our research remit focused solely on sexual health service provision, rather than sexual health education. This distinction follows both policy initiatives and funding streams, where education in the classroom (for example, by PSHE teachers) tends to be separated from advice and/or service provision elsewhere in school (for example, by school nurses).

Nevertheless, both survey and interview respondents illustrated the ways in which both formal and informal collaboration between teachers and sexual health service staff could be very beneficial. Collaboration, for instance, could address gaps in awareness and confidence among teachers, regarding SRE:

> *We were finding that teachers weren't necessarily confident to be able to deliver the SRE work, and so by having this external* [sexual health] *team who delivered the* [SRE] *work, it was actually achieving quite a lot of knowledge… awareness raising, but also attitude change.* (Interview participant 11)

Collaborative links could also facilitate and encourage service access among young people:

> *One strength is that the school nurse… also runs drop-ins* [and] *…also contributes to sexual health education within* [the] *classroom, to help connect what is taught in* [the] *classroom to linking with service provision.* (Survey participant 709)

> *You get a lot of the curious and sexually inquisitive youngsters come across when we've done their* [PSHE] *sessions in school.* (Interview participant 12)

However, this model of collaborative practice was only described by a minority of respondents. Examples were also given of friction or ambivalence:

> *The PSHE coordinator gives out what's supposedly positive messages, but she's actually quite blocking… Communications are very poor within the school*. (Interview participant 28)

Where models of close collaboration or an integrated approach across the school were not in place, practitioners regularly reported wanting to see it developed. School nurses and sexual health workers, for example, often reported wanting closer links to SRE, but this was not always possible in a context in which school head teachers and governors sought to 'down-play' or disguise sexual health service provision or, alternatively, not to offer comprehensive SRE. This highlights again the consequences of the current non-statutory basis of PSHE, and of SRE within that, and of the rights of schools and their governors to determine their approach to SRE (DfEE, 2000).

Linked to this, the governance of faith schools, together with the parental rights to remove children from SRE, was also seen as problematic by some of our research participants. Similarly, when asked what policy changes they would like to see in relation to sexual health for young people, respondents in every country and region wanted improvements in PSHE/SRE, with most expressing the view that it should indeed be compulsory.

Creating 'young people friendly' services

Our findings highlight a number of concerns about making services 'young people friendly'. The most prominent of these was the question of confidentiality. In particular, many respondents illustrated the ways in which different professional models of confidentiality, in work with children and young people, could cause tension. The most common observations highlighted the contrast between policy and practice in the health sector, as compared to the education sector. For a school nurse or another health professional, the confidential relationship with a patient or service user cannot be compromised (once the Fraser competence criteria have been met). For a teacher, on the other hand, there may be competing pressures:

> *The* [teachers] *feel that… they've got a responsibility for those young people within their school setting, and it's almost as though they're deceiving the parent… and they've got to share that information. Well, we* [NHS staff] *don't share that kind of information. It must be confidential.* (Interview participant 15)

Some gave graphic examples of teacher actions or school policies that could put confidentiality at risk:

> *Interference by teachers whilst pupils are waiting, moving them on… and noting who is there*. (Survey participant 140)

> *…we have had a couple of glitches, such as one school, who told the school nurse that they would only let young people come if they knew at the end of the day who'd been and what for, so we had to have a bit of a chat with that school…* (Interview participant 47)

Clearly, whilst there is the potential for strong working relationships between health practitioners and SRE teachers and coordinators, inter-professional and inter-agency collaboration needs to be based on shared understandings, policies, and practices. These need to apply to formal policy agreements, and day-to-day practice.

A second concern, and one with a clear impact on the safeguarding of confidentiality, was the allocation and design of service premises. Although dedicated premises were generally viewed as an improvement, in comparison with some of the temporary or shared spaces we have commented on above, our findings revealed the ways in which it can be difficult to reconcile different policy priorities when school

buildings are being designed or renovated. Anti-bullying designs, for example, emphasise open, visible layouts that may compromise the privacy that young people value in accessing sexual health services:

> *One of the issues has been with a lot of the new-builds... I think it's a sort of anti-bullying kind of design and so it's quite hard sometimes to find confidential spaces.* (Interview participant 18)

Discussion and conclusions

School-based and school-linked sexual health services certainly have an important role in supporting young people to protect their sexual health. Although the models vary, the existence of any level of service has significance in three ways. First, they offer user-specific support and services which enhance choice and decision-making with regard to available services, and hence can contribute to improving sexual health. Second, sexual health services which are in, or linked to, schools have genuine potential to complement and support effective SRE delivery. A key aspect of young people-centred programmes of school-based SRE is the development of the skills and competencies needed to access and use sexual heath services effectively. This includes knowledge of 'youth friendly' confidential services, their location, what to expect, the range of products and services available, and support to use them effectively (for further detail, see Ingham and Hirst, 2010).

The incorporation of sexual health services on school premises will make them naturally more accessible and more normalised as a firm scaffold between SRE provision, teachers, and sexual health service providers. Third, the presence and promotion of sexual health services, on or near school premises, send a positive message about the status of young people's sexuality and sexual health among staff, students and the wider community. They position these aspects of identity, well-being

and sexual health practices as significant and valued; as such, they serve as important counterpoints to the more traditional ethos with tendencies to over-protectionism and reluctance to acknowledge young people's current and future sexual selves.

However, as our data illustrate, the means by which school-based and school-linked sexual health services are offered is hugely variable. The evidence reviewed above suggests there are three broad models of service. As yet, the kinds of studies needed to provide robust comparisons between different service models have not been done. However, the most comprehensive model optimises opportunities for reaching and supporting more young people, and is indeed the model to which most practitioners who took part in our study aspired. None of these models rested on firm foundations with their future secure, though. The evidence points to some key factors that are salient to their development and sustainability. Insufficient, insecure, or short-term funding militates against routinely available services with an appropriate location and specialist staff.

Unsurprisingly, there is an enduring requirement for partnership and cross-disciplinary working (from the outset) in policy, planning and delivery, to ensure colleagues are working towards joint goals, with clearly defined roles and responsibilities. However, other factors can also have a significant impact on the quality and ethos of provision, and appear as difficult to remedy. Concern, for instance, that sexual health services for young people might attract negative attention from parents, community, and the media is used as justification for no services at all, or for masking the nature of provision in ambiguous names for clinics, or (non-explicit) inclusion in more generic services. Though our evidence suggests that the extent and type of sexual health provision can be more than doubled in sexual health, rather than general health, services, practitioners assert that the generic

model is easier to incorporate and market in schools, and preferred by school authorities and some (though not all) young people. Ostensibly, generic services offer a screen to protect confidentiality, but systematic practices drawn up in partnership should be able to overcome this. Rather, the potential for stigma and uninvited attention that a sexual health service for young people might bring compromises the provision of services based on young people's expressed needs. Many sexual health service providers and teachers feel ill-equipped through lack of specialist training or support to fight the challenges this presents. Until sexual health services are normalised as a right and a requirement for schools, this precarious state of affair is likely to remain.

This brings us to some final thoughts on priorities for future research. As for SRE, any related sexual health services must be built on young people's needs. A majority of our participants had yet to include needs assessment and evaluation as a routine aspect of the service. Insights from young people (prior to developing services) concerning their preferences and needs, and experiences from those already using services, would enrich service development. Related to this is the need for exploration of the perceptions and potential stigma attached to services - with an explicit sexual health name and focus - from the perspectives of students, teachers, and other community stakeholders. Currently, it seems services are being shaped by (sometimes imagined) fear of opposition from dominant, though not necessarily representative, voices. Locality-based research to identify facilitators and obstacles to collaboration, effective inter-professional working, and provision of holistic services will be a necessary first-step. Pragmatically, this will include the need for safe arenas for airing and identifying concerns about confidentiality and stigma because, as our data suggest, this can undermine the whole ethos of a service, its marketing materials, and ultimately the services on offer. In addition to these issues, the sustainability of services is a universal and enduring problem. With the plan to

implement statutory PSHE from 2011, there would have been clear scope to enhance partnership working between SRE and SBSHS/SLSHS, within a context of increasing choice and accessibiltiy for young people (DH, 2007; TPIAG, 2009). The loss of these plans for mandatory SRE, however, removes a key element in the potential for joined up services and education that can support young people to enhance their confidence, knowledge and, ultimately, their sexual health.

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Table 1: Models and modes of delivery for school sexual health services

Model	Mode of delivery
1. School-based services staffed entirely by school nurses	On-site services with school nurse, alone, providing ad hoc advice/provision on a one-to-one basis
	On-site services with school nurse, alone, providing more formalised lunchtime or after school drop-in sessions
2. School-based and school-linked services staffed by multi-professional teams, excluding medical practitioners	On-site drop-in service staffed by school nurse with other staff, such as youth worker(s)
	Off-site drop-in service (possibly with additional outreach) in formal collaboration with the youth service
3. School-based and school-linked services staffed by multi-professional teams, including medical practitioners	On-site drop-in service staffed by school nurse with other staff, such as sexual health nurse(s)
	Off-site drop-in service (possibly with additional outreach) in formal collaboration with primary care