

## **TITLE**

Listening for commissioning: A participatory study exploring young people's experiences, views and preferences of school-based sexual health and school nursing.

## **ABSTRACT**

### **Aims and objectives**

To explore the experiences, views and preferences of young people aged 11-19 years old regarding school-based sexual health and school nursing to inform commissioning for one local authority area in England during 2015.

### **Background**

Promoting sexual health for young people remains a challenging, even controversial, but important public health issue. Concerns regarding accessibility, acceptability and efficacy in school-based sexual health and school nursing are evident in the literature. Additionally, a complex public health policy context now governs the funding, provision and delivery of sexual health and school nursing, which potentially presents further challenges.

### **Design**

A qualitative, participatory design was used to explore sexual health and school nursing. Data were generated from 15 focus groups (n 74), with young people aged 11-19 years old, in educational-based settings in one local authority area in England.

### **Results**

The resultant themes of visibility in relation to sexual health education and school nursing revealed both the complex tensions in designing and delivering acceptable and appropriate sexual health services for young people and the significance of participatory approaches.

### **Conclusion**

Our study shows the importance of participatory approaches in working with young people to clearly identify what they want and need in relation to sexual health. The findings also confirm the ways in which school-based sexual health remains challenging but requires a theoretical and conceptual shift. This we argue must be underpinned by participatory approaches.

### **Relevance to clinical practice**

School nurses have always had a significant role to play in promoting positive sexual health for young people and they are exceptionally well placed to challenge the risk-based cultures that frequently dominate school-based sexual health. A shift of debates and practices towards the promotion of positive sexual health cultures though previously argued for, now requires the active engagement and involvement of young people.

### **KEY WORDS**

Sexual health; young people; health improvement; sex education; school nursing; qualitative; participatory; focus groups.

## WHAT DOES THIS ARTICLE CONTRIBUTE TO THE WIDER GLOBAL CLINICAL COMMUNITY?

- Meeting the sexual health needs of young people is a recognised global public health issue, though effective, appropriate and acceptable school-based and related school nursing provision remains elusive, with research continuing to document well-known challenges, issues and concerns.
- School nurses, schools and related stakeholders face both visible and invisible tensions in delivering appropriate, effective and acceptable sexual health education and school nursing service for young people and are well placed to respond to young people's views and preferences.
- A timely theoretical and culture shift is proposed for school-based sexual health education in which school nurses have a key role to play requiring the active involvement of young people in developing provision that promotes positive sexual health to deliver more acceptable services and care.

## INTRODUCTION

The promotion of positive sexual health for young people remains one of the most challenging, controversial, often contested but important of all global public health issues. This is clearly evidenced in numerous national and international research reports and studies (Owen *et al.* 2010, AUTHOR *et al.* 2011, Carroll *et al.* 2012, Hayter *et al.* 2012; Attwood & Smith 2014). In England, school nurses are qualified nurses with specialist training in the public health needs of school-aged children and young people (Department of Health 2012a, Maughan *et al.* 2015, Jenkins 2016). The 'School Health Service' or Whole School approach aims to provide programmes and interventions to prevent inequalities, as well as promote and support healthy outcomes for children and young people in educational settings (Department of Health (DH) 2012a, 2013, Public Health England (PHE) 2015a&b). Involving or engaging children and young people in the design and delivery of this service is encouraged, but the extent to which this occurs remains unclear (Hayter *et al.* 2012, Larrson *et al.* 2013).

In addition, in England, the policy context governing responsibilities for funding and service provision for sexual health and school nursing has recently changed, following the implementation of the Health and Social Care Act (DH 2012b, PHE 2015 a&b). Sexual health is now commissioned or funded and delivered through variously configured partnerships between local government or local authorities, charity and voluntary sector organisations and the NHS (DH 2013, PHE 2015b, Sex Education Forum 2015). This exceptionally complex policy context potentially presents unprecedented but specific challenges for school nursing and school-based sexual health in England. In the three remaining nations of Scotland, Wales and Northern Ireland, school nurses work within different structures and systems where the

emphasis is less on competition, or use of private providers, and more on statutory provision and collaboration or joint working. This means school nurses face very similar but many specific challenges working to support children and young people with regards to sexual health improvement and promotion (RCN 2012, Bevan *et al.* 2014).

## BACKGROUND

In England, young people aged 15 to 25 years old continue to have significantly high rates of poor sexual health, including inconsistent contraceptive use and increasing sexually transmitted infections. And although conception and abortion rates have started to fall in the UK, use of effective contraception to prevent unintended pregnancy remains a challenge (Department of Health (DH) 2012a, 2013, Bailey *et al.* 2014, Public Health England (PHE) 2015a). While young people are known to find schools and school nurses a useful and/or preferred source of information on sexual health and sexuality (Coleman & Testa 2007, Hayter *et al.* 2012), there is currently no single dominant model of service delivery in UK schools (Owen *et al.* 2010). Therefore the quality of sexual health education and improvement programmes varies enormously (Bailey *et al.* 2014). This inconsistency in approach and quality is evident in other international studies has long been criticised and is deemed to be one of the reasons why provision often fails to meet young people's needs (British Youth Council 2011, Secor-Turner *et al.* 2011, Cheetham, 2013; McKee *et al.* 2014, Helmer *et al.* 2015, Harper *et al.* 2016). Moreover, scientific or biological approaches often dominate, resulting in programmes that are too clinical, didactic or omit relevant relationship information or skills and which young people find difficult to relate to or engage with (Westwood & Mullan 2006, St Leger & Young 2009). This disconnect is known to cause them to disengage from both school and parents when wanting to discuss sexual health issues (McKee *et al.* 2014, Helmer

*et al.* 2015). Similar concerns for young people are known to exist over issues of confidentiality, disclosure and the prominence or invisibility of school nurse or sexual health services or facilities (Owen *et al.* 2010, Carroll *et al.* 2012, Harper *et al.* 2016).

Conversely, young people want positive sexual health education. Such education would include discussions of pleasure, desire and relationships and not just focus on risk, safer sex, or the avoidance of pregnancy (Bailey *et al.* 2014). Yet discussions of sexual activity with young people is still perceived as troubling, especially those involving same-sex relationships, being viewed as promoting promiscuous or dangerous sexual experimentation or behaviours (Formby 2011; Attwood & Smith 2014; Parker 2014; Helmer *et al.* 2015). Moreover, much provision remains predominately heteronormative and /or trans or homophobic in content and delivery (Formby 2011, AUTHORS 2016). These aforementioned approaches reinforces a risk culture that underpins much sexual health and school-based sexual health provision (Attwood & Smith 2014; Helmer *et al.* 2015).

With increased use of social media in daily life, unsurprisingly young people want access to sexual health information and advice online, though as well as direct from adults (parents, teachers, and clinic staff). However, when technologies are recognised as potential new tools for engaging youth in sexual health promotion (Guse *et al.* 2012), schools are often limited by out of date or ineffective technology (Parker 2014). Moreover, this use of social media has meant young people frequently encounter sexual pressure, discrimination and bullying online (Bullying UK 2016), as well direct within in schools. Globally, racism and gender-based sexual harassment and violence has been found to be entrenched within schools (Whitten & Sethna

2014). Lesbian, gay, bisexual, transgender and questioning young people frequently experience systemic homophobia and bullying, sometimes with little support or help from their school or school nurse (Wigmore *et al.* 2009; AUTHOR *et al.* 2011; Magee *et al.* 2012; Fish & Karban 2015; Rasberry *et al.* 2015; Pigozi & Bartoli 2016; AUTHORS 2016). Young women are especially subjected to verbal and physical abuse, harassment, objectification and assault within classrooms, with little if any active or explicit intervention from teachers (van Daalen-Smith 2008; Chang *et al.* 2010; House of Commons 2016).

Given this background and the recent complex policy changes in responsibilities for public health, with funding and delivery moving from the NHS to local authorities, our paper is timely. It reports findings from a participatory research study, funded by a local authority in the South of England. This local authority sought to fund a study, which aimed to listen and engage young people in health improvement in order to inform the commissioning and delivery of services. A larger study sought to do this by exploring three areas: emotional well-being and resilience, whole school approaches to health improvement (including school nursing) and sexual health. In this paper, the experiences, views and preferences of young people concerning two of these areas; namely sexual health and school nursing are reported (see AUTHOR *et al.* 2015, AUTHOR 2015). We argue this paper makes a well-timed contribution for several reasons in that it documents participation in what is deemed a sensitive area of research (Hayter *et al.* 2012), through their involvement in designing and managing research. We also capture a range of experiences and views about school-based sexual health and school nursing that are contemporary, occurring within the aforementioned complex policy environment. Finally; we wish to contribute to the debates proposing a

theoretical and conceptual shift in sexual health. We argue this move toward positive sexual health cultures may be strengthened by furthering demands for active and meaningful involvement and engagement of young people in the design and delivery of sexual health services. We discuss the implications of this for school nurses in their planning and delivery of school-based sex and relationship education and sexual health promotion.

## **METHODS**

### **Design**

In the design of this qualitative and participatory research study, we drew on elements of realist evaluation, which is essentially a methodological orientation with its roots in realist philosophy and the relationship between cultural constructions, social behaviour and material conditions. In our research this meant moving away from epistemological objectivism and thinking about health improvement and commissioning with respect to unpacking “what works for whom, in what circumstances, in what respects and how” (Pawson *et al.* 2005, p.21).

The participatory design of this research study meant that from the outset young people worked with the research team to contribute to the design and execution of the research, as well as formulating, confirming, and revising the recommendations. Young people helped inform the recruitment materials, the data collection methods, the analytical foci and outputs and reporting formats from the study. This form of participatory inquiry shifts from a view of young people as passive objects of research, to young people as active participants or social actors who understand their own realities best (National Children’s Bureau 2011). A dedicated steering group to manage and oversee the study met three times during the year, with young

people engaged as full members of that group. A further eight young people from a local school (not involved in data generation) helped to collectively co-produce the recommendations.

### **Data Collection**

The young people were all students or pupils. As research participants, they were recruited from across all five boroughs and from a range of educational school-based settings (*e.g.* schools, academies, youth centres, colleges, community schools). Inclusion criteria meant that the sample aimed to be inclusive and diverse. Thus recruitment made efforts to include a range of school year groups as well as considered urban/rural locations, together with scores of deprivation or the demographic characteristics of young people such as gender, ethnicity, disability and where feasible sexual/gender identity.

Data were generated during February-March 2015. The purposive sample (n=74) was based on 15 focus groups. A total of fifteen focus groups were held with young people aged 11-19 years old (see Table One and Two). Focus groups were conducted by two researchers, held usually during the school day, with some taking place in the evening at youth clubs and centres (AUTHOR *et al.* 2015, AUTHOR *et al.* 2016).

As noted in the educational and health literature (*e.g.* Sherriff *et al.* 2014), single sex groupings are particularly important for girls to create such 'safe' spaces, preventing and denying boys opportunities to use sexual language to denigrate girls, victimise, and harass them (sometimes physically). The sample was therefore deliberately segregated in terms of

gender and age in relation to levels of appropriateness and gender and power issues (AUTHOR *et al.* 2015, p59).

Topic guides were developed, guided, and agreed with relevant stakeholders prior to data collection, including the commissioning Local Authority. The topics included discussions of sexual health and views on health improvement, which included questions about school nursing. The same questions were asked of all groups related to the two topic areas of sexual health and health improvement/school nursing *e.g.* *'What do young people think about sex and relationship education programmes and the advice they have received from schools and other professionals'*, or for example, *'Where do young people go to get information about sexual health and local sexual health services?'* or *'What could be done better and what would help most?'* The focus groups lasted around an hour on average and discussion was digitally voice recorded and data files were transcribed verbatim.

## **Ethics**

The project received ethics and governance approval via from the County Research Governance Panel and a University Research Ethics and Governance Committee. The issue of parental consent was informed by the British Psychological Society ethical guidelines which state that although parental consent is needed for young people under 16, when potentially sensitive material is to be discussed, parental 'opt-out' (as opposed to 'opt-in') can be appropriate. Schools sent letters to parents providing information on the project and giving parents the opportunity to 'opt-out' via a slip that could be returned to the school. Other schools explicitly required parents to 'opt-in' by returning a signed slip to the school. For

youth groups and recruitment sites, the same procedures were followed as with schools, with a youth leader or equivalent acting as the gatekeeper and locus parentis.

For young people an explicit 'opt-in' was always required. In the first instance, young people indicated to gatekeepers whether they wanted to be involved at which point they were provided with a participant information sheet and any questions addressed by the gatekeeper. On the day and just prior to commencing, the researcher checked again that the participant had read and understood the information related to the project. At this point, participants were asked to sign a consent form and complete a short monitoring form comprised of demographic data. At the end of each focus group, consent was checked again and finally, participants were given a £10 voucher as a 'thank-you' for their participation. As this study questioned vulnerable participants (children and young people) regarding sensitive topics (e.g. sexual health), a risk assessment and appropriate safeguarding procedures were put in place to support the study's processes.

#### **TABLE ONE AND TWO HERE**

#### **Analysis**

The University research team as a whole were responsible for the analysis of data (NS; LC: CC; and KA; LZ & LC), overseen by the lead Principle Investigator (NS). As the data generated were largely qualitative in nature, a combination of thematic analysis (focus groups, interviews) and content analysis (e.g. post-it notes from interactive activities, data from kites and balloons activities and so on,) were adopted.

All engagement activities using focus groups/interviews were recorded on a digital voice recorder (with young people's permission) and allocated a unique identifying number. Files were then transcribed verbatim, by an external University approved supplier. This was someone who was experienced in dealing with sensitive and confidential data. All transcripts were anonymised by the research team, using pseudonyms (including names of young people, schools, and any other identifying information). Transcripts along with the digital files were imported into specialised qualitative data analysis software (NVivo 10) using a password protected (and University networked) computer.

Using NVivo, data were inspected initially through iterative listening and reading to ensure that there had been accurate transfer of information between the digital audio tracks and transcription (quality checks). In doing so, a preliminary coding structure was devised as emerging themes were identified within and across the data set. Development of the final thematic categories were then informed and guided by the project's key foci including topic guides, and also grounded from the data itself (*i.e.* whereby patterns, themes, and categories of analysis emerge out of the data). Finally, adopting a team approach, analytical processes were triangulated to increase reliability and validity of the findings. For instance, a series of 'blind' checks were conducted on the data set as a whole to assess the analytical process to ensure, for example, that the focus groups were interpreted by all members of the research team in the same manner.

In this paper, we present the main findings from the sexual health and school nursing topic areas. In sum, the themes relating to sex and relationship education and school nursing found provision to be inadequate and not taken seriously by the schools, teachers or

students (AUTHORS, 2015). However, key to these findings were the views, experiences and preferences of young people concerning the complex nature of visibility of both school nurses and the sexual health provision which we report on here.

## RESULTS

### Visible sexual health education

Young people viewed sexual health improvement broadly, beyond schools and school nursing, and more within the context of their lives. In their specific discussions of sex and relationships education, young people shared a range of approaches. For one focus group there was much reference to a 'drop-down' day as the primary source of education. This day consisted of a variety of different 'stalls' around one of the schools for hour-long sessions with around 20-30 young people each time. The session on sexual health was run by the school nurse and included contraception, condom use (including how to put one on using a condom demonstrator), the influence alcohol can have on decision making and risk of sexually transmitted infections. Although some students described the nurse-teacher interaction within the drop-down day as 'spot-on', the majority of young people reported that the 'drop-down' day had had little impact on them.

M: ...We had a big day where we went round and had, I learnt how to, well how to put condoms on plastic models and had STI talks and stuff like that so that was quite an in depth one. (School 1, male FG-SH, Grp2, Yr1)

I: Do you think it's had any impact on you [sex and relationship education at school, the drop-down day]?

M: I know how to put a condom on but that's probably more from, not in this school, it's from going to the C-Card lady at the [location] - really not anything at school. (School 1, male FG-SH, Grp1, Yr12)

Reasons why young people saw the 'drop-down' day and sex and relationship education more broadly as having limited impact, were related to its exclusivity to a single school day and that sex and relationship related issues were interwoven within additional health and well-being behaviours, which though placing sexual health more in context, diluted the detail:

M: It was just anything and everything.

M: One part was healthy eating, one part was smoking, we spent 20 minutes in each.

M: They were just trying to go for a broad approach.

M: So one bit was healthy eating, one bit was smoking, one bit was drugs. (School 1, male FG-SH, Grp2, Yr12)

In addition to the drop-down day, two focus groups were held among young people who had participated in a local and targeted safe sex programme designed to engage young people perceived to be at risk of negative sexual health and other outcomes by the relevant schools. In two schools young people were 'chosen' specifically to participate in small single-sex 'health groups' to make their voices heard on important issues and messages around sexual health. Importantly, the related schools selected young people in this manner specifically to reduce any stigma and to maximise participation, self-esteem and empowerment. For example, in one group, this targeted initiative was offered to the students as a 'men's health group,' where young people felt they had been selected as those who 'voiced' their opinions

rather than those in particular need in terms of risks from sexually transmitted infections or unplanned pregnancy.

As a result of participating groups, these young people were aware of the existence of local sexual health clinics (but not necessarily how to access them); however they raised concerns about being seen by others when attending. Consequently, discussions over alternative means of accessing information and advice in school were mentioned, including leaflets, but importantly, there were suggestions for an individual anonymous question and answer service by text message. Furthermore, a number of young people saw online services as a means of accessing information when required, being available 24/7 and as a means of guaranteeing anonymity:

F: I know I think that's just a place where you can go where you don't have to broadcast to everyone that you want to know more. Some people might feel really self-conscious about asking about it or they don't like talking, then they might just be able to access their computer at home or just go on there with a friend that they want to and just have a look at it with someone if they want to. (Youth Centre, female FG-SH, Yr9).

With existing sex and relationship education covering a wide range of topics such as contraception (including the correct usage of condoms) and sexually transmitted infections, there were instances of valuable additional information, such as consent for sex and legislation regarding age at which sex is permitted, the female condom or femidom, and some information on relationships. These instances of information, beyond the statutory notions of contraception, were however in the minority. In terms of preferences regarding future

content of sex and relationship education, students mentioned many of the topics already covered in school. The isolated exceptions to this were recommendations for more information on sexting (sexual text messaging) ; the consequences of not following sexual health advice (for example, becoming pregnant at a young age); and for young women, managing young men's boasting of sexual exploits by, for example, using an initiative known as the 'C-Card' for contraception, more for status than for condom use:

F: Cos some boys like you're going to have sex with them and they'll be, they'll go to their mates and go, oh yeh I've done this you know and immediately take it not seriously. And some people will just take it [C-Card] and say things that are not true just to make them look cool.

(School 3, female FG-SH, Yrs 7-8).

### **Invisible school nursing**

Overall, young people's awareness of the school nurse, their role, what they did or could offer, was poor. For example, young people demonstrated little awareness or knowledge of neither their school nurse nor related initiatives, facilities or provision available in their respective schools. Young people commonly recounted that they did not know whom the school nurse was, or where he/she was located:

I: Do you think the school nurse is the best person [to answer questions about health]?

M1: I don't even know who she is.

M2: I don't know who she is.

M1: I don't think we ever had it explained at assembly who our actual school nurse was.

M2: I think there are a couple of school nurses but I'm not sure when or what they specialise in or if they specialise in something. (School 1, male FG-WSA, Grp1, Y11)

I: Do you care about seeing the school nurse, would you want to see them more?

M1: It would be nice to know she was there.

M2: Who here knows [sounds like where she lives/what she looks like]?

M4: I don't know.

M3: I never even knew we had one. (Youth Centre, male FG-WSA, Yr 9)

For one young man, this lack of visibility translated into a lesser likelihood of ever seeing the nurse, given that she was so unfamiliar, even though he knew she was present in the school:

M: Well she's [nurse] here on Thursdays, the problem is though even though we can go to her, the problem is we don't know her that well to go and, say if [name], he thought he had an sexually transmitted infection and he wanted to go and speak to the school nurse, I don't think he'd be that willing to try and show her because he doesn't know her that well and to him she's an outsider, she's a stranger, we never see her. (School 1, male FG-SH, Grp2, Yr10),

Furthermore many young people were not aware of the range of health opportunities available to them via the school nurse (such as the C-Card initiative), viewing a school nurse as somewhere to go only if injured, feeling unwell, or to be inoculated (jabs); rather than as an opportunity to actively improve and promote health (e.g. via advice, information, and strategies on key health issues such as healthy eating, anxiety, alcohol, sexual health, relationships etc.):

I: What about, in terms of school facilities, you talk about health through school but-

F1: School nurse.

F2: We've only got one so if somebody's being sick or something and you come in and say, I've got a headache, they're like oh you'll be fine and send you away.

(School 3, mixed FG-WSA, Grp 1, Yrs 8-9)

I: The condom card, C-Card did you know that you can get that from her [school nurse]?

M2: I didn't know you could get it from her. [M1: You can.]

M4: I didn't know you can. (School 1, male FG-WSA, Grp1, Yr11)

This lack of visibility and poor awareness of the range of health opportunities available via the school nurse meant young people did not feel connected to the service and that they were less likely to access this, even if they felt they needed to; when asked where they would go for help or advice on health in school, say on a sexual matter, and whether they might go to the school nurse, they were mostly unsure:

M1: No. I think in that situation you wouldn't go to the school nurse, you just wouldn't feel comfortable, because we don't know who she is like properly...our school nurse is literally just there, we're not feeling well, can you call our parents to come and pick us up. That is all I've ever had to do with the school nurse.

M2: Yeh same. I think if you had anything like that you would automatically go to your doctor rather than someone at school. (School 1, male FG-WSA, Grp1, Yr11)

Anxiety over privacy was another key concern, especially regarding the location of the office:

M: It's kind of awkward because her [school nurse] office is in reception so she works with, like she's around everyone else so it's not really the person you want to talk to considering there's all the gossip going on and they're on their computers. (School 3, mixed FG-WSA, Grp 1, Yrs 8- 9)

These fears over discretion and confidentiality were also raised in a mixed focus group, where several young women reflected on the process of receiving their Human Papilloma Virus (HPV) vaccination. Although the next quote recognises the constraints on school nurses to deliver large numbers of vaccinations to young people, as well as privacy, it also raises important issues over consent, lack of information and understanding for/by young people, as well as issues of sexual health stigma and power, whereby young women experience little control over their own health or bodies:

F1: We went for the needle [HPV vaccination]... some girls had to take off their blouses F2: They shut the curtains but you still have to take our tops off in front of everybody. F1: Yeh cos obviously we thought you'd go in and you'd have something covering up... F3: ... you had to sit and wait in the middle of everyone.

F1: ...and then lots of girls had to wait and they were watching.

F: I think it was waiting didn't help. There's a lot of people and I think it could have been organised a bit better... it was the waiting and watching everyone.

F: My friend, she was really worried about it and the nurse asked her loads of questions and I was next to her, I could hear them and one of them was, are you pregnant and if she was it would be hard to her to tell them in front of everyone. (School 3, mixed FG-WSA, Grp 1, Yrs 8-9).

In response to these concerns some male students again cited the use of technology to post anonymous questions as preferable to face-to-face contact:

M1: Maybe like 'Embarrassing Bodies' [UK television programme], but an anonymous thing so you can text in your questions and they just send you a text back...

I: So something like that maybe in school where you could text questions and get a response.

M1: Yeh, just like a text back.

M2: Even if it's anonymous, you could just type it and they could type back and then you know it's you but other people just think-

M5: It needs to be anonymous yeh because otherwise people would be like, I'm not typing anything (School 1, male FG-SH, Grp1, Yr10).

This preference for anonymity and use of the internet was however conditional; for some young people reported that their phones were monitored by their parents, or that internet access in the home was limited or firewalled by parents. This meant that in reality online information regarding sex or sexual health was actually quite difficult to access. Together these two sets of combined findings, from a diverse number of young people, demonstrate a number of specific but recurring concerns and issues regarding the provision of sex and relationship education and school nurse provision in particular, which we discuss more fully next.

## **DISCUSSION**

The study aimed to explore young people's experiences, views and preferences regarding school-based sexual health and school nursing. Our findings showed these to be complex. For even when sexual health was delivered through visible initiatives, services, or when school nurses were present, provision was deemed fairly ineffective, inappropriate or unacceptable to young people. Conversely, young people's preferences for bespoke provision, capable of attending to very different needs, as well as the importance of confidentiality, trust and privacy was found to be paramount. More problematically, offering explicit visible provision in terms of targeted delivery, often in attempts to respond to stigma, potentially reinforced it.

Conversely, generalised provision meant specific details in relation to sex or relationship advice or education wanted by young people appeared missing. The school nurse's role and their specific input to sexual health promotion appears invisible to young people.

Significantly, there remains a continuing ambivalence over young people's actual or potential own use of their school nurse, as well as the school nurse's relevance or role in discussing sexual health concerns. Young people's lack of awareness or knowledge of the range and location of services, plus their critical ongoing concerns over embarrassment, privacy and anonymity of use are similarly evidenced in the literature (Hayter *et al.*, 2012; Brewin *et al.*, 2014; AUTHORS 2015).

In relation to listening to what young people want and having them involved or participating in that agenda, our study shows young people clearly know what issues and concerns are

important to them. They know what they would like to see happen to improve current school-based sexual health provision. This apparent mismatch between what is provided and what young people want further suggests the importance of meaningful engagement in this sensitive area of work. There is a need to respect young people's views and preferences over sexual health provision in it being both present and available, but private and discrete.

Overall however, and within the context of complex legislative change in England, our findings show little has changed and that challenges remain regarding young people and school-based sexual health services and school nursing. More importantly, it would seem young people's views and experiences, though well-known, appear to be having very little effect or impact on shaping sexual health provision in school or in influencing school nursing. Again participation has recently been noted as being mostly tokenistic or minimalist in approach in school-linked sexual health (Hayter *et al.* 2012). This lack of meaningful participation is becoming ever more problematic as the current policy context similarly endorses young people's active involvement and engagement in sexual health provision (PHE 2014). Despite the fact that many schools appear to engage with a rhetoric of youth participation, in the school's decision making, in practice, and from our study, their views appear not to be taken into account when it comes to design and delivery.

Explanations for the mismatch between young people's involvement and engagement and what is provided often produces calls or demands for more effective school nursing, or improved management or organisation of a service; what might be termed more 'technical or instrumental' fixes. In order to more fully understand the underpinning logics for the continuing mismatch and to explain the apparent resistance to not only listen to young people

but to involve them and to act on these views, we turned to contemporary critical perspectives on sexual health (Attwood & Smith 2014; Simovska and Kane 2015). Like others, we suggest the mismatch may be more fully understood or explained as a continuing embodiment of conflicting societal fears over young people's sexuality (Attwood & Smith 2014, Hayter *et al.* 2012). This manifests as sex and relationship education that unhelpfully continues to focus on prevention, avoidance and abstinence messages, when instead young people want more discussion of pleasure, desire and knowledge on navigating or negotiating relationships, importantly including questions or discussion related to all sexualities.

Drawing upon critical perspectives on sexual health helps conceive of young people as actively producing and participating in 'sexual health cultures'. This moves from the fear or the pathologising of young people's actions or behaviours to focus on the ways in which sexual knowledge, values and norms are constructed and struggled over. This approach shows how sex is depicted in every day life, which in many schools is still frequently heteronormative (Formby 2011, Attwood & Smith 2014). However, what is less noted or acted upon is that young people's sexual health cultures are first and foremost, sites of participation, negotiation, reproduction, resistance and challenge (Formby 2011). To draw on this perspective suggests an important theoretical and cultural shift is needed in school-based sexual health and underpinning notions of sexual health promotion. This shift relates not only to endorsing positive cultures for responding to young people's sexual health needs but crucially recognises and requires their active participation and involvement. This recognition of involvement as core to any conception of positive sexual health cultures would ensure young people's views, experiences and preferences must be meaningfully embedded in service commissioning, design and delivery. This shift would involve schools and school

nurses especially prioritising the participation of young people to enable their values, norms and beliefs be heard. It is a shift that would ensure young people feel enabled to negotiate with, navigate or challenge normative cultures to ensure positive, and non-normative, sexual health cultures flourish.

Convincing young people that their views are valued is the first step. This would entail involvement and engagement that is central rather than peripheral, is ongoing and not just tokenistic or symbolic, and that ultimately creates shared visible spaces, as members of peer steering groups, school committees, even timetabled sessions, to challenge and change normative service design and delivery. One important caveat to advocating visible shared spaces for this exchange of views is the need to be mindful of current school-based cultures. Homophobia, racism and/or sexism, for example, are known to exist (Fromby 2011, Whitten & Sethna 2014). There is a need therefore to avoid naive notions of involvement or inclusion, but instead work to create and cultivate safe spaces, together with young people (AUTHORS *et al.* 2016).

In considering the limits of our research, it is of course possible that young people's awareness and views were influenced by their perceived need; in other words, some young people may not have paid attention to knowledge and/or communications about the school nurse simply because they felt they did not have need to do so. A further limitation is that the sample was predominately White British, with very small numbers of other white and non-white minority ethnic participants (see Tables One & Two). Although this was representative of local demographics, a further limit is that it was only one location, whereas some schools nationally may be more committed than others to sex and relationship education. Nor have we sought

the views of school nurses which would be a very necessary next step given the current policy context. But a key strength is the range of young people involved and engaged in meaningful ways in this study and that young people were recruited not just from schools but from a range of settings relevant to school nursing sexual health provision. Importantly, any future research would benefit from extending this participatory approach.

## **CONCLUSION**

The importance and potential of any school-based sexual health service inclusive of school nursing cannot be over stated, yet as this study shows, significant challenges remain. In England, given the complex policy context that now exists regarding the funding and delivery of sexual health improvement, judgements over efficacy and acceptability may become more difficult to discern. Listening to young people's views, preferences and experiences of sexual health may help with this. Moreover, it is clear school nurses have a key role in engaging young people and moving discussions regarding sex beyond risk and avoidance towards norms that view sex as a positive integral part of young people's lives and wellbeing.

## **RELEVANCE FOR CLINICAL PRACTICE**

School nurses and schools, together with commissioners of sexual health provision need to develop positive cultures, as well as systems, processes and practices that fully support diverse, non-normative understandings of sexual health. There is also a need for cultures that enable respectful listening and the active involvement of young people in the development of school-based sexual health provision. Young people's views on what makes sex education effective may differ considerably from the policies dictating school nurse provision. School nurses need to be prepared to critically challenge these normative

approaches to ensure attentive, respectful and affirming and safe encounters and experiences for young people in seeking to secure positive sexual health experiences and relationships.

The school nurse service should be highly visible to young people in schools but this assumed presence needs regular scrutiny. Although this suggestion for greater visibility is compromised greatly by the deeply damaging cuts to local authorities and the public health budgets (Kings Fund 2016), which potentially seriously undermine school nurses future efforts to promote school-based sexual health improvement (RCN 2016).

However, school nurses are best placed to support and lead a school's meaningful participation agenda in delivering sexual health improvement programmes. This would engage and involve young people in developing and delivering or advocating and supporting services in line with their needs. Together, school nurses and young people can establish processes and systems and trusting relationships in order to listen to young people and prioritise their needs, preferences and interests, which can pay attention to intersectional nature of difference. More specifically, school nurses can engage and involve young people through health promotion school councils, student feedback and opinion surveys for example or for school nurses specifically, the use of text messaging, trained staff on site, and further publicity on their full role and remit for young people (AUTHORS 2015).

Crucially, competent, appropriately trained and trustworthy/non-judgemental school nurses should form part of a multi-professional team that aim to create safe and secure environments that ensure appropriate confidentiality, privacy, accessibility and

approachability. A proactive school nurse approach here might require initiating update or training for all school staff. As importantly, school nurses' responses to the prevalence of discrimination and violence young people face in navigating their sexual health requires a specific skill sets and knowledge. School nurses are well placed to promote zero tolerance towards such damaging, discriminatory practices, whilst at the same time ensure the repeated call for confidential settings for students to disclose or share their concerns (AUTHOR *et al.* 2011, AUTHORS 2016, Pigozi & Bartoli 2016).

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