FROM OUR CONSUMER CORRESPONDENT

What did you do at school today dear?

Susan Quilliam

Background
Here’s an interesting eye-opener on the changing face of British culture. While most adult Britons probably got their first insight into sex via an embarrassed parent, a giggling friend, or a fumble behind the bike sheds, today’s younger Brits apparently learn most about sex while sitting at a desk in a school classroom.

Even 5 years ago, in an initial report on sex and relationships education (SRE) by the British Schools Inspectorate Office for Standards in Education (Ofsted), the main source of sexual information for young people was identified as home-based. The most recent report – published in April 2007 and covering activity in 350 schools for 2001 to 2006 – suggests that young people now rely most on what is delivered through school-based education. As Ofsted’s Director of Education, Miriam Rosen, comments: “It is the school rather than the home that provides the moral code”. It is for this reason that I’m devoting this issue’s Consumer Correspondent article to a comment on what is happening in British schools today, though, as I hope I will show, the British situation holds messages that are relevant worldwide.

When it comes to teenage sexual behaviour, what is sown in the classroom results in a crop that is reaped in the consulting room.

But hold on a moment. Readers of this Journal are health professionals, not teachers, so why am I devoting an entire article to school-based practice? The reason is simple. Whether in Britain or abroad, when it comes to teenage sexual behaviour, what is sown in the classroom results in a crop that is reaped in the consulting room. Whatever is happening in the field of SRE is, in the most fundamental sense, very much our business.

Less than there should be
So what is happening? To be frank, less than there should be. Despite the Every Child Matters programme south of the border, and the Action Plan for Improving Sexual Health north of it, the entire UK still offers no statutory SRE provision at primary level. Furthermore, SRE provision at primary school level, and in Scotland no Home and abroad

My recent survey of SRE in European countries suggests that some do a better job than their British neighbours and teachers may be asked to deliver SRE whether or not they are comfortable doing so. Equally, heavy examination schedules and tons of paperwork mean that time may be siphoned away from the subject. As Professor Michael Reiss of the London Institute of Education commented to the BBC in the wake of the publication of the 2007 Ofsted report: “The priority in schools is the national drive towards better literacy and numeracy”. Or, to put it more succinctly, in the words of one working SRE teacher I spoke to: “We’re the Cinderella of the system”.

Consumer complaints
It’s not just Professor Reiss and the frontline teaching staff who aren’t happy. A recent survey of sexually active adults by the fpa (Family Planning Association) suggests that while only 4% of them thought their SRE was ‘excellent’, 38% described it as poor and 18% said they didn’t get any.

Perhaps even more worryingly, the young people themselves are protesting problems. The UK Youth Parliament recently surveyed 20 000 young people under the age of 18 years, and they were less than impressed with what they were getting. These young people want their SRE to be statutory. They want it delivered at primary as well as secondary level. They want it delivered by trained teachers. They want it delivered in quantity and with quality. And, perhaps most telling of all, they want it to cover not just the mechanics but the emotions of sex, how to choose it, use it, say no to it.

Young people want their SRE to cover not just the mechanics but the emotions of sex, how to choose it, use it, say no to it.

In short, young Brits are complaining that what they’ve received is “too little ... too late ... too biological”. At a time when a recent Institute for Public Policy Research study suggests that one in three teenagers don’t use condoms and that the levels of genital chlamydia are increasing by as much as 500%, I would argue this is not too much to ask.


Cambridge, UK
Susan Quilliam, BA, Cert Ed, MNLP, Freelance Writer, Broadcaster and Agony Aunt

Correspondence to: Ms Susan Quilliam.
E-mail: susan@susanquilliam.com

©FFPRHC J Fam Plann Reprod Health Care 2007; 33(4)
most include coverage of contraception and relationships. But many don’t, many have no statutory requirement at all, others offer teaching to pupils only once they have reached puberty, and some countries are even shifting towards a pro-abstinence and anti-sex-education stance.

Plus, even where resourcing and commitment seem greater than in Britain, sex educators constantly struggle to get recognition and funding. In 2006, a vote following a debate at the Congress of the European Federation of Sexology backed the contention that “sex education in schools is insufficient to support adolescents in the 21st century” so overwhelmingly that there were, in fact, no ‘nays’.

More than there could be

And therein, actually, lies the good news. Because while those committed to SRE may lack government funding, they rarely lack energy and passion. Hence there is, actually, a wealth of good practice, both from institutions – three-quarters of British schools have specialist teams teaching SRE – and from individuals – the frontline teacher mentioned earlier is just one of thousands who work tirelessly to create, write and deliver top-quality courses.

Teaching schemes have also been developed. To take just two examples, in England and Wales, APAUSE (Added Power and Understanding in Sex Education) aims to provide skills and understanding by using health professionals and peer educators, and in an independent study10 was found to increase student maturity about sexual issues. In Scotland, the SHARE (Sexual Health and Relationships Education: Safe, Happy and Responsible) pilot programme focuses on skills, decision making and role-play. And though a study11 of SHARE by the Medical Research Council found that it seemed to have little impact on pregnancy and abortion figures, nevertheless it did have a positive impact on sexual health knowledge and relationship quality.

SRE is essential, it’s vital, and in Britain it’s currently inadequate.

Organisations in Britain are also energetically involved, lobbying, calling on the government to make SRE statutory. I have talked to the spokespeople of three key British sex and health organisations – the Sex Education Forum, the fpa and Brook – and received an impressively unilateral and energetic message from all: SRE is essential, it’s vital, and in Britain it’s currently inadequate.

Worldwide? The number of individual projects is too numerous to mention. But I will add that the above-mentioned European Federation of Sexology debate created so strong an upsurge of interest that it resulted in the founding of the International Platform for Sex and Relationships Education, a worldwide network enabling teachers, youth workers and other sex educators to share knowledge, experiences, challenges and opportunities (see Acknowledgments section for contact details).

Health and education

As we review positive developments, we come back, in fact, to our own home base: the supporting of school SRE by the expertise of health professionals. The most obvious way this occurs is simply when schools signpost students onto local sexual health services such as family planning clinics for individual consultation. This is an essential piece of the jigsaw, for classrooms may be great venues for group discussion but not for confidential advice; while teachers may educate, they can’t legally issue contraceptives, treat sexually transmitted infections (STIs) or offer termination counselling. Plus, linking school and clinic is surely a logical and natural transition: the delivery of SRE, where students learn the importance of prevention and protection, should surely flow seamlessly into the delivery of that very prevention and protection.

“Supporting SRE is one of the most effective ways of improving sexual health because it strikes early and offers the possibility that students are ‘taught not caught’.”

In Britain, the aim is currently to make the links even more seamless. Increasingly, SRE programmes include modules taught by local doctors and nurses, who come into schools and present to the students direct. This doesn’t just bring added expertise into the classroom, it also breaks down barriers and makes the face of sexual health much more approachable. During the SRE lesson, students apparently find it easier to trust a health professional than a teacher, particularly a health professional who is somewhat anonymous, who doesn’t know their name, and who won’t be facing them in the classroom the next day! After the lesson the effect continues; the bottom line is that once students have seen a ‘real’ doctor or nurse talking freely and without embarrassment about sexual issues, they will

<table>
<thead>
<tr>
<th>Box 1: Suggestions for getting involved in sex and relationships education (SRE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Share the task</strong> – Get your entire practice or team involved so that one person isn’t doing all the work or taking all the responsibility.</td>
</tr>
<tr>
<td><strong>Audit your neighbourhood</strong> – Contact the SRE co-ordinator or equivalent in each of your local schools; if there is a school nurse or local teenage pregnancy co-ordinator liaise with them.</td>
</tr>
<tr>
<td><strong>Work with teaching staff</strong> – Work out together how each side can help the other towards best practice. Offer training courses or regular updates to school staff on sexual health developments.</td>
</tr>
<tr>
<td><strong>Bring students to you</strong> – Arrange small group visits to your practice or clinic, with a tour and questions. Role-play a clinic visit in situ, with you as the health professional and a brave student as the ‘patient’.</td>
</tr>
<tr>
<td><strong>Spread the word</strong> – Handouts and notice boards in both schools and surgeries should all have up-to-date details of family planning services, written in friendly, easy-to-understand language and with translation to suit local cultural balance.</td>
</tr>
<tr>
<td><strong>Widen the net</strong> – Don’t just tailor what you do to teenage girls. Boys may be less motivated but even more in need. Aim also to reach cultures that may view sexual health services as ethically or socially threatening.</td>
</tr>
<tr>
<td><strong>Be available</strong> – If at all possible make sure that your opening times tally with school lunch hours and end of day. Where a school doesn’t have a nurse, think about offering a drop-in service on campus.</td>
</tr>
<tr>
<td><strong>Flow information both ways</strong> – Get from and give schools (anonymous) feedback on particular issues you’re each coming across, such as an increased rise in a particular STI.</td>
</tr>
<tr>
<td><strong>Stress confidentiality</strong> – Of all the issues that motivate students to use sexual health services, number one is the knowledge that their attendance is confidential. Make this point clearly both in any literature and during face-to-face encounters.</td>
</tr>
</tbody>
</table>

©FFPRHC J Fam Plann Reprod Health Care 2007: 33(4) 281

*J Fam Plann Reprod Health Care: first published as 10.1783/147118907782102057 on 1 October 2007. Downloaded from http://jfprhc.bmj.com on September 15, 2023 by guest. Protected by copyright.
Sex education in schools

find it much easier to beat a path to the sexual health door when they need to.

Although, in fact, they may not need to do any path-beating, for in some schools the clinic is already on site. I refer, of course, to the existence of those stars of the education–health alliance, school nurses. Their peripatetic service to schools, providing contraceptive advice, emergency hormonal contraception and support on STIs as part of their more general brief, is of increasing importance to the sexual health agenda. In fact, according to a recent Royal College of Nursing report, 90% of school nurses actively offer sexual advice and support.12

Call to arms

That, then, is what’s being done. But finally – and even more importantly – let’s mention what needs to be done in addition. And yes, here comes one of those calls to action that, as regular readers will know, end many of my Consumer Correspondent articles.

Worldwide, we certainly need direction at governmental level to create more, earlier, better and mandatory SRE in schools. And we need teachers, school governors and parents to back the whole issue. But we also need more support from the health service to the education service: more doctors and nurses in classrooms, more students making field trips to clinics, more joint projects between school and surgery.

I do know that this sounds like just another way to add to workload and stretch already-stretched resources, and I do know how hard it is sometimes just to keep one’s head above water, let alone deal with a whole extra bundle of liaison with, and delivery to, your local school sector. Equally, I’m not criticising existing school-medic liaison, simply arguing for it in those areas where it’s not already happening.

For there is a need. Everyone I talked to in connection with this article – individual teachers, health professionals, organisations, British, Dutch, Iranian, Canadian and all points of the compass – everyone said the same thing: “Please ask your readers to get involved. Schools need medical professionals”.

The delivery of SRE should flow seamlessly into the delivery of prevention and protection.

And along with that need, there is an opportunity. Supporting SRE is one of the most effective ways of improving sexual health because it strikes early and offers the possibility that students are “taught ... not caught”.

In summary, let me bring you back to the beginning of this article, where I pointed out that it’s useful for us to know about SRE because what is sown in the classroom is what we reap in the consulting room. But let me take the metaphor even further. If we don’t actively support what is sown in the classroom, we will increasingly reap a ruined harvest in the consulting room: more teenage pregnancies, more STIs, more terminations, and more emotionally damaged lives.

Acknowledgements

The author would like to acknowledge the assistance provided by the following individuals and organisations in the preparation of this article: Simon Blake, Chief Executive, Brook (www.brook.org.uk); Maryanne Docherty, Associate Dean, Faculty of Education, Edmonton, Canada (mdocherty@ualberta.ca); Rebecca Findlay, fpa (www.fpa.org.uk); International Platform for Sex and Relationships Education (for more information contact Yuri Ohrichs – see below); Gill Mullinar, Sex Education Forum (www.ncb.org.uk/sef); Sara Nasserzadeh, independent advisor on sex and relationship education and policy; Yuri Ohrichs, sexologist (licensed by the Dutch Society of Sexology), Rutgers Nisso Group, The Netherlands (y.ohrichs@mg.nl). The Royal College of Nursing School Nurses Forum was invited to comment but did not reply.

Statements on funding and competing interests

Funding None identified.

Competing interests None identified.

References


