By reading this article and writing a practice profile, you can gain ten continuing education points (CEPs). You have up to a year to send in your practice profile. Guidelines on how to write and submit a profile are featured at the end of this article.

Sex and relationships education: the role of the school nurse

The aims of this article are to outline the nature of sex and relationships education, identify the relevant national documents and initiatives, provide a summary of the role of school nurses and highlight the benefits and limitations of using school nurse services. It also aims to answer some of the commonly asked questions about the nurse's role in sex and relationships education. After reading this article you should be able to:

1. Identify the key parts of an effective evidence-based programme of sex and relationships education.
2. Identify key legislation and guidance.
3. Describe the variety of roles that nurses can play in ensuring effective education in this area.
4. Differentiate between the role of the nurse as classroom educator and health adviser, particularly in relation to confidentiality.

Effective sex and relationships education can reduce sexual ill-health among young people (DoH 2001a). However, it is not narrowly focused on the prevention of sexually transmitted infections or reducing unplanned and unwanted pregnancy. Sex and relationships education involves lifelong learning about sex, sexuality, emotions, relationships and sexual health. It also involves acquiring information, developing skills and forming positive beliefs, values and attitudes (SEF 1999). Consequently, this form of education encompasses activity that is sustained over time, relates to children's experiences and expressed needs, is progressive and continuous, provides consistent messages, and supports children as they move from childhood through to puberty and adolescence. It prepares them for an adult life in which they:

1. Are aware of and enjoy their sexuality.
2. Develop positive values and a moral framework that will guide their decisions, judgements and behaviour.
3. Have the confidence and self-esteem to value themselves and others.
4. Behave responsibly within sexual and personal relationships.
5. Communicate effectively.
6. Have sufficient information and skills to protect themselves and their partner from unintended or unwanted conceptions and sexually transmitted infections, including HIV.
7. Neither exploit nor are exploited.
8. Can access confidential advice and support.

Research has shown that these objectives are best served by comprehensive, multifaceted sex and relationships education programmes that involve parents, schools, community agencies and professionals (DiCenso et al 2002). School-based programmes that take place within this context enable young people to convert the gains they make in terms of knowledge, skills and attitudes into behaviour (Wight et al 2002). Other research (SEU 1999) suggests...
that the UK still has much to do to achieve these goals. Expectations are low and social exclusion is high among young people in the UK compared with many other rich nations (UNICEF 2001). Levels of sex and relationships education provision are not adequate to prepare young people for life in complex social and sexual cultures (UNICEF 2001). It is clear that many schools are not fully able to meet their obligation to fulfil children’s and young people’s entitlement to sex and relationships education. Provision through the curriculum remains patchy, narrowly focused on providing information rather than coupling this with skills development, and is poorly monitored. Staff are also not supported with training (OFSTED 2002).

Additional impetus has been given to research, policy and practice development in this area by emerging epidemiological and behavioural data, which shows that the UK has one of the highest rates of conception among under-16 year olds in Europe (SEU 1999) (Table 1).

In 1998 the government directed the Social Exclusion Unit (SEU) to report on teenage pregnancies in the UK and make recommendations. The report identifies three major factors, based on international research that explain high teenage pregnancy rates (SEU 1999):

- Low expectations – teenage pregnancy is common among young people who have been disadvantaged in childhood and have poor expectations of education or the job market. However, it is also important to note that even the most affluent areas in England have teenage birth rates that are high by European standards.

- Ignorance – some young people lack accurate knowledge about contraception, sexually transmitted infections, what to expect in relationships, how easy it is to get pregnant, and how difficult it is to be a parent.

- Mixed messages – one part of the adult world bombards teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. Another part, including many parents and public institutions, is at best embarrassed and at worst silent, hoping that if sex is not talked about, it will not happen. The net result is not less sex, but less protected sex.

Coupled with high rates of unplanned and unwanted pregnancies among teenagers, the UK has experienced significant increases in the number of diagnoses of genital chlamydial infection (Table 2), genital warts and gonorrhoea since 1995 (PHLS 2001). The rises were steepest in the 16-19 years age group. Thirty nine per cent of people with AIDS in the UK are in their 20s, most of whom will have contracted HIV in their teens (DoH 2001a). Research by the Schools’ Health Education Unit indicated that young adults might be becoming complacent about the importance of safer sex, thereby increasing risk of infection and unwanted pregnancy or paternity (Balding 2001).

The sexual behaviour of young people has also changed radically in the past 30 years. National surveys in 1994 and 2001 (Johnson et al 1994, Wellings et al 2001) showed a decrease in the median age of first sexual intercourse among 16- to 19-year-olds to 16 years old, with a particularly noticeable trend towards convergence for young men and women (previously young women tended to report their first sexual intercourse later than young men). Young people are reporting an increase in the use of contraception at first sexual intercourse (Wellings et al 2001). Fewer than one in ten

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*per thousand women aged 15- to 17-years-old

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**per thousand women aged 13- to 15-years-old

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teenagers have unprotected (against pregnancy and sexually transmitted infections) first intercourse (Johnson et al 1994).

These behavioural and epidemiological data have provided the rationale for governmental focus on sex and relationships education for children and young people. Not surprisingly, therefore, the legislative framework is in part driven by a desire to link sex and relationships education with a reduction in teenage pregnancies and sexually transmitted infections. The establishment of a link might also help ameliorate the moral sensitivity of the issue, which still has the power to inflame debate, particularly in the print media (Furedi 2002). Consequently, the current legislative context is marked by guidance and law that tries to accommodate morality, values and progressive views about best practice.

Legislation and guidance on sex and relationships

The national curriculum 2000 (DfES 2000) makes it a statutory requirement for schools ‘to promote pupils’ spiritual, moral, social and cultural development, and prepare all pupils for the opportunities, responsibilities and experiences of life’. Effective sex and relationships education clearly contributes towards this task. There is a statutory requirement for schools to provide sex and relationships education, which is explained in detail in the Education Act 1996 (DfEE 1996).

Maintained secondary schools are required to provide a basic curriculum that covers ‘education about acquired immune deficiency syndrome and human immunodeficiency virus, and other sexually transmitted diseases’ (DfEE 1996). They are also required to consider whether sex and relationships education should also be accommodated in the secular curriculum and, if so, to hold policies on what the programme comprises.

There is a statutory obligation for schools to deliver information on the biological aspects of sex through the national curriculum for science. It is recommended that this should be linked to provision on other aspects of sex and relationships education in the personal, social, health education and citizenship curriculum (PSHE & C). The Department for Education and Skills (DfES) Guidance on Sex and Relationship Education (DfES 2000) draws heavily on research and recommendations highlighted in the SEU report on teenage pregnancy. Guidance is offered on the development and implementation of sex and relationships education policies and programmes. The guidance describes the role of governors, head teachers and other staff, local education authorities and parents, and indicates the action expected from those concerned. It also outlines a parent’s right to withdraw his or her child from all or part of a sex and relationships education (SRE) programme, except for those parts included in the national science curriculum. The Learning and Skills Act 2000 emphasised the need to raise pupils’ awareness of the nature of marriage and the importance of family life: it also sought to protect them ‘from teaching and materials that are inappropriate with regard to the age and the religious and cultural background of the pupils concerned’ (DfEE 2000). This focus does not represent an obstacle to presenting realistic and inclusive views about what constitutes a family, including acknowledging that children and young people might be living in single-parent households, with lesbian, gay or bisexual parents and carers, in care, and so on.

The National Healthy School Standard (NHSS) (DfEE and DoH 1999 a and b) and curriculum 2000 framework for personal, social, health education and citizenship, provide important contextual reference points for sex and relationships education. The standard is a partnership between the Department for Education and Skills and the Department of Health (DoH), based on the premise that the school is a key setting in which to improve health and education. It identifies and sets the minimum criteria for a whole school approach that will help maintain and develop healthy school activities. The framework for personal, social, health education and citizenship (DfES 2000) locates sex and relationships education within the four strands of the framework. These are:

- Developing confidence and responsibility, and making the most of students’ abilities.
- Developing a healthy, safer lifestyle.
- Developing good relationships and respecting differences between people.

All maintained schools are covered by Office for Standards in Education (OFSTED) inspections, which include the establishment, implementation and monitoring of sex and relationships policies. In addition, inspectors are required to report on the extent to which pupils display:

- An understanding of the difference between right and wrong.
- Respect for persons, truth and property.
- A concern for how actions affect others.
- The ability to make reasoned judgements.
- Moral behaviour.

The recent OFSTED (2002) report Sex and Relationships contains a helpful list of age-appropriate learning outcomes to help schools plan, assess and evaluate their programmes of SRE. It also makes the following recommendations:

- Schools should actively seek pupils’ views on the sex and relationships programme to ensure that they are meeting pupils’ needs and reflecting their levels of understanding.
Schools and parents should be encouraged to work together to ensure that the needs of all young people are identified and met.

Parents have the skills necessary to engage in the successful education of their own children.

Local education and health authorities should consider how more pupils in secondary schools can have better and more equitable access to individual advice from specialist professionals, including centres on school sites.

**TIME OUT 2**

Imagine that you have been asked to support a PSHE & C Co-ordinator to prepare a presentation for the school’s governing body, which at present is reluctant to provide sex and relationships education. Using the information from the first two sections of this article, plan the first few slides and accompanying notes to help the co-ordinator make a strong case for developing this education in the school.

**Effective sex and relationships education**

Having established a clear rationale as well as an understanding of the national context for the provision of sex and relationships education, the next step is to clarify the components of an effective programme (Box 1).

School nurses have an important role to play in helping to ensure that these components are present in the school’s programme, but what are the particular advantages that school nurse involvement can bring, over and above what can be offered by teachers alone?

**TIME OUT 3**

Consider the ways in which school nurses in your area are already contributing towards the provision of effective programmes of sex and relationships education. Write a brief summary of school nurse involvement in this area in your locality, including three recommendations for future development.

**The role of school nurses in sex and relationships education**

School nurses have had a long history of involvement in sex and relationships education. The significance of their contribution was emphasised in Saving Lives: Our Healthier Nation (DoH 1999a) and Making a Difference (DoH 1999b), and is further explored in the School Nurse Practice Development Resource Pack (DoH 2001b). The contribution of the school nurse can be viewed as a number of separate, yet interlinked, roles. There is tremendous variation across the country, and even within primary care trusts (PCTs), regarding the role of individual nurses. It is vital, therefore, that PCTs look at these roles in the context of the local school nursing service and in the wider context of local multi-agency partnerships, to establish how limited resources can best be used.

The advantages for teachers and pupils in developing the role of the school nurse in sex and relationships education are shown in Box 2.

**Health advisor** Like other professional groups, including teachers, school nurses are able to provide pupils with information about where they can receive confidential contraceptive and sexual health advice and treatment. In addition, school nurses are able to provide sexual health information and advice to pupils in ways that are not always open to teachers, who are bound by different professional codes of conduct. They can provide confidential individual information to pupils. This is a vital service, as pupils often feel unable to raise personal worries in a way that would maintain their confidentiality in a classroom situation.

In addition, pupils’ differing rates of sexual development and activity mean that it is impossible to...
CONTINUING PROFESSIONAL DEVELOPMENT

School nursing

Box 2. Advantages of incorporating the school nurse into sex and relationships education for teachers and pupils

- Nurses bring expert medical knowledge with them
- They can raise schools’ awareness of and develop partnerships with organisations and services in their local community, particularly services that are friendly to young people
- They bring knowledge of relevant national initiatives and local health priorities
- Nurses can provide sessions for parents to support them in their central role as educators

match all their needs as part of a formal age-based curriculum. The school nurse also has a crucial role to play in ensuring that the needs of children and young people with disabilities and/or medical conditions are met through their SRE, particularly when their individual needs may affect their experience of puberty and future sexual relationships. One-to-one advice and information provided by the school nurse can help to ensure that these individual needs are met adequately and questions that teaching staff are unable to answer can be answered. Sometimes the school nurse will be able to fulfil this role and sometimes their role will be to refer individuals to specialist services. Pupils should be made aware of the school nurse, so they can access him or her if needed.

Many schools now provide drop-in sessions run by school nurses who provide advice and information. Their broad remit helps maintain pupils’ confidentiality, as they are not linked specifically to sexual health. Some schools have developed guidelines for drop-in sessions.

The school nurse’s role in the provision of support and advice is particularly important in rural areas, where services can be some distance from the schools and homes of young people and public transport is limited or non-existent.

In South Derbyshire, a pilot project has been undertaken to alleviate the problems for young people who need to access emergency contraception. The project enhanced an existing drop-in service in schools and involved a school nurse with competence in school health and family planning, providing advice and counselling on a range of topics.

These included physical, psychological and mental health, alongside a variety of social issues. After consultation with the head teacher and governing body, unanimous support was given for the school nurse to issue emergency contraception. This was introduced to enhance an already comprehensive sex and relationships education programme. Consultation with parents followed. It was felt that the counselling and follow-up offered by the school nurse would be more beneficial to sexually active students than access via pharmacists. The parents, teachers and governors have been extremely supportive of the service, and students appreciate it because of its user-friendliness and accessibility.

Bodjalone, a multi-agency project in Oxfordshire with strong school nurse involvement, also provides this service in 16 rural schools.

The school nurse can also act as a referral point for and a link to community sexual health services. In one area, the school developed strong links with the local GP practice. Following meetings with doctors to raise awareness of under-16 year olds’ need for confidential advice and treatment, the school nurse makes appointments with the GPs before or after school or during the lunch hour. Another practice working with a school nurse developed a fast-track confidential method for students to access a GP for emergency contraception. Girls are given a small brightly coloured card detailing surgery opening times. If they need an urgent appointment, they simply turn up, show the card and are given an immediate appointment. The GPs keep supplies of emergency contraception and all receptionists have received relevant training.

Policy development Every area in England now has a healthy schools programme, which is accredited to the national healthy school standard (DfEE 1999a and b). The local programme co-ordinator can support schools in setting up a task group to work towards education and health improvement targets, which could include development of the school’s sex and relationships education policy and programme. The school nurse is an important member of such a task group. One aspect of the policy work might involve contributing to the development or review of the school’s policy on confidentiality. Using their health experience, school nurses can help to ensure the development of a policy cen-
Box 3. Considerations for the school nurse before delivering sex and relationships education

- How comfortable they feel talking about different aspects of sex and sexuality, and how their own attitudes and values will affect their work with young people
- The law and best practice. If a school nurse is teaching sex education in the classroom, he or she is bound by the school’s sex and relationships education policy. This includes the policy on confidentiality and the instructions of the head teacher. This is because they are acting in the role of educator rather than nurse. This would be the same for any visitor who might contribute to the programme. Before taking on this role, the school nurse has to be familiar with these policies and feel able to work within them. Further guidance for schools and visitors is provided in Forum Factsheet 8, Guidelines on the Effective Use of Outside Visitors in School Sex Education (SEF-1996a).
- Are they able to provide accurate up-to-date information? It is just as important for school nurses as it is for teachers to access continuing professional development opportunities. For example, if a school nurse is leading a lesson on contraception, it is essential that he or she has the most up-to-date information on methods available and related benefits, drawbacks and contraindications. If the focus of the lesson is HIV and AIDS, the school nurse must be clear about and prepared to answer questions on routes of transmission, HIV prevention and treatment, based on knowledge of up-to-date research data. Information on training opportunities is available from the key contacts listed in Box 4.
- Is this effective use of their time? For school nurses whose time is limited it might be better to take on a more strategic role in sex and relationships education. Other national health priorities (such as national immunisation initiatives) can divert school nurses away from this work. When this happens, relationships might need to be developed again. There is not the capacity to carry out all of the work, and it is imperative that the continuing professional development of teachers is supported. This can be done by providing expert advice in policy development or providing training and support for teachers. This will enable them to confidently deliver parts of the programme, such as contraception and sexually transmitted infections.

How is this element going to be evaluated?

Who will reinforce learning and pick up any further issues raised?

Who will take responsibility for classroom control?

How will they ensure that pupils have learnt new information, practised skills and explored attitudes and values?

What are the aims of the proposed input in terms of knowledge, skills, and exploration of attitudes and values?

Is it age appropriate?

Does it provide access to confidential specialist services?

School nurses produce profiles of school health, and can provide localised information, for example, regarding teenage pregnancy rates. They can assist schools in achieving the criteria for school achievement in relation to sex and relationships education. This includes:

- Ensuring that staff have a sound basic knowledge of sex and relationships issues and are confident in their skills to teach and discuss this area.
- Ensuring that staff have an understanding of the role of schools in contributing to the reduction of unwanted teenage conceptions and the promotion of sexual health.
- Ensuring that staff have up-to-date information on local services and how young people can access them.
- Supporting professional development through team teaching.

Classroom educator. If confident and trained, a school nurse can play a part in delivering some aspects of sex and relationships education in primary, secondary and special schools. Their role should be complementary to that of teaching staff. Schools should not rely solely on school nurses to deliver this education. Teachers should be present during sex and relationships education, because this will enable them to be aware of the context for issues or questions raised by children and young people after the session. It also helps to develop teaching skills, knowledge and confidence in this area of teaching. In addition, school nurses develop expertise in classroom management, and it is an exchange of skills. Group work and active learning methods are easier to accommodate with more than one facilitator. Careful planning of input to the programme is vital to ensure that expectations on both sides are clear and can be met. The school nurse and teacher should meet to clarify:

- Where the input of the school nurse fits in with the rest of the SRE programme.
- What do the students already know?
- Does the proposed input take account of different gender needs?
- Does it take into account different sexualities?
- Does it take into account different religious and cultural beliefs and practices?
- What are the aims of the proposed input in terms of knowledge, skills, and exploration of attitudes and values?

Who will take responsibility for classroom control?

How will they ensure that pupils have learnt new information, practised skills and explored attitudes and values?

Is it age appropriate?

Does it provide access to confidential specialist services?

Who will reinforce learning and pick up any further issues raised?

How is this element going to be evaluated?

One school nurse has developed her own sex and
relationships education game for use with Year 10 students. The game can be used with the whole class, and includes the types of dilemmas and situations that often arise with young people. The game has been used with young people in different contexts, such as pupil referral units, and also with parents. It has now been adapted to use in ‘puberty and growing-up’ sessions in primary schools. The nurse won a Queen’s Nursing Institute grant innovation award for the game.

Another nursing team in Bristol co-ordinated ‘mock visits’ to sexual health services. This was based on evaluation of earlier work that showed that, although students’ knowledge of the local services had improved, they still lacked skills and confidence to access them. The visits were arranged in collaboration with schools and family planning staff. The school nurses held briefing sessions before each visit, during which pupils prepared questions. Not all school nurses, however, will have the time or will feel capable of planning and running direct learning activities. Anecdotal evidence shows that some reluctant schools have used the school nurse as a way of excusing teaching staff from delivering comprehensive sex education. Reliance on the school nurse can lead to an over-medicalisation of sex and relationships education and can reinforce the message that sex is something that only health professionals can discuss. It can mean that relationship aspects are not adequately covered. Therefore, the school nurse should consider the aspects listed in Box 3 before delivering sex and relationships education.

Common questions

The following section offers answers to some of the questions that commonly arise when school nurse involvement in sex and relationships education is being considered. They should be discussed in the school nursing team and with the school in advance of involvement, so the school nurse’s position is clear to staff, pupils and parents. The school’s personal, social, health education, and sex and relationships education policies should address these issues.

Box 4. Key contacts

| LOCAL | | | |
| --- | --- | --- | |
| Local healthy schools co-ordinator (contact details available on Wired for Health website www.wiredforhealth.gov.uk) | | | |
| Local teenage pregnancy co-ordinator | | | |

| NATIONAL | | | |
| --- | --- | --- | |
| Brook Advisory Centres | | | |
| www.brook.org.uk | | | |
| Studio 421, Highgate Studios, 51-79 Highgate Road, London NW5 1TL | | | |
| Tel: 0800 0185 023 | | | |
| Provides a confidential contraceptive and counselling service for young people | | | |

| Department for Education and Skills | | | |
| --- | --- | --- | |
| www.dfes.gov.uk | | | |
| The Teenage Pregnancy Unit is a national organisation, and provides a relationship and development service. SEF produces a quarterly newsletter Sex Education Matters, and develops projects and publications. | | | |
| The national healthy schools website aims to provide: | | | |
| Accurate and engaging information on health for teachers and learners | | | |
| Information on the healthy schools programme, a joint initiative between the DoH and the DfES | | | |
| Information about national health policies and initiatives | | | |

The website has a section on sex and relationships education as well as links to pupil websites for each key stage: | | | |
Key stage 1 (4-7 years old) | | | |
Key stage 2 (7-11 years old) | | | |
Key stage 3 (11-14 years old) | | | |
Key stage 4 (14-16 years old) | | | |

Wired for Health

www.wiredforhealth.gov.uk

The national healthy schools website aims to provide:

- Accurate and engaging information on health for teachers and learners
- Information on the healthy schools programme, a joint initiative between the DoH and the DfES
- Information about national health policies and initiatives

The website has a section on sex and relationships education as well as links to pupil websites for each key stage: Key stage 1 (4-7 years old) Key stage 2 (7-11 years old) Key stage 3 (11-14 years old) Key stage 4 (14-16 years old) www.mindbodysoul.gov.uk

The Teenage Pregnancy Unit is a cross-government unit located within the DoH. The unit was set up to implement the social exclusion unit’s report on teenage pregnancy, launched by the prime minister in June 1999. The report is available in downloadable format on the site.

Family Planning Association

www.fpa.org.uk

2-12 Pentonville Road, London N1 9FP

Tel: 020 7837 5432

Provides information on sexual health and family planning. Runs a contraceptive education service helpline (020 7837 4044), which gives details of all clinics. Offers education and training to teachers and other professionals on sexual health. Produces sex education publications, including approved leaflets on contraception, which are available through a mail-order service.

Sex Education Forum

www.nets.org.uk/lef

8 Wakley Street, London EC1V 7QH

Tel: 020 7843 6051

SEF is an umbrella body of more than 50 national organisations, and provides a relationships and health education information service. SEF produces a quarterly newsletter Sex Education Matters, and develops projects and publications.

Teenage Pregnancy Unit

www.teenagepregnancyunit.gov.uk

Department of Health, 5th Floor, Skipton House, 80 London Road, London SE1 6LH

General enquiry line: 020 7972 5098

The Teenage Pregnancy Unit is a
Can a school nurse offer young people confidential sexual health advice? There is a clear difference between a health professional giving medical advice about contraception and a teacher or health professional giving general information about contraception in the classroom. School nurses can give confidential medical advice to individual pupils about the different kinds of contraceptive available and which one might be most suitable for them, providing they are trained and competent to do so, and they follow the Fraser (White 1995) guidelines (Box 5). Patient group directives allow appropriately trained nurses to issue emergency contraception in adherence with a local protocol. The school governing body would need to endorse this arrangement.

Can a school nurse give information to a pupil who has been withdrawn from sex and relationships education? Parents have the right to withdraw their children from all or part of sex and relationships education, except for those parts included in the statutory national curriculum (DfEE 2000). Fraser guidelines still apply (Box 5). School nurses can give any pupil information about where he or she can access confidential advice and information or can supply that information themselves.

Can a school nurse refer a pupil from school to a health service? Yes, schools will occasionally need to refer a pupil directly to a health service. Each school should have a clear system for referral that is communicated to, and understood by, school staff and health professionals. Ideally, schools should negotiate a ‘preferred’ route of referral, with alternative local health services. School nurses can help negotiate this. Schools can also provide skills development work on how pupils might access sexual health services as part of sex and relationships education.

How can the school nurse maintain confidentiality in a classroom setting? Like teachers, health professionals need to ensure that children’s and young people’s confidentiality is protected. This can be done by:

| Setting and referring young people to ground rules, including: ‘no one will be expected to answer a personal question’. |
| Using the third person, for example, ‘If you were Khaled, what would you do?’ |
| Collecting anonymous answers on paper or group ideas without identifying individuals. |
| Using sensitive role play. |
| Using case studies with invented but relevant scenarios. |
| Using distancing techniques, for example, ‘What options are open to the couple in this situation?’ |

School nurses might need some practice in working with groups in a way that protects confidentiality. What can be done if the school’s policy conflicts with the school nurse’s professional code of conduct? It is good practice for the distinction of a school nurse’s role to be agreed when he or she is initially employed, and for it to be recorded in the school’s personal, social, health education, and sex and relationships education policies. This will reduce the likelihood of conflicts in situations such as a pupil becoming pregnant.

Can school nurses distribute condoms in schools? Yes, in response to individual requests, but not in

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**Box 5. Fraser guidelines for health professionals (also referred to as Gillick competency)**

In 1985 Lord Fraser said in judgement of the Gillick case that a doctor can give contraceptive advice or treatment to a person under 16 years of age without parental consent, providing the doctor is satisfied that:

- The young person will understand the advice
- The young person cannot be persuaded to tell his or her parents, or allow the doctor to tell his or her parents, that he or she is seeking contraceptive advice
- The young person is likely to begin or continue having unprotected sex with or without contraceptive treatment
- The young person’s physical or mental health is likely to suffer unless he or she receives contraceptive advice or treatment
- It is in the young person’s best interests to give contraceptive advice or treatment

Although these guidelines are only legally binding for doctors, they represent good practice for other health professionals (SEF 1996b)
**CONTINUING PROFESSIONAL DEVELOPMENT**

**School nursing**

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**Box 6. Training needs assessment exercise**

Use the checklists below to identify your training needs.

**Part 1 – School nurse competency: contributing to school programmes**

- Experience of delivering a range of health promotion programmes to children and young people at school. [ ]
- Understanding of learning theories relevant to children and young people aged five to 16. [ ]
- Experience of involvement in peer education programmes for children and young people. [ ]
- Understanding of childhood and adolescent emotional and physical development, and major deviations from norms. [ ]
- Experience of working jointly with teachers to deliver health programmes to children and young people. [ ]
- Experience of working with schools to incorporate key health messages into core national curriculum subjects. [ ]

**Part 2 – School nurse competency: contributing to sex and relationships education in schools**

- I know and understand the context for effective teaching of sex and relationships education in terms of national guidance, the law and school policy. [ ]
- I am clear about the purpose and boundary of my role within this area. I can also ensure my role is clear to young people, while informing them where and how they can access confidential support and information. [ ]
- I have a clear understanding of Gillick competency and am able to support schools in ensuring their policy on confidentiality is clear, meets the best interests of young people, and is workable by staff. [ ]
- I have up-to-date knowledge and understanding of puberty, conception, contraception, safer sex, sexually transmitted infections (including HIV), fertility treatments and related topics. [ ]
- I have a sound knowledge and understanding of how sex and relationships education fits into the national curriculum. [ ]
- I know how to use pupil evaluation to increase the effectiveness of my teaching of this area and to inform my future planning. [ ]
- I am able to plan lessons with clear learning objectives that are consistent with a school’s scheme of work for personal, social and health education. [ ]
- I effectively and appropriately teach a range of active learning methods. [ ]
- I create a safe learning environment in my teaching of sex and relationships education for pupils, regardless of their gender, ethnicity, sexuality or disability. [ ]
- I promote diversity and develop strategies to recognise and consistently challenge prejudice, including homophobia, in my teaching. [ ]
- I support schools to involve parents and carers, governors and other external agencies in the planning and delivery of sex and relationships education. [ ]
- I periodically review the resources I use to teach in this area, and I know where and how to access appropriate new resources. [ ]
- I access appropriate support and professional development for my teaching in my local area and from national organisations. [ ]
- I reflect on my personal values and professional boundaries to be more effective in my teaching. [ ]
- I have an up-to-date knowledge of local sexual health, contraceptive and counselling services to which I can signpost or refer pupils. [ ]

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**Next steps**

**Primary care trust** It is clear that school nurses can play a key role in improving the provision of sex and relationships education in partnership with schools, parents and other members of the community. However, it is not something that school nurses should take on without consideration of the wider context of the team in which they work. Involvement should be discussed at PCT level to ensure that:

- Best use is made of limited resources.
- There is equality of provision across the PCT, not just in areas where there is a particularly enthusiastic school nurse.

A PCT could agree a minimum level of involvement for all its school nurses, such as ensuring that teachers in every secondary school receive an annual update from the school nurse on availability and a classroom setting unless agreed with the school. Distribution must also be in accordance with Fraser guidelines (Box 5). However, this should be agreed first with the school.

Can a young person under 16 years of age give consent to contraception and sexual health treatment? Yes, as long as this decision is made in accordance with Fraser guidelines (Box 5).

Can school nurses carry out pregnancy tests for pupils under 16 years, and give emergency contraception where requested without informing parents? Legally yes. School nurses doing so must work within agreed protocols. If a young person receives either of these services, she should be encouraged to tell her parents and supported in doing so. Confidentiality should not be breached except in rare cases – such as protecting vulnerable people from harm – and the young person should be told first. All schools must have a child protection policy and procedures and the school nurse is required to follow these.

How can school nurses work best with ‘reluctant’ schools? Schools often ask school nurses to deliver ‘the sex education session’. This is not ideal as sex and relationships education should be provided in a continual and developmentally appropriate way. The school nurse could use it as a way of forging a relationship with the school and should prioritise the aim of the session according to pupil need, for example, examining with pupils the meaning of confidentiality, and who and where offers confidential advice in the locality. One of the aims of the national healthy school standard is to encourage and support reluctant or less confident schools to develop policy and practice in sex and relationships education. Detailed training activities addressing issues of confidentiality are provided in a revised publication Confidentially in Schools: A Training Manual (White 1995).

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access to local counselling, sexual health and contraceptive services for young people, including the service provided by the school nurse. Where there is capacity to become more fully involved, PCTs need to decide whether all school nurses will contribute to sex and relationships education policy, and/or classroom sessions, or whether there is a need for a few specialists within the team to take on this responsibility.

**School nurse** Having read this article, you might wish to complete the training needs assessment exercise shown in Box 6 to identify your current learning needs. The first part of the exercise is taken from the DoH public health skills audit tool, School Nurse Competency 2: Contributing to School Programmes (DoH 2001b). This requires you to score your current level of competence using five levels, 1 being novice and 5 being expert. The second part of the exercise focuses more directly on sex and relationships education, and only requires you to tick the statements that correspond to your current situation.

On completion of this exercise you could contact your school nurse manager, local teenage pregnancy co-ordinator or healthy schools co-ordinator to find out about local and national training opportunities, which could help you address your identified learning needs. You might also choose to find out more about a programme currently being developed by the NHSSS, with the DoH and DfES, to accredit community nurses and other health professionals involved in PSHE and SRE teaching in schools. A pilot for nurses will begin next year, with roll-out across the country following soon afterwards. For further information please contact Wendy Arnold-Dean at wendyarnold-dean@hdo-online.org.uk or by telephoning 020 7061 3073. It is clear that effective SRE can make an important contribution to reducing teenage pregnancy and improving the sexual health of young people. It is also clear that the school nurse can have an important role to play in ensuring that SRE is appropriate and effective. It is a multifaceted role, which needs to be discussed, agreed and developed in partnership with schools, other health professionals and the wider community in each local area. It involves forging links between secondary schools and local contraceptive/sexual health services. Developing this important role in partnership with others, rather than simply within the school nursing team itself, will help to ensure that best use is made of local resources and that support can be tailored to the specific needs of young people in each area. Teenage Pregnancy Co-ordinators and Healthy Schools Co-ordinators are in a key position to promote this development to ensure that the contribution of school nurses is an integral element of a co-ordinated programme of SRE rather than a bolt on extra.

**TIME OUT 6**

Now that you have completed the article, you might like to write a practice profile. Guidelines to help you are on page 55.

**REFERENCES**


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