

Onsite Sexual Health Provision

Why do it?

Aside from the statistics presented to the Governors in July that show around 25% of our students are sexually active before the age of 16 and that half of them are not using contraception, there is a strong guidance from the Government at both Local and National levels that onsite sexual health services are the most effective. The lead on this is clear, and has not changed since the Election. The DfE still states that: "The Children's Plan endorses the value and legitimacy of on-site sexual health services by committing to "increase young people's knowledge of effective contraception and improve their access to advice through encouraging the provision of on-site sexual health services in schools, colleges and youth centres." (DCSF (as was), 2007)

The DfE also states that: 'Anecdotal evidence suggests that services based in non-clinical settings are more appealing to boys' (2010); ensuring that boys are using barrier contraception is the best way of reducing incidences of Chlamydia which is increasing in frequency across the coast. North Yorkshire County Council, the PCT and the Cambridge Centre all agree that this is the best way to secure the health and safety of our students and have all be involved in the planning and training of staff for this initiative.

Are we encouraging students to have sex?

It is likely that it will only be a minority of families who may feel this way; but to help those understand what we are trying to achieve, we have the following research:

'Schmeidl (2004) reported on five school-based condom distribution interventions (Schuster et al., 1998; Wolk and Rosenbaum, 1995; Guttmacher et al., 1997; Kirby et al., 1999; Blake et al., 2003). Findings from Schuster et al. (1998) **showed that there was no increase in the level of sexual activity at one-year follow-up.** However, **condom use increased among males, and there was an increase in the percentage of male students who had used condoms at recent first sex.** Wolk and Rosenbaum (1995) found that condom distribution in schools was three times more beneficial to a sexually active student than the risk of encouraging a non-sexually active young person to become sexually active. Guttmacher et al. (1997) reported increased

In the first wave of the tracking survey, a sample of 600 parents were interviewed. **Fewer than three in ten parents (28%) saw the provision of free contraception to under-16s as wrong. Fewer than one in five (18%) considered giving confidential contraception advice to under-16s to be wrong.**

BMRB International (2001). Evaluation of the Teenage Pregnancy Strategy. Tracking survey. Report of results of benchmark wave. January 2001.

In a representative survey of nearly 3,000 members of the general population aged 18 and over in 2000, **64% of adults agreed that contraception should be more easily available to all teenagers, including those under 16.**

Clarke, L. and Thomson, K. (2001). Teenage mums. In Park, A. Curtice, J., Thomson, K., Jarvis, L., Bromley, C. and Stratford, N. (eds) British social attitudes: the 18th report – public policy, social ties. London: Sage.

condom use in students with three or more partners in the last six months in a school with condom provision compared to a school without. Kirby et al. (1999) found that **condom provision did not increase sexual activity in students.** Blake et al. (2003) found that **students from schools with condom provision were less likely to report sexual intercourse**, more likely to receive condom use education, and **where they did report sexual activity, were more likely to use condoms [...].** Overall, **findings showed that some young people received condoms but did not use them.'**

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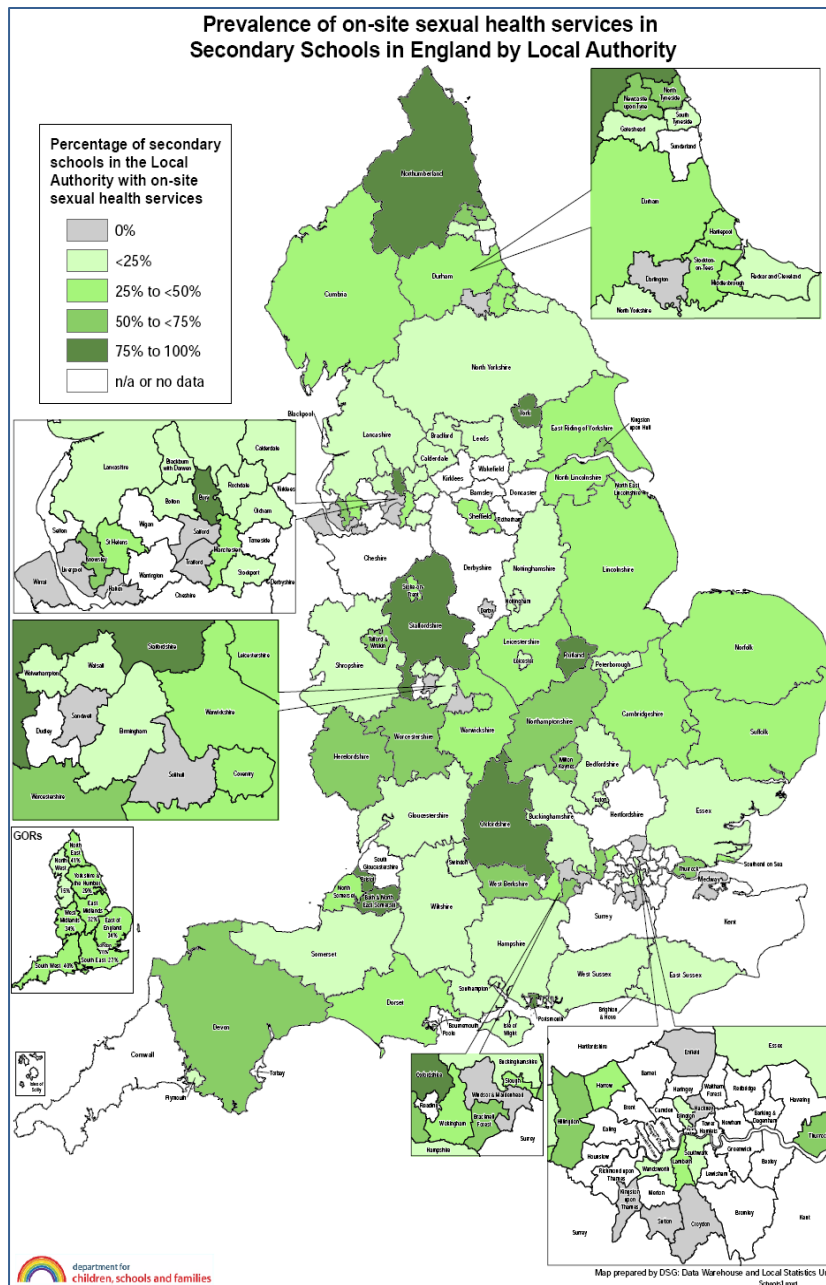
(My emphasis)

Schmiedl (2004) states that, "school-based condom availability programs were not associated with an increase in teen sexual activity, whereas data from most programs indicated increased use of condoms by teens who are sexually active" (p.19).

That is, onsite sexual health services including condom distribution **do not increase sexual activity**; all that happens is that those young people who are sexually active start using condoms. **As part of an established SRE program, onsite sexual health provision actually decreases the incidence of sexual activity.**

Who else is doing it?

We would not be alone: in 2010, the national map of schools with on-site sexual health services looks like this:



There are, as of this survey, 33 secondary schools in North Yorkshire providing onsite sexual health services. The closest to us is Whitby Community College, which offers Advanced services.

“Supported by the appointment by NHS Blackpool of a full time health mentor, Bispham High School – Arts College has set up a school based health service, including a weekly sexual health clinic. In the two years since the introduction of the clinic, only one student pregnancy has been recorded, compared to 16 in the previous two years.”