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## **Chapter 5**

### **Sites of Good Practice: How do Education, Health and Youth Work Spaces Shape Sex Education?**

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#### **Abstract**

Among professionals delivering Sex & Relationship Education (SRE) in the UK, my earlier research found that teachers and school nurses held contrasting views of SRE: most notably differing over how young people and young people's sexual activity was seen, but also in their understandings of sex education and of their own role in delivering it (Allred & David 2007). Practices in health and in education respectively gave rise to differing understandings that reflect distinct professional concerns. This chapter extends this analysis to incorporate a youth work angle. It compares accounts of sex education work from these three groups of professionals and explores the significance of their differing approaches for attributing agency to young people. I conclude that SRE operates differently within these differing professional approaches, and that youth work and health services are more able to grant what Allen (2005) called 'sexual subjecthood' to young people, while an educational understanding of 'child-as-pupil' profoundly limits how teachers understand sexualities education. This highlights the value of youth work sites and approaches for SRE because of pedagogies that are young person- and relationship-centred and therefore more easily recognise young people as sexual subjects.

#### **Keywords**

Youth sexualities, sexual subjects, sexual subjecthood, Sex and Relationship Education (SRE), relational pedagogies, youth work approaches, agency, critical pedagogies

#### **Introduction**

The tensions between sex education as approached by health and by education services in the UK were analysed by Rachel Thomson back in 1994 and the implications of these alternative approaches examined by Daniel Monk (2000). Thomson (1994) showed how schools were expected to deliver health outcomes through sex education from the 1960s onwards, and described the tension between social authoritarianism and public health pragmatism in the development of sex education in the UK. Where health approaches

dominated, the aims of sex education were defined in terms of limiting unplanned pregnancy and the spread of Sexually Transmitted Illness (STI's). Where moral discourses dominated, sex education was formulated in terms of concerns about the legitimacy of adolescent sexual activity or concerns over sexual exploitation (Thomson, 1994). These differences are still evident in the accounts of practitioners today.

Allred and David (2007) criticised the UK's 2000 Sex and Relationships Education Guidance for marginalising young people within sexualities education policy and instead addressing parents as the consumers of education, whose values schools should endeavour to reflect. The 1986 Education Act had devolved control of sex education to school governing bodies creating the requirement to consult with parents, and that it "be taught within a moral framework" (Thomson, 1994, p. 48). Furthermore, whilst value plurality is espoused, the guidance is not value-free and is instead offensively value-laden in its heterosexism and its assumption that early childbearing is necessarily problematic (Allred & David *ibid*; Corteen, 2006). Schools are a material site for engendering particular, normative values despite reference to the local community shaping the values of a school and hence SRE. It seems that education remains a moral mission, and hence a political battleground between stakeholders, on which pupils' views are rarely heard.

In contrast, health services are clear who their client is. Health professionals provide access to sexual and other health services for clients and offer confidentiality. It follows then that school nurses - who deliver collective health interventions (e.g. immunisation to year groups) and whole-class education (e.g. on sexual health, nutrition) as well as individual health consultations - should 'provide and promote confidential drop-ins' for students at school or community venues and even text or email pupils who cannot attend sessions face-to-face (DH/DfES 2006). They must be "aware of confidentiality issues" and that under-16s have the right to contraceptive services without parental consent [and] "ensure the school policy on confidentiality is clear, [and] meets the best interests of

young people” (ibid., 23). Their professional guidance is clear that young people may have sexual health needs and have the usual right to confidentiality of anyone using health services. However it has on occasion been represented in the UK popular press as encouraging young people to have sex and undermining the role of parents, suggesting that it remains contentious in the UK to address young people as sexual subjects (Allen 2005).

This chapter develops this earlier comparison of educational and health approaches to sexualities education by adding a third perspective, that of youth work. Youth workers, operating across differing sites, times and communities, have shared the aim of supporting the personal development of young people as human beings (Bessant, 2009) and youth work has been described as grounded in education that is informal, conversational and critical (Batsleer, 2008). Unlike education and health, youth work as a sector is founded on the principles of voluntary and respectful engagement of young people and seeks explicitly to promote their empowerment (Davies, 1999, p. 2010). In 2002, after wide consultation, the National Youth Agency (the UK’s youth work accrediting body) published what it considered a ‘consensual and strongly supported statement of youth work’s values and principles’. According to this statement, ‘youth work is informed by a set of beliefs which include a commitment to equal opportunity, to young people as partners in learning and decision-making and to helping young people develop their own set of values’; it entails working with young people ‘to help them make informed choices about their personal responsibilities within their communities’; respecting and promoting young people’s rights to make their own decisions and choices, and promoting social justice for young people and in society generally through encouraging respect for difference and diversity and challenging discrimination.’ According to these principles, everyone involved in the service (as managers, policy makers, trustees, employees, volunteers) should share a “belief in the capacity of youth work to help young people themselves learn to make moral decisions and take effective action” (NYA, 2004, p. 4).

Thus, whilst many UK-based youth workers (like their colleagues elsewhere) are explicitly informed and inspired by critical pedagogy and Freirean approaches to community education for social change, even state-funded services put recognising and promoting young people's agency at the core (Cullen 2013).

### **The studies**

This chapter brings together material from two studies. The first was a two-year study with Miriam E. David and Pat S. Smith that sought to raise the status of PSHCE ('Personal, Social, Health & Citizenship Education') in order to improve school-based SRE across an English region (Alldred & David, 2007). It was funded by the UK's Education department to (meet a health agenda to) reduce teenage pregnancy rates. I interviewed (twice each) the 17 teachers with responsibility for SRE, usually as the secondary school's PSHCE Coordinator, and gathered accounts from the 15 school nurses serving these 17 secondary schools and their feeder schools.

Here I add material from subsequent unpublished research: the 'Sites of Good Practice' study that I conducted in 2009 with approval by Brunel University London's Research Ethics Committee. This later study interviewed 12 youth workers who were engaged in sexual health work with young people, though whether they called this 'sex education', 'sexual health information' or otherwise was one of the issues for discussion. This third group was recruited with knowledge of the findings from the other two groups, in a small study explicitly framed as seeking 'to extend [the inter-professional] comparison to understand how youth workers approach sexual health or sex education-related work with young people' (Participant Information Sheet). They were asked more directly than the previous interviewees about the principles and personal or professional values that informed their work. Interviews were similarly semi-structured and responsive in order to gain a broad sense of their work and their approach to it.

In what follows, I consider each practitioner group in turn through excerpts from interviews that illustrate how they approached their work. I admit that professional identities are a fiction in terms of their being indefensible unitary constructs (Stronach et al., 2002) and universalizing groups problematically (Davies, 2010), but I wish to capture ways in which the material practices of each role provide for certain logics that produce ‘young people’, ‘young people’s sexual activity’ and the task of educating about sexuality differently. I link what professionals said with their guiding policy statements. The subsequent discussion evaluates these different approaches to professional practice and draws conclusions about the implications for sexualities education work with children and young people.

### **Teachers and the educational approach**

UK state schools should deliver comprehensive SRE ‘within a values framework’, and not abstinence-only education. The Introduction to the Guidance (2000) locates SRE within PSHE, to help pupils deal with “difficult moral and social questions” (ibid, p. 3); to “support young people through their physical, emotional and moral development” (ibid); to learn the “importance of values and individual conscience and moral considerations” (ibid, p. 5) so that they “make responsible and well-informed decisions about their lives”. Education’s role in the production of responsible citizens filters through to the issue of sexuality.

Many teachers in our study saw discussing sexuality with children and young people as parents’ responsibility. They reluctantly accepted the need to make up for parental deficit but were anxious about criticism of their personal values, and were uncertain about professional values and boundaries, and constraints from school rules and national policy, and were therefore extremely cautious. The centrality of values made them

more, not less anxious compared with the rest of the curriculum. The way this risky subject produced anxiety among adults was why one teacher planned to resign the role:

*It's a lot of hard work, very little appreciation from anybody... And because there's a lot of staff who don't feel comfortable teaching it, you're the one who gets it in the neck at the end of the day ... Where staff or pupils aren't happy about it, or are threatened by it, it can come out in aggression (*

PSHE co-ordinators felt burdened by the role and reported little recognition of its importance or of their responsibilities. They described PSHE as “so low on everyone’s agenda”:

*Everybody says it's important, but you're under pressure to fit everything else in, and PSHE, as non-examined, gets squeezed.*

We documented the low status of SRE, and its competition with high status academic subjects within the National Curriculum which left it poorly served for resources and time, sometimes conflicting with a teacher’s ‘official’ curriculum subject: one teacher described “stealing” time to prepare PSHE lessons. Low status meant less staff training and material resources for SRE which seemed to impact on staff confidence. Our interviewees themselves were confident discussing sex and relationships, but they recognized the reasons others were not:

*Being under-prepared for it is horrible: I think the biggest fear as a teacher in a situation like that is being asked a question that you just don't know how to answer.*

As in Buston et al’s (2001) findings in Scottish schools, the words ‘difficult’ and ‘uncomfortable’ and their derivatives featured heavily in coordinators’ reports of how other teachers found materials. As in Preston’s work (2013) work with teachers in the USA this made the task of SRE ‘very, very risky’ indeed.

In addition to SRE being a necessary compensation for parental neglect of a difficult topic, they viewed it as a response to social pressure that young people felt to be 'sexy', attractive and sexually available. Popular expressions of outrage or concern about young people's sexual activity led to anxiety at all levels in school, for parents and governors, and was felt acutely by coordinators and form tutors. This coordinator reported staff views that question the curriculum and the legitimacy of the topic:

*Some staff would argue as well that Year 9 pupils are too young and some of them aren't ready for sex education. And fair enough, there's probably 3 or 4 that are very young Year 9s, but there's some who need it in Years 7 and 8. Some staff argue it's not their job, it's the parents' job. And there's a whole range of reasons ... You should get the whole staff group in and they'll tell you just why they shouldn't have to teach it! It's not a popular subject! People do it reluctantly, even the staff that don't feel uncomfortable with it ... with the training and planning the way it is ... they feel under-prepared.*

References to age appropriateness in interviews are frequent, unsurprising given the popular concern with 'sexualisation' which is reflected almost hysterically in the SRE policy which refers to it frequently, echoing anxieties attributed to parents that pupils hear 'too much, too young'. A developmental model of the child pupil is evident not just in the overt age-stage discourse (Burman, 1994a), but also in repeated references to students' maturation: "the emotional and physical aspects of growing up" and "the challenges and responsibilities that sexual maturity brings", pupils' 'changing bodies' and 'preparedness for puberty" (DfEE, 2000, p. 25). In other areas of education, a pupil's readiness to learn might mean earlier introduction might not be effective, but does not amount to anxiety about 'corruption'. Here the anxiety outstrips any evidence for concern.

The notion of the pupil has been understood as making the task of educating about sexualities more difficult in schools (Monk 2000; Paechter 2006) because it constructs them as children and as ideally non sexual. The decision making in which they must be well informed, value lead, confident and responsible is implicitly located in the future at a safe distance from the pupil now. Their own sexualities are carefully projected onto their future selves and education is oriented towards their future well-being.

### **School nurses and the health approach**

The school nurses saw themselves playing a key SRE role within schools, one clearly distinguished from the teacher's role. They spoke with remarkable unity about their professional practice, specific training and competences in sexual health and delivering sexual health education to young people. Their role as health professionals was to give information individually to students and to whole classes. As health educators, *sexual health education* was increasingly their primary focus (as opposed to hygiene, drugs or alcohol), and they had confidence in their knowledge of sexual health, emphasising their specific training. They saw themselves as *sexual health experts*, despite school staff sometimes viewing them as the 'nit nurse'.

Nurses' roles in schools varied, but usually included drop-in sessions for individual consultations and the delivery of Year 7 and 9 (aged 11-12 and 13-14) SRE lessons. They were rarely involved in curriculum design, despite their training for this. School nurses felt of low status in schools, which we interpreted as reflecting the general institutional esteem for the mind relative to the body (Paechter, 2006). One nurse described being "allowed" to sit in a "cupboard" to run her drop-in, and lamented the message this gave young people about the importance of the issues they were discussing, another said pupils "had to brave a corridor of power" to knock on her door. However nurses' exclusion from discussion of



the curriculum showed both lack of recognition of their training as sexual health educators, and what seemed like a territorial demarcation.

A major plank of school nurses' work was to support a national campaign to reduce teenage pregnancy rates. Some of the nurses welcomed this national agenda and hoped that funding would follow; some explicitly sought to reduce unplanned conception, but all rejected the evaluation of their service by area conception or pregnancy rates:

*I don't consider I've failed if a girl gets pregnant as long as she's got pregnant because she knew where advice was and chose not to access it.*

They all emphasised informed decision-making:

*I want them to be able to say to their boyfriend who says 'I'm not using a condom because they don't work, they split', 'If you use them properly they are very reliable'. I want them to be equipped with that information. I am there to give them the information, and they act on the information.*

*What I'm interested in is: at the point they got pregnant, had they got all the information that they needed? Could they have prevented it had they wanted to? Whatever choice they make, as long as it's an informed choice and they make it because it's what they want to make, I've no problem with it. [...]*

Nurses saw themselves as providing up-to-date, accessible medical information that empowered pupils to make informed decisions, without moral judgment. Whether they conducted whole class sessions or individual consultations, young people were their clients, and their provision was young person, rather than school-centred.

*I don't just pick out the pregnancy bits. I think it's equally important that they know how to protect themselves from sexually transmitted diseases. They get a lot of*

*mixed messages and I want them to know there is somebody there that they can talk to, who won't tell their parents and who will point them in the right direction. That it is confidential.*

As health professionals, the nurses were clear they provided a confidential service for individual students. The principle of 'the child's best interests' and the primacy of their client's needs guided their work: pupils, as 'young people', were entitled to access services. This approach could bring nurses into conflict with school staff. Those working in faith schools felt they were viewed with suspicion and their work limited to delivering 'biological facts'. Several felt self-conscious talking to pupils about contraception and abortion, but were clear that their professional codes meant that schools had nothing to fear - they did not *advocate* abortion or condone under-age sex, but simply *provided medical and legal information*, which young people had a right to know. Their information-giving remit was important in defending their work.

Confidentiality was consistently raised as the key to young people's decision to use services or for pupils using 'drop-in' clinics. Nurses' clarity about confidentiality contrasted with teachers' uncertainty about their legal and professional responsibilities. This seemed to obviate the anxiety that sexuality (whether consensual sex or sexual abuse) elicited in teachers. Nurses argued that teachers' 'muddled thinking' and conflicting loyalties to pupils, parents and school, with the balance of power in favour of school and parents, led them to disclose pupils' concerns inappropriately. One assistant head-teacher had expected a nurse to report to him what a pupil had discussed in a consultation; two deputy heads asked nurses to breach client confidentiality; and one nurse described her refusal to do so as the end of her positive relationship with her school's senior management team.

For health professionals then, the young person was clearly understood as the client and was constructed as having agency and decision making capacity. They could have legitimate health and sexual health needs and – especially – questions about sexuality and sexual health. This agency contrasted with the teachers’ accounts, in which young people, framed as ‘pupils’, tended to be viewed as passive in the face of external pressures to be sexual, devoid of agency or sexual desire themselves.

Recognising young people’s sexual agency, was not to assume they were all sexually active, nor contributing to the pressure to be so, but it was to be unabashed in approaching them as potentially sexually active, perhaps soon to become sexually active and allowing them to raise concerns about sexuality. It did not mean nurses over-estimated sexual activity among young people. They had a clear sense of how sexually active young people were and recognised peer pressure around this, and so embraced dispelling myths within their SRE. One said:

*Most of the children aren’t doing it [having sexual intercourse], but are made to feel it’s not normal if they’re not.*

Granting young people both sexual and moral agency was to recognise their *potential* to be moral and sexual decision makers, and to see the role of sex education as enabling them to make informed life choices. Nurses’ information-giving role was contrasted with the morality of situated decisions that young people themselves had to make. These decisions might be future ones but for some young people they were in the present.

### **Youth workers and the youth work approach**

The second study that I shall report here sought youth workers’ views on SRE. For these professionals, their work around SRE was called different things with different groups. When working with youth groups or in schools, it might be ‘sexual health and relationships’, at other times ‘sexual health and self-esteem’ work. All of them provided

both group work and 1:1 work with young people, framing them both as supporting young people's well-being. I asked youth workers directly what principles guided their work on sexual health:

*Openness, [being] non judgemental, inclusive.*

*the majority are the principles of PSHE – balanced life education for young people, the ECM principles, like staying safe and being healthy.*

*The general youth work principle of giving people the choice and the chance to make informed choices. And the principles of informal education, certainly as regards delivery style, etc.*

*Helping them with their self-esteem because how they feel about themselves is at the base of it.*

In addition to considering how they viewed their role in general, I wanted to know how they viewed sexualities education and how that shaped their role in relation to young people:

*Giving young people choices, by letting them know about what services are available and choices about the sex they chose to have and who with.*

Another explained his role as:

*raising young people's awareness of the range of decisions and choices open to them around sex and offering opportunities for discussion and debate on the implications of particular choices; offering learning opportunities for young people to develop their capacities and confidence in making decisions...;*

*respecting young people's choices and views, unless the welfare or legitimate interests of themselves or other people are seriously threatened.*

Responses to these questions offered an indication of how their professional practice produced the objects of 'sexuality', 'the young person' and 'sex and relationship education'. One worker, in describing the aim of his work, referred to gendered young people:

*to get young people talking about sex and relationships. To see choices around the sex and relationships that they have or could have. To get young men to take responsibility towards young women they see (in relation to relationships, consent, sexual health etc.)*

One made the point that embarrassment inhibits young people's ability to make informed choices. Her job was that of:

*Making it less embarrassing. Sex is part of a healthy life. We don't talk about sex with young people enough, or at the right ages, so, ... openness is key... Meeting young people where they're at, which is what my youth work practice has always been about, and why you need to meet a group first' [before you can run a sexual health session]*

Another, commented tellingly that she was:

*not trying to protect them from sexuality*

These comments show how youth workers normalised discussion of sex rather than treating it as a likely problem for young people or for themselves to discuss with them, and they did not present the task as anxiety-provoking for themselves or fellow youth workers.

In terms of how they saw 'young people', comments included:

*[I] See them as potentially sexually active, especially from year 10 upwards.*

*I see them [service users] as young people, definitely, even when they're in school.*

*They start to call me 'Miss' cos they're in school mode, but I'm not their teacher.*

In comparing their role to that of teachers or school nurses, youth workers volunteered comments like:

*Schools are crying out for youth workers to do sexual health work, because they don't feel they have the right experience or training to do it themselves and they acknowledge it's a better approach that youth workers take.... [Our approach is] More informal, more fun, using different tools, more games and more input from young people. More responsive.*

*Openness in discussing gender and trans-issues - even gay teachers shy away from this.*

Like the nurses, they felt that they were sometimes invited into schools 'after the horse has bolted':

*It's sometimes a 'bit too late': they're already sexually active or [are] young fathers etc) This illustrates how failing to recognise young people's sexuality and potential sexual agency results in a post-hoc response that tends to be responsive to negative consequences, or perceived negative consequences.*

The account youth workers gave consistently was unhesitant in recognising young people as *sexual subjects*, potentially sexually active and with desires, fantasies, experiences (perhaps with other people). Granting *sexual subjecthood* in this way meant recognising young people's agency, not as *tabula rasa* to have values inculcated in them by education or even to be taught; but people with their own values, dynamic processes of reflecting on and forming their views, and potentially with sexual knowledge (and experience); and potentially with their own sense of themselves as sexual subjects. Sexuality is on the table for discussion in the present, not only to inform their future selves, and as an object of potential development, relation and positive experience, not only as an activity risking negative consequences.

#### **Discussion: professional practice and youth agency**

The data from these two studies suggest that education, health and youth work practitioners' perspectives on SRE are powerfully influenced by their underpinning professional philosophies, and their material practices within institutions such as schools, and these have differing consequences for how young people are viewed, how sexuality itself is seen and how their role in sexualities education is therefore understood. Most importantly for the present discussion, there are implications for the recognition of young people's sexual agency.

UK schools are dominated by the achievement agenda, which has de-privileged social justice concerns or even pupil well-being, in favour of a narrow focus upon academic attainment (McNess, et al., 2003). League tables that rank schools by examination success in academic subjects produce schools with little time for non-league table subjects like sexualities education or PSHE. Education about (and care of) the body is relegated as a result this concern with the cerebral. However teachers and nurses operating in the school

context mobilise differing understandings of young people, of sex, and of sexualities education.

For teachers, pupils are people who are taught and who they hope will achieve on the curriculum they set. They are ideally ‘non sexual’, but will face challenges, make decisions, and ‘take responsibility’ in their future lives. This formulation of pupils’ *future* sexualities side-steps the moral dimension to SRE, as it allows for pragmatic delivery of sex education in the present, deferring moral concerns about the application of this knowledge in future decisions.

School nurses operated within this school context but framing their practice within a health approach that instead treats pupils as clients, with individual needs, and with individualised responsibility for rational choices in their self-interest on the basis of the information provided. Sometimes the school system is able to embrace the health approach via a health promotion logic that foregrounds information and knowledge as the way forward. However, the extent to which a school nurse’s ‘client-based’ perspective can be brought to bear within a school setting is limited, not only by the dominant perspective of education managers that tend to marginalise school nurses, sometimes undermining the confidentiality of consultations, but also because of their limited involvement in assessment and in developing the SRE curriculum.

Youth workers are similarly oriented to the young person and their particular needs, but also their choices, which includes about engagement with the service or not. If a health approach risks assuming that individuals will make rational decisions on the basis of medical information, youth work explicitly acknowledges young people’s autonomous use or disregard of advice. Showing its critical pedagogy roots, youth workers know that education starts from ‘where someone is at’ and cannot be *done to* or *given*, even with the best of intentions. With a greater focus on the processes of discussion and reflection it seems that youth workers might support the dynamic and on-going processes of thinking



through ethical choices, developing and revising positions and possibilities for action. They will judge success by process not outcome (Batsleer, 2008; Davies, 2010) despite pressures otherwise that echo those on school nurses and teachers.

References to sexuality in education are dominated by issues of STIs, abuse, ‘unwanted’ pregnancy, underage sex, criminal or ‘promiscuous’ sexual activity amount to the familiar ‘scare tactics of sex education’. The health promotion (or safeguarding) emphasis on equipping pupils to avoid physical and emotional harm contributes to the negativity around sex and constructs individuals as personally responsible for preventing harm to themselves. Whereas teachers’ accounts tended to present sexuality as a difficult subject, and sexual activity a risky business that amounted to an overall negativity about sex, nurses were matter-of-fact and able to discuss sex neutrally, presenting information about medical risks and also the logical options for risk reduction or harm minimisation. Youth workers provided the most sex-positive accounts, and were able to discuss the positive contributions sex might make to relationships or well-being, as well as the risks to health or self-esteem.

These different views of young people and the general sex negativity/positivity had consequences for how sexualities education was understood and their role in it. While for teachers, sex was a negative topic making SRE a ‘hot potato’ that could burn them and bring professional risks for them, with some doubt apparent over the legitimacy of the curriculum, for nurses it was wholly embraced as a legitimate, indeed core, responsibility of theirs, within the apparently morally neutral framing of information-provision. For youth workers, sexuality was a part of life in which they saw relevance for individual well-being and social justice agendas, both of which were their professional business. As regarding legitimacy of discussion with young people, it was just another topic that if it was on young people’s radar, was on theirs too.

It seemed therefore that the school nurses and youth workers granted agency, both sexual and moral, to young people more than the teachers' accounts suggest because first, they had information-giving roles and did not expect to inculcate particular moral values, and second, because they were clear about who their client was, so addressed young people and their current concerns directly, were confident that they could offer them confidentiality and accept that they determine the outcome. The implication of youth workers' approach was that young people might open or close discussions about sexuality, and might opt in or out of sexual health education. In practice, a range of framing devices could be deployed and discussion of *well-being*, *respect* or *making difficult decisions* could be the entre to reflecting on intimate relationships if young people lead the discussion in that direction, as they often did. This illustrates how granting autonomy to young people might well result in discussions that ticked the sexualities education 'box' (youth workers are required to audit their sessions also) only in a way and moment and framing that suited them.

Negativity about young people's sexuality produced anxiety for school-based practitioners which meant that the task of SRE often became sex negative in teacher-led SRE and potentially also in the class sessions on STIs that schools asked nurses to provide, which could lead to SRE simply missing young people's agenda and interest. As Allen argued: "When young people receive the message from school that sexual activity is predominantly about danger, guilt and risk while elsewhere it is promoted as involving fun, pleasure and power, sexuality education's warnings can appear didactic and boring" (2005, p. 169). Furthermore, this stance on accessing sexual health information and services is not *for* young people, and is not therefore "underpinned by an understanding of, or a desire to afford rights to children" (Corteen, 2006, p. 93). The challenge lies in making responsible teaching about sex, including STI risks, 'sex positive' and making sex

positivity sensitive to the pressures it can create, helping young people question some of the gendered 'rules' governing sexual pleasure, and in making SRE more practical.

### **Concluding remarks**

Sexualities education is itself transformed within these differing approaches; youth work appears most able to grant what Allen (2005) called *sexual subjecthood* to young people, and viewing children and young people as *pupils* profoundly limits what teachers feel can be done in SRE. This seriously compromised the school as a site of good practice for sexualities education in this research and highlights the need for sex positive approaches within sexualities education.

Health professionals were clear what entitlements accrued their clients, in contrast to schools' anachronistic orientation to parents as consumers of education. Youth work, like health, is concerned with ensuring young people are well-enough informed to take decisions about their own sexual health, but arguably is more broadly concerned with young people's empowerment to make choices and to develop their capacities and values to do so. This is unsurprising given that youth work as a profession centres on an overarching concern with young people, of which sexual health is but one area to apply these principles. However, youth work's concern with social justice, not just individual well-being is to be celebrated. In relation to SRE, the specific implications of this are illustrated in how the youth workers justified making interventions against homophobia, whereas teachers sometimes felt they had to wait to respond to the needs of individual pupils for support around sexual orientation. School-based SRE is seriously limited by this pastoral, rather than social justice framing of sexual diversity (Alldred & David, 2007). The youth workers were often doing value-based work in either classroom or youth work settings, that was distinct from but supported one-to-one work.

Overall, a youth work perspective has something particular to offer the framing of professionals work on sexualities education. First, in its concern for social justice or wider community benefit, in addition to the wellbeing of the individuals using a service, it illustrates how education need not be individualistic or narrowly focused. Second, in its pedagogies of relational and youth-centred approaches, it is able to respond to the agendas, needs and interests of particular young people and hence to recognise and attend to their diversity rather than assuming particular needs for sexual or potentially sexual being. Third, in recognising youthful sexualities, rather than an *a priori* subject imagined ‘innocent of’ sexuality and being formed morally for their sexual future, actual and current issues can also be addressed. The ability to recognise young people’s agency in both sexual and non-sexual ways shapes the pedagogic relation in ways that are conducive of a respectful and thus productive relationship.

A frank, fearless, feminist, embodied sexualities education must start from young people’s own agendas and interests, be honest about the pleasures *and* risks, of sex and must empower young people to achieve positive sexual lives, and to have agency and reflexivity in their ‘sexual careers’. It should be pleasure-, intimacy- and relationship-enhancing and help them to be critical of cultural norms and pressures about sex and sexuality – a critical values education, not moralising or value-presumptious. To adequately address concerns over sexual exploitation, it has to recognise the legitimacy of young people – or children’s - sexual activity or interest. Only this can adequately support young people to be empowered in their sexual careers.

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