Chapter Seven

Policy change and future prospects

Introduction

As is the case with any area of policy, continuity as well as change and development are common features. The main policy areas that have been considered in this thesis have witnessed a great deal of continuity throughout the 1980s and early 1990s. The mid-1990s was however, a time of change in both Finland and Scotland and this chapter explores both the direction of those changes and their implications for the future.

Each policy area will be considered in turn, detailing the changes that have occurred within the national framework and at the local level of implementation. This is followed by discussion of the potential implications of the changes on the future rate of teenage pregnancy in both countries.

Sex education policy

Since the mid-1990s there have been a number of developments in both countries which have already been noted to have impacted upon the provision of sex education. These developments came about as a direct result of the changes in educational policy discussed in more detail later in this chapter. In order to illustrate the main changes to sex education policy in Finland and Scotland since the mid-1990s, Tables 7.1 and 7.2 summarise the key points that are developed in the following section of this chapter.

Table 7.1

Key changes to sex education policy in Finland since the mid-1990s

National level

- In 1994 the new comprehensive school curriculum enabled all schools to remove (if desired) two hours of previously compulsory subjects, Physical Education and Home Economics.

Municipality level

- In response to noted cutbacks in their schools each municipality had decided to develop a municipality-wide curriculum for their schools. In *Tehtaala* and *Vaarama* the curriculum was for health education, in *Alajoki* it was for family education.

School level

- In response to the curriculum changes, all schools studied had chosen to remove the hour a week of Health Education (in Physical Education) and all but one school had removed the hour a week of Family Education (in Home Economics) thereby removing the sex education that these subjects provided for pupils.

Table 7.2

Key changes to sex education policy in Scotland since the mid-1990s

National level

- In 1993 the 5-14 Programme was developed, enabling all schools to set aside time for the teaching of sex education.
- Clear targets for the implementation of the 5-14 programme were set and sex education became included as part of HM inspections of schools.
- In 1996 a three-year project into accreditation of pre-service teacher training began, resulting in all higher and further education training establishments providing accredited courses from 1999-2000.
- Development of future projects and initiatives at the national level are to be based on research findings of young people's needs and wants in the provision of sex education.

Local authority level

- The creation of the 5-14 programme had a knock-on effect for each local authority, whereby development at the local level was notable in the provision of guidance by each local authority to their schools about the provision of sex education.

School level

- The 5-14 programme was described at the school level as the first helpful documentation produced by the Scottish Office relating to sex education.
- Each school had revised their school sex education provision on the basis of the documentation from the Scottish Office and their local authority.
- In the case of Scotallen Secondary School, this included the development of this school's first ever PSE programme. The development of this programme was however, suggested to be more a result of the desire of the new Headteacher to have such a programme, rather than the effect of government or local authority policy.

Finland - National framework

A new style curriculum for the comprehensive school was implemented in all Finnish schools in 1994, with, it has been argued (Liinamo 2000) negative effects. In order to enable each school to develop a varied range of optional subjects, a number of subjects that were previously compulsory had to be removed to make room for these new optional developments. This change has impacted upon sex education in that two of the compulsory hours per week that were removed, were in the provision of Physical Education and Home Economics - the two subjects within which Health and Family Education were taught.

Schools were not compelled to remove these hours, they had the choice of keeping them as compulsory, making them 'optional' subjects, or removing them altogether. Schools were under an obligation to cover certain topics, which included Health and Family Education, however, it was up to each individual school to decide how to fulfil those obligations, and this did not necessarily mean keeping the two hours of previously compulsory provision.

Despite the existence of these obligations, the NBE official stated that it had already been brought to her attention that many schools had not interpreted the changes in the way that they were intended to. She said that "we are very worried about this system right now…, we have the knowledge that many schools are saying that actually Health Education is not supposed to be taught anymore".

This has raised particular concerns at government level because it was the belief that sex education combined with the "excellent" school health service that had

been responsible for the decreasing rate of teenage pregnancy in Finland. Therefore in the next framework curriculum process, (to take effect most likely from 2001), which was underway at the time of interview, they were considering that "Health Education will be one area where we must give more time because otherwise it just doesn't give enough time" (her emphasis).

Finland – local level of implementation

Prior to the curriculum changes, none of the three municipalities under exploration had provided any guidance to schools regarding the subjects within which sex education was taught, because schools had all followed government guidelines. After the changes had been made to the national curriculum, all three municipalities reviewed their schools' curricula and had noticed that there had been a substantial drop in the number of hours set aside for health or Family Education in some of their schools. As a result, they all decided to develop their own municipal curriculum framework for either Health or Family Education.

The municipalities of *Tehtaala* and *Vaarama* had decided to develop a curriculum framework for the provision of Health Education, whilst the municipality of *Alajoki* had decided to focus on Family Education. Schools were not obliged to follow this curriculum, but the municipal officers hoped that it would at least make schools review their provision, in order to make sure that they were providing enough.

In *Tehtaala* the curriculum had been devised entirely at the municipal level with consultation between the health and education sectors. In *Vaarama* and in *Alajoki*

it was being developed in co-operation with the municipal officers and the head teachers of all the local *Peruskoulu*.

At the individual school level, teachers in all four schools had noted that there had been a decrease in the provision of subjects providing sex education during the two years prior to this research.

Koskela Peruskoulu

At *Koskela Peruskoulu* when the school began to consider what optional subjects it was going to offer, it had consulted parents and teachers as to what they thought were the most important options. The second most popular choice of all options by parents was Family Education. The final decision on which subjects to incorporate was however made by the school's staff via a vote and the end result was to remove Family and Health Education as compulsory subjects.

The head teacher did not view the removal of these two previously compulsory hours with concern, due to the fact that they could rely on their school nurse. "I think the information for the pupils which is coming from the school nurse is very good, in our school. It is different in different schools, but here in our school she is very good. And because we have such a very good school nurse, the education, it is enough, I think so" (her emphasis).

The members of staff who used to teach those subjects did not share the sentiments of the head teacher that the provisions of Health and Family Education were satisfactory. All of the teachers noted that they no longer believed that school saw

its role as a provider of sex education as important because they had cut out so much of the provision.

The school nurse at *Koskela Peruskoulu* voiced further concern that she was bearing the burden of these cutbacks. Whilst she stated that she was happy to provide the education because it was important, she stated that "the school considers that it is the school nurse's duty to educate the children, as if it would be my speciality…each school makes up its curriculum and unfortunately, in our school there's now nothing" (her emphasis).

Tehtaala Peruskoulu

At *Tehtaala Peruskoulu* the head teacher was also very positive about the provisions in their school. She believed that since the changes, their sex education had become more integrated than before and whilst it had changed, it had not decreased. The teachers interviewed however, did not share the same views as their head teacher. The majority believed that the cutbacks showed that the school no longer saw its role as a provider of sex education as important. This school had removed both the extra hour a week for Family Education and Health Education. The male Physical Education teacher explained that this had happened because three years before (in 1995), when the school had created its new curriculum there was recognition that the same sex education was being taught by a number of subjects. He stated "we wanted to make… that we can co-ordinate it from Physical Education and Home Economics, so we can do better thing and then end result was nothing. So now, no-body teaches it regularly once a week".

All of the teachers who used to teach Health and Family Education expressed a desire to have the additional compulsory hour a week brought back into the curriculum. Both of the Physical Education teachers were aware that the school could easily reinstate Health Education into the curriculum, but they had chosen not too. To compensate for the reduction in compulsory hours of teaching, a number of the teachers stated that they still made time for sex education even if it means missing out something else. For example, the female Physical Education teacher noted, "If I don't teach anything else about Health Education, I have to teach that section [sexual health]".

Vaarama Peruskoulu

The view of the head teacher at *Vaarama Peruskoulu* was somewhat different from the other three schools in that he did show overt concern about the provision of sex education. He noted that they were for the most part satisfied with the old style curriculum and therefore had only developed a small element of the optional choice available to them. The extra hour of Physical Education per week had been removed, but the provision of sex education had remained the same in Family Education. Health Education was still taught but there was less time allocated to it than before.

The head teacher also referred to the work that they had been undertaking with the municipality with regard to developing the provision of Health Education. This project had come about from recognition in their school and the municipality of the increasing drug and alcohol problems in the area. They perceived that the over-reliance by some young women on emergency contraception was related to these

other problems. The head teacher hoped that the end result of this co-operative work would be an improved programme of Health Education for the 1999 curriculum.

Interestingly, noting this school's commitment to maintaining provision, the teachers were also much more satisfied with the level of provision than was found to be the case in the other three schools. On the whole teachers continued to believe that their school saw its role as a provider as important, which was reflected by their higher level of provision than they knew was the case in other schools.

Alajoki Peruskoulu

The head teacher at *Alajoki Peruskoulu* appeared to be in two minds about the provision of sex education in his school. On the one hand he noted that "some teachers have commented that pupils do not understand the subjects well and that more time is needed to increase their understanding". On the other hand he stated that "the situation is alright because there is now more sex education than before", an opinion that was not confirmed by the various teachers interviewed.

In fact at this school both the extra hour in Physical Education and Home Economics had been removed as compulsory subjects and the subjects to be removed within them were Health and Family Education. The Physical Education teachers still taught sex education but there was only time for one or two lessons a year per year group.

The Family Education course although no longer compulsory had been made into an optional subject in 1998, called '*dating dynamics*' taught by a male English teacher. This course was an option for 8th and 9th graders (14-16 year-olds), taught 2 hours per week for six weeks. It was available to both sexes, but in 1998 only young women had chosen the option and it was the teacher's understanding that because of a lack of finance this course would not be taught the following year.

This school had tried unsuccessfully to develop some co-ordination between the various subjects, "we try to take care of it… try to devise some common lines and so on, but the situation has got worse" (school nurse). The teachers responsible for Health and Family Education still believed the school had an important role to play "but here in our school – no… we could have Health Education in pupils' schedules, but the whole school don't see it so important" (male Physical Education teacher).

Implications of change

Of the four schools under exploration, all had removed their compulsory hour of Health Education in the 8th grade and only *Vaarama Peruskoulu* had retained its compulsory Family Education in the 9th grade. The removal by every school of compulsory Health Education in the 8th grade has, however, meant more than the removal of a source of knowledge - it has also meant the loss of the 'dual' aspect of provision. In other words the removal of the one class which taught issues relating to sex and sexuality in a single-sex environment. Therefore, the pupils no longer had the 'safe' arena at a younger age in which to raise sensitive issues that they may not be as comfortable discussing in a mixed arena.

Of the three head teachers, only the one at *Vaarama Peruskoulu* appeared worried about the current provision and despite the other head teachers appearing content with their provision, the majority of their teachers were not. In addition all the municipal officers and the NBE official were aware that many schools had chosen to remove Health and Family Education from their curriculums and they were not happy with this situation. Further to this, results of the latest School Health Study (Liinamo 2000) have indicated that there has been a reduction in the amount of sex education received by pupils throughout Finland, confirming that this reduction in provision is not confined to the four schools under study in this thesis.

Further to this, research has highlighted that since the changes to the curriculum, sex education in schools has generally become less co-ordinated (Kontula 1997) and the tone of teaching has been criticised for moving from the more positive promotion of healthy sexuality to one that emphasises the negatives of teenage sexual activity (Liinamo 2000), which research has shown is not an effective context in which to provide sex education (Oakley 1994, 1995; HEA 1998; Silver 1998).

Whilst sex education in Finland continues to promote co-operation between education and health sectors and "from a sexual rights perspective policy makers have made considerable progress in guaranteeing young people their right to sexual knowledge and information…there are still schools where sex education is quite inadequate. The quality of sex education varies very much according to individual municipalities and schools" (Liinamo 2000:227).

The outcome of this inequality of provision already appears to have had an effect upon teenage pregnancy rates in Finland. Most interviewees in Finland believed that it had been the combination of school health services and the variety of subjects which made up sex education that were key factors in the reduction of teenage pregnancy in Finland. The provision of both school health services and sex education had remained constant until the mid-1990s and the rate of teenage pregnancy had continued to decline until that time. In 1999 however, five years after the cutbacks began, Finland has been witness to the first rise in teenage pregnancy in over two decades. The rise is small, but noted because it is the first time that it has happened since the early 1970s and it has occurred over a period of five years from 20.7 per 1000 women aged 15-19 in 1995 to 23.5 per 1000 in 1999 (Gissler et al. 1996; Gissler 1999; STAKES 2000 – Personal communication). Whilst it would be impossible within the confines of this research to relate the effect of these cutbacks to the increase in the rate of pregnancy, there is a plausible connection warranting further research.

Scotland – National framework

There have been a number of developments within policy relating to sex education in Scotland at government, local authority and school level since the mid-1990s. One aspect that has remained constant however is that sex education remains a non-statutory area of education. In other words, there remains no obligation for schools in Scotland to provide their pupils with sex education. There has however, been strong encouragement from the Scottish Office for schools to do so over the last eight years. To enable this process of development at the school level, the

Scottish Office has developed policy and guidance in this area in order to provide local authorities and schools with advice based on "best practice".

The main formal policy developed so far has been the national advice documented within the 5-14 Environmental Studies programme (SOED 1993) which began in schools in 1993 and the new 'Higher Still' PSE provision (2000-2001). The approach of both is to help pupils establish baseline knowledge about their own body and its value and then to encourage pupils to develop the skills and knowledge needed to enable them to make informed decisions.

In addition to these guidelines, the Scottish Office has set clear targets for primary and secondary schools for this programme to be fully implemented by 1999-2000, to ensure that all pupils arriving at secondary school have obtained the same level of education in this subject (and all other subjects). To ensure this development schools' progress in this area is to now be included within formal HM school inspections.

There has been recognition of the need to improve the quality of sex education provision across schools by encouraging schools as a whole to recognise the importance of sex education, have the confidence to deliver it and be involved in self-evaluation. In supporting this process, the Scottish Office has begun to provide a range of training initiatives through grants, and Health and sex education have been given priority status. Therefore the SOED official noted that the Scottish Office Education Department perceives their role as "not just giving advice, but helping them to use it".

In addition to this in-service training, in 1998 a three-year project by the Scottish Office looking at the issue of pre-service training came to an end. The result of this project has been that all education-training establishments in Scotland have agreed to provide a particular structure of Health Education for pre-service training. This programme the official noted "will include health promotion to create the right climate within an institution and the receiving school, for the teacher to feel that this can be part of the taught curriculum". This was perceived by the Scottish Office official to be a major advance in training that will benefit the individual teacher as well as the school that he/she will work in.

In the process of continual updating of the 5-14 programme, there has been an increased awareness of "young people's right to information". The SOED official noted that this had come about as a result of a "cultural shift both within the Scottish Office and society in general". By focusing on up-to-date research on young people such as that by Currie & Todd (1993) and Currie et al. (1998) into the Health Behaviours of Scottish School Children, the Scottish Office has been made more aware of the knowledge, understanding, belief and attitudes of young people in Scotland. Information from such studies was noted to have helped the Scottish Office to commission further work on advice, training and support in the area of sex education, in order that research is used in a practical way, such as the development of the SHARE project[1].

[1] The SHARE project is a programme of teacher-led sex and relationships education has been evaluated via an RCT in 25 Scottish schools.

The SOED official further noted that development of future projects on the basis on young people's needs was crucial if they were to be effective and there was "large recognition now that giving advice is simply not enough. We must establish that the advice is meeting the needs of staff and young people". This willingness to acknowledge the findings of research which highlights young people's views, needs and wants was described by the official as a further example of "political commitment to establishing 'best practice'".

Scotland - Local level of implementation

In response to the policy development at the Scottish Office creating the 5-14 programme, all three local authorities under exploration began to look more closely at their potential role in helping schools develop the advice into practical application in their schools.

Glendale local authority

In Glendale local authority the national 5-14 guidelines lead this authority to develop their own health promotion policy. This policy contained very detailed aims and objectives with yearly targets of achievement from 1994 onwards and provided schools. This included a detailed programme for Health Education from primary 1 to senior 6 to complement the guidance the schools would have received from the Scottish Office.

According to the Glendale official, the authority made a good start towards putting the various policies into place including providing appropriate training opportunities for staff and getting provision in schools in order. All of the aims/

targets up to 1995-6 were achieved, but due to a sudden cut in funding from the Scottish Office, the whole programme of development stopped between 1996 and 1998. In 1998 in an attempt to get things back on track the local authority undertook the first audit of its kind in Scotland, to see what schools were doing with regards to providing Health Education and where schools felt that they needed help to develop those programmes. In 1998 as a result of the audit, Glendale were in the process of reviewing and updating all documentation and all support services they had. Therefore at the time of interview the official stated that this was an "interesting time" with regard to policy and Health Education.

One of the main findings of the audit had been that after 1996 things became "pretty piecemeal". Some schools had developed very impressive, coherent area group policies[1], with an agreed policy statement and agreed provision, which was found to be working well. Others had "barely reached the starting post". They had adopted the original Glendale policy but development had lain fallow since the cuts in 1996.

One of the original policy aims was to ensure that all schools were providing the same level of education by 1999-2000, as set out in Scottish Office advice. The cut in funding however meant that this was no longer considered a viable goal and schools were therefore not forced to adhere to the national guidance on this matter until a later date. The Glendale official noted that a deadline was still to be set for the future, but the authority recognised that 'best practice' in target setting would be for those targets to be both flexible and realistic.

[1] An area group is a secondary school plus all associated primaries.

The 1998 audit revealed that one of the authority's provisions deemed most useful by schools had been the detailed guidance about what to teach at each school level. The main criticism from the audit however, was that that guidance was considered to be out of date. Hence, one development within the authority at the time of interview was the updating of all documentation for schools which was being given a high priority.

Overall the Glendale official was quite positive about what they were trying to achieve within schools, however he noted that as PSE was not an attainment subject, it was difficult to get all schools to view PSE as important. As he further noted "from the kids' point of view it's perceived as being of secondary importance [because it is not assessed] … for the best will in the world, teachers are under pressure when they are teaching it, perhaps giving the impression that it is of secondary importance, and until we get that sorted out, PSE provision is going to be second rate in a sense". With the current focus by government on attainment subjects and league tables, the official believed that whether or not schools have the additional time for PSE, schools do not perceive there to be time in terms of their other priorities. "It's back to getting your Highers – that's what seen to be important [by teachers, young people and parents]".

Scotallen local authority

Within Scotallen authority, development which began in 1996, had focused on producing a Health Education curriculum for schools in the form of a package called the 'Health Education for Living Project' (HELP). In order to make this

package easy for schools to use it was developed in relation to the 5-14 guidelines - making the two interdependent on each other. HELP was also based on the format of a previous drugs project which staff and pupils had said was good and hence the authority saw that it would be 'best practice' to develop the healthy living project in the same mould. Further to this the authority developed a committee paper which looked at the available curriculum materials and then identified the resources that teachers would be likely to find most useful and highlighted those resources to the schools in their authority.

One of the biggest developments in the area of sex education in Scotallen at the time of interview was within teacher training. Scotallen decided to produce an annual catalogue of in-services courses available to teachers which in 1998 they produced in collaboration with the health board. The aim was to provide a number of courses that would hopefully meet the needs of both health professionals and teachers.

Arbourness local authority

In Arbourness local authority policy relating to sex education had also developed from the basis of the national 5-14 guidance but further to this, from a recognition of the very high teenage pregnancy rate in this authority and a recognition that often sex education was "too little, too late, too uncomfortable".

The documentation itself is described as "a policy statement and guidelines for Health Education and health promotion in the context of PSE". The policy was

implemented in 1993 after a two-year consultation period and is based on what was considered at the time to be 'best practice' already in practice in the authority.

With regard to helping schools develop their sex and Health Education programmes, Arbourness perceived its role as of 1996 as that of a facilitator - helping schools through staff development opportunities. The authority arranged teacher-training courses to show teachers how to develop and implement PSE programmes at the school level. With regard to this teacher training, the authority had begun to provide training on the basis of funding and priority needs, with teacher training in sex education being perceived as a priority issue in 1998. As this training developed the official stated that they would "expect to see continuity and progression with regard to picking up sex education across the school to provide balance and progression".

At the school level, the introduction of the 5-14 programme was recognised by all schools to be "the first helpful documentation" produced by the Scottish Office with regard to sex education. In turn, development was noted during the mid-late 1990s in the provision of sex education within the four schools explored. Those developments however, appear so far to have been driven more by the efforts at the level of local authority than Scottish Office.

Glendale schools (Glendale Academy and Lochend Secondary school)

The two schools located in Glendale, Lochend Secondary School and Glendale Academy, both commented on the considerable help provided by their local authority back in 1993 with the provision of a very structured programme for

Health Education based on the 5-14 guidance. They further noted however, that since then progress had slowed as funding had disappeared at the local level and there had been no notable improvement at the school level since then. Despite this, the PSE teacher at Lochend Secondary School perceived the introduction of the 5-14 programme to have made a notable improvement in the equality of educational levels of young people on reaching senior 1 level.

Glendale Academy had felt that both the government and local authority guidance since the mid-1990s had had a significant impact on their PSE programme which was only three years old and not very well structured when the guidance was produced. Since the arrival of the Glendale documentation, this school had worked towards the production of its own policy which was being finalised at the time of interview.

Unlike Lochend Secondary School, Glendale Academy was still noting considerable differences between the levels of education that had been provided at their six associated primaries. They were, however, aware of the progress being made by their primaries and hoped that this would mean that within three or four years they would all be at the same level on entering S1 at Glendale Academy.

The two PSE teachers at Glendale Academy noted that the audit itself showed a level of commitment (which had previously been lacking) by the local authority to improve the situation. At the time of interview however, there remained a great deal of concern about the lack of expert help from outside the school in the teaching of sex education. As a result one thing this school had placed on their

audit form was the idea of a school-based nurse who would be able to guarantee the provision of education and advice for their pupils.

Scotallen Secondary School

The introduction of the 5-14 programme made no impact upon Scotallen Secondary School until the arrival of a new head teacher in 1995. As discussed in Chapter Five, the head at this school was aware that the provision that existed for 3rd to 6th years was limited and that there was nothing at all for 1st and 2nd years. He noted "I obviously want a PSE programme, the authority thinks you should have, your HMI, everybody, I think a school like this should have a PSE programme". He wanted in particular to develop a new programme in line with Scotallen guidelines and used their local authority advisor a great deal to make sure that their team was working to all correct documentation and guidelines.

The head teacher stated that the school overall was generally supportive of this new programme although some teachers were said to have been unhappy about cuts in their time to provide the programme but "there is commitment in there in the wider sense that we want the whole PSE programme to work, for the school, there is a big commitment to that".

Arbourness High School

Finally at Arbourness High School, the level of provision prior to 1993 was the most substantial of all four schools and had changed relatively little since then. When the authority brought out their first formal policy, the school did review a

formal plan of what they taught to make sure that it related to the Health Education advice and information form the local authority.

The main development within this school since the mid-1990s has been outside of the formalised sex education provision, in the development of a school health stall (this is discussed in relation to sexual health policy in the next section of this chapter).

Implications of change

The introduction of the 5-14 programme developed by the Scottish Office in 1993 has had the impact of chain-reaction through local authority provision down to the individual school level. Prior to 1993 only Scotallen local authority had done any particular policy development in the field of sex education - in relation to AIDS education. Since 1993 all local authorities under exploration made considerable advances in the documentation, resources and advice that they provided for their schools. In turn, the schools that appear to have benefited the most of those explored were those who had the least provision to begin with. For those with an established programme already, the local authority advice had helped to formalise and provide better structure to the provision that already existed.

While Scotallen local authority has made a significant input in the development of the new PSE programme at Scotallen Secondary School it only came about after the new head teacher decided that the school needed a programme. Had the new head teacher not come into this school the teachers involved in developing the new programme believed that it would not have been developed, regardless of what the

local authority had done to develop sex education in other schools. This raises an important reminder that without any formal obligation to provide sex education, some schools in Scotland without strong direction (pro-sex education) from senior management, may continue to have little or no provision.

Only the future will tell as to how successful these various initiatives will be and although the local authorities and schools were encouraged by recent and forthcoming developments, there was a degree of scepticism at each level as to the level of financial sustainability for many of the initiatives being developed.

Sexual Health Policy

Since the mid-1990s there have been a number of developments within the area of sexual health in both countries. In Finland the changes have come as a direct result of structural changes within the nation's health service. In Scotland the changes have come about primarily through recognition at Scottish Office and Executive and local authority levels concerning the lack of sexual health services aimed specifically at young people. The two Tables below (7.3 & 7.4) summarise the key changes in sexual health policy at the national and local level in Finland and Scotland.

Table 7.3

Key changes to sexual health policy in Finland since the mid-1990s

National level

- Changes to the funding for health care services and the de-centralisation of how that money is distributed at the local level has resulted in a shift of emphasis away from preventative health to curative health.
- Cutbacks have been made within the provision of school health services resulting in two main changes:
  1. School nurses generally will have responsibility for more than one school or area of health care provision and therefore less time to spend in any one school.
  2. The training of school nurses has begun to change from a system that trained them specifically to work with young people, to a more general broad-based training to prepare them for all types of nursing.

Municipality level

- In *Tehtaala,* cutbacks had been noticed in the amount of time school nurses had to spend in schools and the style of nurse training was moving to that of broad-based as opposed to youth-specialist.
- In *Vaarama*, cutbacks had been noticed in the amount of time school nurses had to spend in schools.
- In *Alajoki*, cutbacks had encouraged co-operation with a neighbouring municipality for the provision of school health services, this co-operation had resulted in the availability of one extra school nurse in this municipality.

School level

- At *Koskela Peruskoulu* the school nurse remained fulltime, but felt over-relied upon to provide sex education for all pupils.
- At *Tehtaala Peruskoulu* the school nurse was now responsible for an additional school.
- At *Vaarama Peruskoulu* the school nurse was now responsible for one extra school and the local health centre and when she retired, no additional nurse would take her place.
- At *Alajoki Peruskoulu* although the municipality as a whole had one extra school nurse, this school nurse now had the additional duties of working at the local health clinic.

Table 7.4

Key changes to sexual health policy in Scotland since the mid-1990s

National level

- From the mid-1990s there was an increased awareness at the national level of the need to base future sexual health provisions on the needs and wants of young people in Scotland.
- A 1996 Audit of school health service provision highlighted that the role of the school nurse could be developed in such a way as to provide a primary care style resource for young people; this idea is to be pursued further.
- The Scottish Executive produced the White Paper *Towards a Healthier Scotland*, which was endorsed by parliament in September 1999. Highlighted in this Paper is the new demonstration project *Healthy Respect*, which aims to improve the young people's sexual health, not solely reduce the rate of teenage pregnancy.
- In March 2000, the Scottish Executive hosted a deliberative seminar, the aim of which was again teenage sexual health not teenage pregnancy. The findings of this seminar include a recognition that young people's voices must be heard in processes, design, delivery and monitoring of future services for young people.

Local authority level

- In response to national developments, Glendale local authority had decided to develop an authority-wide improvement of health education at the school level, including fostering better links with community sexual health provisions to increase young people's knowledge of the services available to them outside of school.
- Scotallen local authority had decided to pursue the development of American 'full-service' schools to enable a primary care facility to be located on-site in schools, which whole communities could use, but would be confined to use by young people during school hours.
- Arbourness local authority had developed a project for young people up to the age of 21, harnessing the joint co-operation of health and education sectors to set up new initiatives within the local community for young people as well as fostering links between schools and local services.

School level

- Due to the developments at national and local authority level having only been developed in the late 1990s, the effect at the school level was minimal at the time of interview, however;
  - Scotallen Secondary School had been allocated a fulltime school nurse who would be involved within the provision of PSE and eventually it was hoped she would provide an on-site clinic for pupils.
  - Arbourness High School had developed a health stall one lunchtime a week that connected with a local youth service in town. Problems were noted with the youth service however, as it was only open one afternoon per week.

Finland – National framework

Since the early 1990s the Finnish health care system has been going through a process of de-centralisation and change. In brief the following two paragraphs describe the key changes to the Finnish system that may affect the areas of concern within this thesis.

First, prior to 1993 funding for health care services came in the form of state subsides that were distributed at the discretion of the Ministry of Health according to national plans. Since 1993, a change in the law now means that each municipality is provided with a block grant for health, social service and education[1]. This block grant, in combination with locally collected taxes, is now distributed to the various services at the discretion of the municipality. After the provision of all services defined in law as mandatory provisions[2], municipalities can use the remaining funds to support services that they deem to be most important.

How this money is distributed will depend on the attitudes of decision-makers and health care providers within each municipality. Despite the fact that at ministerial level prevention and health promotion are highly valued, the changes that have occurred have meant that experts at government level and national plans now have

[1] Additionally prior to 1993 these three areas of administration were separate sectors of provision and in practice, all services were provided independently from each other. Since 1993 municipalities have combined the provision and administration of these three sectors, providing a co-operative interagency network.

[2] Within health care provision those services include: GP-level curative services, Preventative services, GP-level hospital care, Dental care, Physiotherapy and rehabilitation, Occupational health, School Health services, Ambulance service, Environmental, work-site and food hygiene and Veterinary services (Hemminki 1995:11).

much less influence on the local level of provision. Since it has also been noted that both lay people and health professionals in Finland place more value on cure and care than preventative health care (Hemminki 1995; Rehnström 1997), there was and remains growing concern that this area of health care provision will suffer financially, unequally in comparison to other areas of health care provision (Hemminki 1995; Rehnström 1997).

Discussions with the NBE official for education revealed that this fear has already begun to manifest itself with regard to the provisions made for school health services in general and that great concern has been noted within educational sectors regarding these cutbacks. Referring to research conducted within STAKES, the NBE official stated that so far two main outcomes of these cutbacks have been noted, first, the effect upon the increased workload of school nurses and second, on their training.

First with regard to the workload, school nurses now generally have to share their time either across more schools or in alternative areas of nursing care, such as care of the elderly. The results in both instances being that school nurses now generally have less time to spend in each school than previously. The NBE official further noted that the time they do have is now mainly used to fulfil the legal obligation of school health services, i.e. the provision of individual health care for pupils. Time for the additional duties that many nurses had undertaken, such as teaching within Health Education programmes and acting as a resource of professional knowledge for teachers has now been reduced.

Second with regard to their training, according to the official prior to these changes nurses would undergo their main nursing training before specialising for example in school health care. This style of training meant that school nurses would be well qualified in dealing with the specific needs of young people (Liinamo et al.1997). What was stated to already be occurring by 1998 in some municipalities[1], was that nurses, rather than having their time spread across more schools, would have their time spread across different sectors of provision. A noted concern with this change was that future training of these nurses was not likely to be confined specifically to one field, such as school health, therefore, potentially reducing their knowledge of and ability to deal specifically with young people (Kosunen 2000a).

Local level of implementation

The changes in provision of school health services within each of the municipalities explored was found to vary in both levels and structure of provision, which reflects the expected differences that were predicted to arise as a result of the changes at the national level (Hemminki 1995; Rehnström 1997).

Tehtaala municipality

Within the municipality of *Tehtaala,* according to the official, there were differing opinions amongst the administrators as to which system of nursing would be the most productive, i.e. nurses who specialise in one field such as school health or nurses who cover a number of different fields in one geographical area. The result of the difference in opinion was that both systems were being tried out within *Tehtaala* in 1998. Some of the schools in *Tehtaala* had reported to the official that

[1] The decision as to whether nurses in a given municipality would have their time allocated to more schools or different sectors of provision is the decision of that municipality.

the new system of non-specialist nurses was causing problems for their schools as "the nurse no longer knows the school or the children so well and they don't have so much time to talk about those important things [sexual health issues] with the children".

Vaarama municipality

Within the municipality of *Vaarama* the system of specialised school nurses was still in practice, however the official reported that those nurses did not have as much time as before in each school.

Alajoki municipality

As a result of the changes at the national level, the municipality of *Alajoki* - being an area which is geographically widespread yet with a relatively small population - had decided to join forces with a neighbouring municipality to provide health care. The result of this combination had been the availability of extra resources including one additional specialist nurse to work in schools and therefore the level of provision in this area had actually improved.

Koskela Peruskoulu

At the individual school level the effect of the national changes were also stated to be having an impact in some schools. At *Koskela Peruskoulu* however, the provision of the school nurse had not changed. She was still available full time in the clinic and as a resource for sex education, both as a provider and as a professional resource for the other teachers. As detailed earlier however, in

relation to the provision of sex education the nurse believed that because her time had remained the same, the school were over-reliant on her.

Tehtaala Peruskoulu

At *Tehtaala Peruskoulu* prior to the national changes the nurse was only responsible for the one school. Since the changes, she has had to take on the responsibility of provision for a lower *Peruskoulu* in the area and spread her time across the two. She noted that this was common in the municipality of *Tehtaala* and there was "more work for school nurses, many of [the] school nurses are working also amongst other fields which they didn't do before, so there have been many cuts". Additionally the nurse noted that when she is sick and could not come in to work, no provisions would be made to cover her work, even if she is ill for a few weeks.

Vaarama Peruskoulu

At *Vaarama Peruskoulu* the nurse noted that there had been many cutbacks in health provision in Finland especially within school health care and that this trend was likely to continue. She noted that fewer nurses than before were working in the field of school health in her municipality and that when she retired in 1999, there would not be another nurse employed to replace her. The school would still receive school nurse provisions, but her work would be shared amongst the remaining school nurses in the municipality. Additionally prior to her appointment at this school she had worked in only one school, now she had to share her time across *Vaarama Peruskoulu*, a lower *Peruskoulu* in the municipality and the local health centre.

The head teacher at this school was very aware of the problems facing his school health service. He stated that he "would like to emphasise the importance of having a school nurse. In Finland the trend is not so good because of the cutbacks. However, having a school nurse is an important part of student welfare work. To have your own school nurse who knows the staff and the pupils. And everything goes well. And we have worked hard for maintaining the situation".

Alajoki Peruskoulu

Finally the situation at *Alajoki Peruskoulu* had improved and reflected the situation described by the municipality officer. The nurse in this school in addition to her school duties however, also worked at the local health clinic and encouraged pupils to visit her both within the school clinic and the local clinic. In order to encourage that link she had made arrangements for the pupils to visit the clinic as part of a school trip.

Implications of change

The effect of the structural changes to the provision of school health services was therefore noted in a number of ways. For the municipality of *Alajoki* the effect was increased municipal co-operation to increase school nurse provisions. For the other two municipalities however, the changes were generally not welcomed.

The NBE official was concerned that evaluation done by STAKES had already noted some negative effects of the cut-backs on young people themselves. She said that so far, sexual health had not been an area of concern, but increasing

problems of alcohol abuse and bullying in schools had been related to the fact that "there is less professional help available in schools to deal with these difficult situations".

As a result of these findings, members of STAKES[1] are trying to encourage on-going developmental work in school nurse in-service training, focusing on helping them to "make the best of the time available". They noted however, that this was becoming increasingly difficult when time was being cut back and priorities had to be made, none of which was helped by the fact that "complacency about our lowering rates, makes them [decision-makers] not worry…but there is a need to worry".

Scotland – National framework

As discussed in the first section of this chapter, the mid-1990s witnessed the introduction of the first official national documentation (5-14 programme) to enable curriculum time for the provision of sex education in Scottish schools. In conjunction with this there was also an increased recognition at the Scottish Office of the need to develop sexual health links outside of school - to use both within schools as teaching 'experts' and also as resources for young people in the wider local community.

The reason given by the Scottish Office for the creation and development of these types of links was because it was "the same youngsters in the school that were also potentially the customers of the local youth club, the local drop-in facility, etc".

[1] This information came as personal communication from the *Family Planning 2000* project members at STAKES in April 1998.

The Scottish Office had started to advise local authorities to develop such links and projects at the local level and their work in schools around the needs of their local communities. The results of progress in some areas that have been reported to the Scottish Office so far have been welcomed. The Scottish Office are satisfied with the progress especially that which has seen "the development of a lot of good provision where people have worked in partnership starting from the basis of young people's needs" (their emphasis).

With regard to the potential development of in-house health provisions, the official at the Scottish Office noted that while the provision of school health services in Scotland is enshrined in statute, very few school have a state-registered nurse based in their school. They were however beginning to accept, through research reported to them on young people's needs, that young people are increasingly talking about the desire for a non-teacher to be based in school to go to for advice. Within this context the notion of a school-based nurse was starting to take hold within official circles.

The SOED official highlighted that the results of the audit of the school health service in Scotland undertaken in 1996 (PHPU 1996), did raise awareness of the potential of the role of the school nurse to be developed in such as way as to be a primary care resource for young people. The audit provided guidance on 'good practice' in the provision of school health services, in particular, a change in emphasis from routine check ups at certain ages regardless of need, to a more targeted and focused service based on the needs of young people if and when they arise (PHPU 1996). The SOED official described it as moving from a system of

"screening to consultancy, based on need… including consideration of the social and mental as well as the physical".

In addition to these developments, the Scottish Executive has also acknowledged the importance of the sexual health needs of young people. In February 1999, a White Paper for Health entitled, *Towards a Healthier Scotland*, was endorsed by the Scottish Parliament in September 1999. Whilst the main sexual health policy focus of this paper remains a quantitative target to reduce teenage pregnancy (13-15 year olds) by 20% by the year 2010, there were a number of important aspects contained within this section.

The first of those aspects is the new health demonstration project, *Healthy Respect*, which has as its central aim, the improvement of teenage sexual health in general, not just the reduction of teenage pregnancy. The White Paper also highlighted additional funds that would be made available to the voluntary sector to help improve the sex education provision (outside experts) in Scottish schools (SODoH 1999).

In addition to this, in March 2000 the Scottish Executive hosted a deliberative seminar in conjunction with the Health Education Board for Scotland (HEBS). This event was set up to enable delegates of the seminar[1] to explore the issue of how "young people in Scotland can be further supported in making healthy choices about their sexuality and sexual health" (Burtney 2000a:1). The emerging agenda[2]

[1] The delegates included a number of interested parties including HM Inspectors for education, church ministers, local education authority officials, health service providers, sex education teachers and researchers.
[2] Details of the emerging agenda can be seen in Appendix ix.

produced by this deliberative group is progressive, inclusive and attempts to approach the issue of teenage sexual health from a broad perspective in the desire to see "A Scotland where sexuality is accepted" (Burtney 2000b:12).

Further to this was the recognition that the way forward must include the "constant involvement of young people's voices in processes, design, delivery, monitoring [and] recognition of the support needed to involve young people" (Burtney 2000b:14). Finally was the recognition that adults need to "trust young people to make their own decisions" (Burtney 2000b:15) and that by providing them with the right to access relevant services, they will be 'able to respond'.

The findings of this seminar and the implications they may have for future policy development were under deliberation at Ministerial level at the time of the submission of this thesis (January 2001). Noted progress thus far is that the Ministers have taken on board the need for a sexual health strategy for Scotland that takes account of the findings of this deliberative seminar[1] (Liz Burtney, HEBS, personal communication November 2000) and have requested my input in the development of the new strategy in relation to the findings of this research (Nigel Lindsay, Scottish Executive, personal communication November 2000).

Scotland - local level of implementation

The amount and type of development of services relating to young people's sexual health at the local level was found to vary across the three local authorities explored.

[1] Personal communication with Liz Burtney at HEBS 1st August 2000.

Glendale local authority

Within Glendale the local education authority had, in an attempt to achieve the goal of every school in the authority being a 'health promotion school', chosen to focus their resources on an authority-wide improvement of Health Education at the individual school level. One of the aims of the new Glendale service plan for 1999-2002 is to foster closer links between all schools and outside agencies including community education, school nurses and doctors and local providers of sexual health services for young people. The intention being to improve the provision of Health Education in schools and to improve young people's knowledge of the help that is available to them outside of school.

Scotallen local authority

After a visit by the Scotallen official to view examples of 'good practice' in the USA, this authority has decided to pursue the development similar to the American 'full-service school' for a number of their schools. The vision for this style of provision in Scotallen would be to start with eight schools in the authority in the first instance and then potentially, if successful, introduce this system in more schools. This style of school would operate twelve months a year, seven days a week, 7am-10.30pm, providing a full range of medical services for young people in a school based clinic.

The services would include general medical and dental care, psychological services, anti-natal (if required) and a full time school nurse available to deal with any issues that young people may have, including sexual health issues. The health

facilities would be available to the entire local community but would be confined to the use of young people during school hours.

The official noted that one of the reasons he personally was so keen on the American model was due to the main lesson that they have learnt from the AIDS crisis - that "access to services is critical". He explained that in relation to access in the late 1980s, many adults in the position to provide sexual health services such as contraception were "so naïve as to be stupid". Therefore in light of the success of this type of provision in the USA and the success of school based clinics in other countries, the Scotallen official believed that introducing such a system in Scotallen will "take the whole issue of teenage pregnancy a quantum leap forward".

Arbourness local authority

Lastly, Arbourness has decided to pool resources into a project for young people up to age of 21. This particular project came about through joint recognition within health and education sectors that Arbourness had particularly high teenage pregnancy rates in comparison to the rest of Scotland. Additionally it was recognised that the conception rate reflected that a certain level of unprotected sex had taken place and therefore those young people were also vulnerable to contracting an STI including HIV.

Therefore a multi-agency steering group[1] was created in 1997 and the result of their deliberations, was that the project which began in January of 1998. The main remit of the steering group was "to support and facilitate the Project worker to involve young people in discussion of how to genuinely make health facilities, particularly on sexual health issues, acceptable and accessible to the widest possible range of young people"

Prior to setting up new initiatives within the local community for young people as well as fostering links between those services and the schools in their locale, the primary aim of this project was to find out what young people needed and wanted. According to the Arbourness official the main outcomes of the Project worker's research with young people revealed that young people had requested that any service developed needed to be confidential, friendly, relaxed, anonymous and non-judgemental. Additionally young people in Arbourness had requested that a number of different facilities be available to them including those which provided free condoms, emergency contraception, contraception, someone to talk to about relationships/school/stress and a local free-phone helpline. Finally those services needed to be located near to or in school, at youth clubs or as part of a youth service and they needed to be easily accessible with free transport for rural areas, open at suitable times and have an age limitation on their use.

[1] The steering group was made up of interested parties from the education development service, health promotion (NHS Trust), community education, health promotion centre (Arbourness) and the designated project worker.

Another main finding of the review by the project worker of services already in existence was the increasing use of school nurses in Arbourness. Having noted that the young people revealed to the project worker that a school nurse, especially one who could provide confidential advice and contraception would be a favoured option in service provision, the local authority is now promoting the development of school nurse clinics. The Arbourness official noted that although this style of provision was very much in its infancy, the local authority was committed to developing this resource, which appeared to be successful where it was being used and which was a service young people have expressed a desire for.

Due to the fact the majority of the initiatives discussed above in relation to all local authorities were at the development stage at the time of interview, what was found to have been implemented at the school level was minimal. The schools were however, aware of the efforts that their local authorities were making to develop the variety of projects discussed. Some were sceptical as to whether the local authorities would in fact "produce the goods", but were also positive about what was being done. Only two of the schools, Scotallen Secondary School and Arbourness High School had already benefited from the developments that were being made.

Scotallen Secondary School

First, although the local authority was still to develop their schools in the mould of the American full-service schools, at the time of interview Scotallen Secondary School had just been guaranteed the provision of a full time nurse. The head teacher stated that the nurse, in addition to health checks, would be utilised heavily

in the development and teaching of the new PSE programme, as well as a resource for staff teaching on this course. He was unsure as to whether they would be able to utilise her in a clinic base setting straight away as there was nowhere to actually accommodate her at that time within the school. This was however, something they would be giving consideration as a school-based clinic had a great deal of appeal amongst staff at this school.

Arbourness High School

During the mid-1990s a youth enquiry service was set up very close to Arbourness High School. In order to encourage young people to make good use of this service the school liase with the community education individuals who work at the youth service in the town. The principle link has been made by the creation of a health stall every Tuesday lunchtime within the school. The stall provides pupils with leaflets and information about health-related issues including information about contraception. Although this school's nurse is not located within a school-based clinic, she does work as the dedicated nurse at the youth service providing a further link with this service.

The youth service is currently only available one afternoon a week and is also under the threat of closure due to under-use. Although it is viewed as a valued service by the local authority and the teachers at Arbourness High School, it appears that young women are still using the main hospital 30 miles away for emergency contraception.

The teachers noted their confusion over this under-use. Comments by young people to the project worker in Arbourness however have revealed that services like the youth service, whilst useful, were not considered to be open often enough. For example if unprotected sex occurred any time between Wednesday night and Saturday night, the youth service would be of no use for emergency contraception, as it would not be open until the following Wednesday, more than 72 hours after the event having taken place[1].

Implications of change

The first change that has occurred in relation to young people and sexual health in Scotland, has been the increased recognition at all levels of policy development and implementation of the need to listen to young people and acknowledge their needs and wants. This recognition was particularly noted within the interviews at the Scottish Office and local authorities and was also prevalent within documentation on the issue produced from the deliberative seminar in March 2000.

The actual projects being proposed for development at the Scottish Office and local authority level, appear in light of the discussions in Chapter Six, to be crucial steps forward towards meeting the needs of young people in relation to sexual health provisions. There was however, scepticism voiced at the different levels with regard to those developments. The local authorities were sceptical about the commitment at government level and the schools were sceptical of the commitment of both the government and their local authorities.

[1] 72 hours being the maximum time within which to take emergency contraception after un-protected sex has taken place.

In particular the concern at both levels was one of continued financial commitment. For example the Glendale official noted that since Labour came into power the Scottish Office have been making a very big deal about sex education and sexual health but as yet they "have not really seen the funding… that we might have expected from the initiatives that have been flying out of the Scottish Office…the initiatives sound great…[but] I'm not quite sure if this government is going to put its money where it's mouth is".

This research has only considered three of the thirty-two authorities in Scotland and whilst similar development may be occurring throughout the country, similarly it may not. Additionally, while the projects being undertaken in the three authorities explored are all steps in the same direction, they are diverse in their approaches, showing that there remains no uniform development.

Therefore there remains an issue of concern in that the lack of any formal obligation for authorities to devote resources to such developments may mean that some will not. The potential outcome therefore being that whilst provision in some areas may be substantial, it may be non-existent in others. Therefore the development of sexual health services for young people may end up mirroring the development of sex education in Scotland whereby the provision is piece-meal. A potential result being, an inequality of access to sexual health services for young people in Scotland.

Education Policy

Within both countries there were changes within education policy during the mid-1990s, which have the potential to affect on teenage pregnancy. In particular, the process of de-centralisation and curriculum changes has already affected the provision of sex education as discussed earlier in the chapter. Additionally, however, some of the changes have the potential to affect young people's motivation to remain in school and therefore indirectly affect teenage pregnancy rates. A summary of the key changes in education policy since the mid-1990s can be seen in Tables 7.5 and 7.6 below.

Table 7.5

Key changes to Finnish education policy since the mid-1990s

National level

- A process of de-centralisation and de-regulation of education, which began in the early 1990s, brought about the most noted key change in relation to this thesis in 1994 – changes to the national curriculum for the comprehensive school. The key effect of this chance was the ability of schools to now remove two hours of previously compulsory subjects within which a large proportion of sex education had been provided.

Municipality and school level

- The resulting effect of this change at the municipal and school level have been noted in Table 7.1

Table 7.6

Key changes to Scottish education policy since the mid-1990s

National level

- The introduction of the 5-14 programme provided the first curriculum development at the primary level that linked to secondary level provision – encouraging a continuity of education between the primary and secondary levels.

- Changes to assessment and certification have resulted in qualifications at the school level moving from an entirely academic, exam-based system to one which involves a mixture of course-work assessment and exams, as well as an increased availability to undertake vocational qualifications at the school level.

School level

- Schools had noticed a general improvement in the equality of educational level of pupils on reaching secondary level – therefore reducing the need to repeat education at the S1 level and risk dis-engagement through boredom or an inability to catch-up.

- In all schools, teachers accredited a growing annual proportion of young people remaining at school beyond compulsory level, to the increasing availability of vocational qualifications at the school level.

- Additionally some guidance teachers noted that GSVQs were providing young people, women in particular, with increased confidence and status.

Finland - National framework

From the creation of the *Peruskoulu* in the early 1970s with its system of strong centralised control regarding curriculum, examination and governance, there was little notable structural change until the mid-1990s. However, the seed of reform had been sown during the late-1980s with encouragement from the Ministry of Education of the development of closer partnerships between municipal education bodies and their schools. The aim of this subtle change was to lay the foundations for the process of decreasing the level of central governmental control in the sphere of education in the 1990s.

This first change was seen as the beginning of the process of de-centralisation and de-regulation of education that would occur during the 1990s in Finland (Lindblad & Lundahl 1999) and was part of a common trend across many European countries at that time (Hirvenoja 1999). The economic recession that Finland suffered during the early 1990s gave momentum to the process of de-centralisation, as it was deemed easier to make the necessary cutbacks in education if control was held at the local level (Hirvenoja 1999).

The most notable changes occurred in 1994, at which time Finland moved from what Green et al. refer to as a "centralised system with some element of devolution and choice" to a system of "localised control with national 'steering' and partial school autonomy" (1999: 74-5). In conjunction with this change, the control of the school curriculum was devolved to the individual school level. Therefore instead of a centrally prescribed curriculum with a small optional element of choice to be

developed at the school level, the entire curriculum was now developed at the school level with minimal guidelines provided by the NBE.

These guidelines still prescribed a compulsory element that had to be taught within each school, but the overall control of how these elements were to be taught was devolved to each individual school. In order to enable this change, a proportion of what had been compulsory hours of teaching in certain subjects were removed to make way for schools to develop a wider optional element for their pupils[1].

The culmination of these two changes means that in order to keep their allocated pupils from moving to other schools and also to attract new pupils, schools are under pressure to develop a wider and more varied 'optional' element to their curriculum. Schools could in theory keep the previously compulsory subjects as either options or compulsory subjects within the new curriculum. Schools however, were actively encouraged instead to develop their strong subjects and in a sense become 'specialists' in a particular area, such as language, music or arts (Sarjala 1996).

Finland - Local level of implementation

Since these changes were implemented during the 1990s each municipal area has remained responsible for making sure that the school system works at the local level. In the past, municipalities played little role in the development of each of its schools' curriculums, as they were for the most part prescribed at the national level. Since curriculum development primarily became the responsibility of each

[1] Of particular interest to this research were the removal of one hour per week of physical education and one hour a week of home economics, as was discussed earlier in this chapter.

school, the municipal role in this area increased at the initial development stage. Each municipality was encouraged to provide a skeleton framework of curriculum provision for their local area. Schools were then encouraged (although not prescribed) to use this framework as they developed their own curriculums.

Developing this closer bond of co-operation between schools and their municipal body, was part of an overall NBE plan to encourage the view that "the educational services in a given municipality as a whole so that the strong points of different schools can be made use of in diversifying the curricula of different schools" (Bertell 1994:18). At the local level however, rather than providing an overall curriculum framework for schools as standard, only *Alajoki* provided a common curriculum for its schools, whilst the municipalities of *Tehtaala* and *Vaarama* opted to place no framework restrictions on schools.

Although not necessarily providing an overall curriculum framework, all three municipalities did provide curriculum frameworks for specific subject areas, as was discussed earlier in the chapter, when it became apparent that some schools in their municipality were not providing enough of a particular subject.

At the school level, as was discussed earlier, the effect of the changes to the curriculum impacted upon the provision of sex education. Hours that had previously been compulsory were removed from all schools except for the provision of Family Education at *Vaarama Peruskoulu*. Some subjects remained as optional courses, however for the most part, schools had decided to develop

their option element for subjects such as internationalism, IT, specialist languages and sport.

Implications of change

With regard to the implications of the changes discussed, the most important in relation to this thesis is the effect that these changes have had on the provision of sex education. The reduction of national guidance and the increase in responsibility at the local and school level has been said to have weakened the provision of sex education in schools in Finland (Liinamo 2000). This has been confirmed through follow-up studies of the provision of the previously compulsory subjects from the school year 1995-1996 to 1997-1998. This study found that whilst approximately 25% of schools had maintained their level of provision and 31% had increased their provision, 44% of schools had decreased levels of sex education provision (Liinamo et al. 2000a).

Scotland – National framework

In Scotland, the process of changing the curriculum actually began in the late 1980s with the first submission by the Scottish Consultative Council on the Curriculum (SCCC) to the Secretary of State, of new guidelines for secondary schools in 1987. The implementation of this reform however, did not take place until the early 1990s.

The first major change was to the curriculum for those at the primary and lower secondary level (aged 5-14), which came about from the recognition that there needed to be a more efficient connection between primary and secondary

education. Secondary schools routinely take pupils from a number of different primaries, including their own associated primaries[1]. Therefore it would often be the case that pupils coming from a range of different primaries on reaching S1 level of the secondary school would not all be at the same educational level as each other because there was no common curriculum within primaries. In an attempt to create a 'bridge' between the two levels of education, the Scottish Office Education Department launched the 5-14 programme. The initial documentation came in the form of working papers before the finalised guidelines were disseminated to schools, which took effect in 1993. Building from core subjects already taught in the majority of primaries, the 5-14 guidelines provided each school with guidance on developing a common curriculum aimed at the "breadth, balance, coherence, continuity and progression" (SCCC 1998:18) of education through the seven levels of primary and the first two levels of secondary education.

Changes to the level of secondary education from S3 through to S6 were then developed to link in with the new 5-14 programme, broadening the five main areas covered at the primary level to eight[2]. Those guidelines also suggested to schools the minimum amounts of time that should be allocated to the various core areas[3].

[1] On average schools in Scotland have between 3-6 associated primaries, whereby pupils from those primaries, unless requested to be placed elsewhere by their parents, would automatically follow through to their associated secondary.

[2] The 5 primary core areas incorporated English, Mathematics, Environmental Studies, Expressive Arts and Religious and Moral education. The 8 secondary core areas incorporated Language and Communication, Mathematical studies and applications, Scientific studies and applications, Social and Environmental studies, Technological activities and applications, Creative and Aesthetic activities, Physical education and Religious and Moral education.

[3] The introduction of the 5-14 programme and further developments in the S3-S6 curriculum will be discussed in more detail later in the chapter, as these guidelines were in effect the first official documentation from government that allocated specific time in the curriculum within which sex education could be taught in Scottish schools.

With regard to assessment and certification procedures for Scottish pupils, there have been numerous changes over the last fifteen years. Some have come as a direct result of the changes made to the curriculum and others preceded that change and in part instigated the changes to the curriculum in 1993.

Prior to the end of the 1980s the qualifications available to pupils were entirely exam-based (Ordinary grades at S4 and Higher grades at S5 and6). In 1989-1990 these qualifications changed to Standard grades (S4) and Revised Higher grades (S5 & S6) respectively. Both were based on the notion of positive assessment, incorporating elements of assessed course-work in addition to formalised examinations.

As discussed in Chapter Four a new system of vocational qualifications was introduced at the beginning of the 1990s which pupils were able to take instead of or in combination with their Standard grades. These were called Scottish Vocational Qualifications (SVQs). Pupils would have the option to choose a range of subjects from a catalogue of modules set by the Scottish Qualifications Authority (SQA) and if successfully completed would provide accreditation towards a 'non-advanced' vocational qualification (national certificate).

For those pupils who opted for the more vocationally based qualifications, a new system was then introduced at the upper secondary level (S5-6), enabling continuity of study with a wide range of short and modular courses (SCOTVEC modules). The introduction of these courses is probably one of the most notable

changes within upper secondary educational policy in recent years, providing the first alternative qualification to academically orientated examinations.

1999 witnessed further change to the assessment and certification system of the upper secondary level. As of August 1999, all schools were expected to move from the Revised Higher grade examinations introduced at the beginning of that decade to the new Higher-Still examination, a system that is even more course-work based than the previous Revised Higher. Eventually it is expected that in the future the five different levels of Higher-Still will replace Standard Grades, Revised Highers and Sixth Year Studies, offering further continuity of education from S3-S6.

In addition a new vocational qualification, General Scottish Vocational Qualification (GSVQ), has been introduced to take over from the SCOTVEC models. This qualification is more broadly based, aimed at those aged 16-19 and can be taken in both secondary schools as well as further education colleges.

Scotland - Local level of implementation

At the individual school level, all four schools explored in Scotland had devised and developed their own curriculums at the school level based on the new 5-14 programme and S3-S6 guidelines that were intended to tie in with what was introduced within the 5-14 programme. Schools had begun to notice (some more than others), a greater degree of equality in the educational levels of pupils upon reaching the secondary school. In some cases this was enabling the progression of pupils from S1 to S2 level to take place without the need to repeat education that

should have been provided at the primary stage - which was noted to effect upon S1 level pupils' level of interest in their courses.

With regard to the changes in assessment and certification, teachers at all of the schools had noted that more pupils were staying on at school than had been the case in previous years. All schools acknowledged that the lack of job opportunities at age sixteen was a likely contributory factor to this increase in staying-on. Some credit for this increased continuation however, was placed upon the increased availability of vocation education at the school level. There was an increasing sense amongst careers guidance teachers that pupils were staying on not only to gain better qualifications but also because they "perceived that there was something for them to gain by staying". In other words, increased opportunity at the school level had increased motivation and aspirations to remain in school for longer.

Although vocational qualifications were still not believed to be perceived by pupils as on the same 'level' as Higher grades, guidance teachers were noting that those who stayed on to achieve GSVQs, gained more than the qualification. As the careers teacher at Glendale Academy noted, "those who've done it have gained a lot in terms of their confidence and their ability to handle different situations… it is the sort of thing that has been excellent in giving status, in particular to girls, who may have otherwise drifted away...".

In three of the four schools careers guidance teachers noted that the increased availability of vocational qualifications were being viewed as a main reason as to

why the stay-on rates were on the increase amongst those who would otherwise have left school at sixteen. There was also a desire amongst careers guidance teachers to encourage the normalisation of these qualifications as valid educational choices for young people to encourage their up-take further.

Implications of change

The implications of the change within education policy in Scotland, as was the case in Finland, have already impacted directly on the provision of sex education as was discussed earlier. There are however, also implications for some of these changes to have an indirect effect upon teenage pregnancy rates in Scotland, in relation to increased motivation to remain in education.

The new curriculum guidelines have now created a system whereby greater continuity in education has been encouraged between primary and secondary schools. This system has the potential to make sure that all pupils are at the same standard of education when they reach secondary school. Some schools were already noting that this had meant that pupils had appeared more interested in learning, because they were not having to repeat education they had already done at primary, or having to catch up education that they had not covered.

The changes in methods of assessment and certification have also meant that since the 1990s pupils are now no longer assessed purely on the basis of how they perform on one examination day. Instead there has been a gradual move towards more and more continual assessment in conjunction with formal examinations.

The introduction of more vocationally based qualifications at the school level has been suggested by careers guidance teachers as part explanation as to why more young people are remaining in education for longer. It is unlikely that any significant impact on stay-on rates will be noted for a period of time. The implication from the schoolteachers however, was that this may well prove to be the case. The combination of the development of and increased availability to pursue more vocationally based qualifications as an alternative to more academic pursuits could prove to be a key factor in encouraging more young people to stay on in education beyond the age of sixteen, than has been the case until now.

In the longer term, this may aid the 'normalising' of continuation in education for young people in Scotland, which was so noted in Finland. The indirect implication therefore being that increased opportunity at the school level and increased motivation to achieve, may provide more young people in Scotland with the incentive to delay pregnancy and parenthood at a relatively young age.

Summary

As can be seen from the discussion within this chapter, there have been a number of interesting developments in all three areas of policy since the mid-1990s. Whilst it is too early to predict what the eventual outcomes of the various developments may be, of interest at this point in time is the apparent direction of change.

The changes within education, school health and sex education that have arisen from the de-centralisation within the sectors of health and education in Finland,

have the potential to negatively effect upon the rate of teenage pregnancy in Finland. Two main areas drawn out from the analysis in Chapter Six as potential key policy differences were those of the combined provision of health services and sex education at the school level in Finland.

Additionally, there was common agreement amongst those interviewed as well as researchers in the field of teenage sexual health in Finland (Kosunen 2000a, 2000b; Liinamo 2000), that these two provisions had been crucial components of the successful reduction of teenage pregnancy in Finland. It would therefore appear that the recent policy changes might continue to have the undesired effect upon the Finnish teenage pregnancy rate that has developed during the latter years of the 1990s.

From the discussion within this chapter, it appears that changes within education, sexual health and sex education policy in Scotland, are moving in the opposite direction to that in Finland. With regard to education policy, the provision of more vocational and course-work based qualifications may well prove to be a strong motivational aspect that encourages a higher stay-on rate in education at the school level and potentially encourage the 'normalisation' of continued education found in Finland.

An acute awareness of young people's needs and wants has formed the basis of development in the area of sexual health services for young people in Scotland. Similarly, the development of sex education guidance based on young people's needs at Scottish Office and local authority level, as well as developments in pre

and in-service teacher training and attempts to raise the profile of PSE and sex education within schools, are all important changes which will hopefully lead to a greater level of provision and equality of provision across Scottish schools.

The next chapter presents the concluding part of this thesis addressing a number of important issues. First, a number of potential policy options that could aid in the reduction of teenage pregnancy in Scotland are discussed, second there is a final discussion drawing together the key themes that have arisen from this research, which highlight what the findings of this research add to the existing literature on social policy and teenage pregnancy. The chapter then concludes by considering the future research agenda drawing from issues which have been raised within this thesis.