

# The National Sexual Health Policy for the Maltese Islands

2010



Ministry for Health,  
the Elderly and  
Community Care

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## Sexual Health: an Integral Part of Our Well Being

There has been a long wait for a national sexual health policy, and I take pride and feel privileged to be launching it as the Minister for Health, Elderly and Community Care. Sexual health is an integral element of the health of all human beings, and thus merits much attention. I am confident this policy will finally seek to secure such due attention.

In essence, this policy seeks to promote sexual health as an essential and integral element of the holistic notion of human well being. Categorically it is not exclusively about contraception, or disease prevention, but about the enhancement of an important dimension of human health – sexual health.

The policy draws on a set of principles of individual and social rights and responsibilities of the human being, underpinned by the values of respect and dignity towards human life from the moment of conception, and on the belief that the stable family unit is the cornerstone of a healthy society, respectful of social, sexual, religious and cultural diversity. It has been informed by evidence located in the local and international literature.

In view of the ministry's conviction regarding the significant value of the participation and contribution of all entities, sectors, groups and representatives of the entire population towards the enhancement of health, a series of live workshops over a period of months will complement the publication of this policy. These workshops should secure the referred participation and contribution of all parties, within the Maltese islands.

I would like to take the opportunity to sincerely ask you to accept this invitation and assist us on our journey towards the development of the subsequent sexual health strategy.

This sexual health policy, coupled with the outcomes of the referred workshops will inform the development of a sexual health strategy, which would in turn, identify a set of targets, goals, measures and deliverables for our nation regarding sexual health.

I trust in your esteemed participation and attention.



Dr Joseph Cassar  
Minister for Health,  
the Elderly and Community Care

This document draws on a set of principles of individual and social rights and responsibilities of the human being, underpinned by the values of respect and dignity towards human life.



## Introduction

### Sexual health: a working definition

The true meaning and understanding of sexual well-being remains to be culture- and context-specific, and thus it is difficult to arrive at a universally acceptable definition of the totality of human sexuality.<sup>1</sup> In view of its complex web of biological, psychological, cognitive, social, political, cultural, ethical, legal, religious and spiritual factors, the following World Health Organisation's definition of sexual health is presented as a step in this direction:

*Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive, respectful approach to sexuality and relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained, the sexual rights of all persons must be respected, protected and fulfilled.*<sup>2,3,4</sup>

For the last 30 years, the concept of sexual health has been invariably described to include these basic three elements:

1. A capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic;
2. Freedom from fear, shame, and guilt associated with false beliefs and misconceptions related to sexuality, and other factors affecting sexual response and relationships;
3. Freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions.

**For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled.**

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The notion of sexual health implies a positive and responsible approach to human sexuality and sexual relationships and goes well beyond the absence of disease. The purpose of sexual health care should be the enhancement of life and personal relationships, as well as pleasurable and safe sexual experiences.<sup>5</sup> Equally so sexual health care should value and nurture respect towards abstinence.

### What are the consequences of sexual ill-health?

Sexual health has a strong impact on a person's personality, life and role in society. It is directly affected by a range of physical, psychological, cognitive, socio-cultural, religious, legal, political and economic factors. An individual may have little or no control over such factors.

There is a clear relationship evidenced between sexual ill-health, poverty and social exclusion.<sup>6,7</sup> Among the most severe consequences of poor sexual health are:

- Psychological consequences of sexual coercion, exploitation and abuse
- Unplanned pregnancies
- Being disadvantaged within established standard educational systems
- Poor educational, social and economic opportunities for teenage mothers

- Bacterial vaginosis and premature delivery
- Pelvic inflammatory disease caused by Gonorrhoea and Chlamydia, which can lead to ectopic pregnancies and infertility
- Recurrent genital herpes
- HIV/AIDS and other Sexually Transmitted Infections (STIs)
- Cervical and other genital cancers
- Hepatitis, chronic liver disease and liver cancer
- Premature loss of life

### Facts and Figures

#### Teenage pregnancies in Malta

- Between the year 2000 and 2009, 936 babies were born to Maltese mothers under 18 years of age
- These amount to just under 2.5 % of all babies delivered over the 10 year period
- 5% of all teenage mothers within the same period were young adolescent girls aged <15 years (who delivered a total of 47 childbirths between 2000-2009)

Source: National Obstetrics Information System, Dept. of Health Information and Research (2010)

Poor sexual health characteristically translates into significant costs to a country. In turn, preventing poor sexual health significantly contributes towards the better and more effective use of finite resources of a country. It follows that protecting, supporting and restoring sexual health is important for both the social well-being and economic growth of a country. It is against this backdrop that a national sexual health policy is being presented.

### What are the indicators of sexual health?

Sexual health relates to educational, ethical, medical, social and cultural components and characteristics which may vary between different countries. Standards of sexual health depend on a complex interaction of many of these factors. Therefore, these must be taken into account in the measurement and enhancement of sexual health in any given context.<sup>8</sup>

Following the International Conference on Population and Development in 1994, various international agencies identified a number of indicators and predictors that reflect the overall sexual health of different populations.<sup>9,10,11,12,13</sup> Some of the indicators are measures of health status (outcome or impact indicators), while others are intended to capture 'processes'. The major indicators of sexual health identified can be classified as those related to:

- Social and behavioural factors
- Monitoring and surveillance policies
- Legislation
- Medical and health services
- Health education
- Evaluation and quality assurance policies

Reference to these indicators in the specific context of Malta provide the cornerstones of this policy which seeks to direct a strategy set to protect and enhance sexual health in the country.

Standards of sexual health depend on a complex interaction of many factors which may vary between different countries.

# 1 Need, Principles and Remit of the Policy

## 1.1 Why does Malta need a sexual health policy?

The past century has witnessed a widespread liberalisation in sexual attitudes across the western world, as regards for example birth control, pre-marital sex, teenage pregnancies, single parenthood, cohabitation of non-married partners and sexual diversity. The reasons for this unprecedented shift in attitudes and behaviours are complex and wide-ranging. Across different contexts, these changes have been met by varying degrees of support or concern. Often, attitudes towards aspects of sexual behaviour are diverse and even polarised across one context, with consequent difficulties for the promotion of better sexual health through the provision of a uniform structure of sexual health services and education, in that context. Needless to say, this poses a greater challenge for strategic planning.<sup>14</sup> A national sexual health policy seeks to provide a consistent framework within which the referred sexual health services and education may be strategically planned and delivered, across the country.

## 1.2 Principles and objectives of the policy

The principles guiding this policy are underpinned by human rights and social justice principles. The core principles stemming from this philosophical approach are:

- Respect and care towards human life from its conception
- Individual rights and responsibilities in the context of the broader society
- Adequate, accessible and accurate information and education which is equally accessible to all members of a population, enabling informed choices
- Freedom from exploitation and abuse
- Freedom of expression
- Psychological and physical expression of one's sexuality in the context of a sound family unit is valued as an essential cornerstone of a society whilst respecting diverse lifestyle choices

The aim of the policy is therefore to inform and direct the development of a comprehensive evidence based national sexual health strategy for the attainment of maximum health and well being of all the population, drawing on the core principles noted above.

The objectives are:

- To establish the need for research to secure accurate data specifically pertaining to the Maltese islands
- To determine the provision of adequate and equitable health and social services and support which match the current needs
- To map the monitoring, surveillance and legal framework
- To provide optimal services through competent and skilled staff supported by adequate resources
- To identify and evaluate the role and contribution of the media

- To collate and evaluate the social, cultural and religious dimensions of sexual health, within the specific context of Malta
- To enhance further co-operation with other countries and entities
- Project and plan to address the challenges of the future

The attainment of excellence across the health and education sectors is a key goal of the Government. Tackling people's sexual health in a concerted manner at national level is one of the tools with which Government may attain its vision for the health sector.

This is Malta's first national policy for sexual health. It illustrates the determination and commitment to address key challenges faced by Maltese society today, which are largely characterised by increased individualisation and the secularisation of sexuality.<sup>15</sup>

## 2 Social and Behavioural Indicators of Sexual Health

### 2.1 Social indicators

#### 2.1.i Sexual Violence

Specific harmful sexual practices such as sexual violence and domestic violence including marital rape, have been identified to be indicators of sexual ill-health. The incidence<sup>16</sup> of sexual violence reported to law enforcement and/or health professionals is thus one of the indicators of the degree of sexual ill-health in a given population or community. The public's opinion, perceptions and social attitude towards sexual and domestic violence are also identified as other indicators of sexual health.

#### 2.1.ii Substance Abuse

A significant body of literature has shown a strong association between substance abuse and risky sexual practices. For example, research<sup>17, 18, 19</sup> has shown that the likelihood of young people engaging in unplanned intercourse increased with higher alcohol use. In particular, the likelihood of engaging in unprotected sex and/

or having multiple sexual partners appears to be consistently high amongst adolescents who frequently drank until they reached a state of inebriation. Particularly for girls, weekly drunkenness-related drinking was associated with multiple partners.

These research studies provide evidence which notes a significant association between unplanned and unprotected intercourse with multiple sexual partners, and an increasing frequency of alcohol,

#### Facts and Figures

**10% of all Maltese teenagers aged 15-16 years reported having unprotected sex because of a personal alcohol problem (European average: 8%)**

Source: ESPAD (2007), SEDGA (2009) – Foundation for Social Welfare Services, Ministry for Social Policy

tobacco and cannabis use, both in the bivariate comparisons and the multivariate models. Out of all substances explored (alcohol, tobacco and cannabis), the evidence suggests that alcohol use was most strongly associated with unplanned intercourse, and was also identified as the strongest risk factor for having had multiple sexual partners. Compared with students who reported not having had unplanned sex when under the influence of a substance, those who reported having done so were almost four times more likely to have had multiple sexual partners. It was also reported that those who had engaged in unplanned sexual intercourse under the influence of alcohol were twice as likely to report inconsistent condom use. In the qualitative analysis, engaging in unprotected sexual behaviours was only second to aggressive behaviour and physical fighting in terms of the perceived consequences of alcohol consumption. Calls for the comprehensive combination of alcohol education and sexuality and relationships education in early adolescence echoes through the reported research studies.

#### 2.1.iii Sexual Competence

Sexual competence is a composite indicator referring to whether sex is consensual, with no regret, protected against STIs and unplanned pregnancy, and to whether the decision to practice any form of sexual activity is made autonomously.<sup>20, 21</sup> There is much debate upon the role of education in developing sexual

#### Facts & Figures

**Close to a third of sexually active young people in Malta aged 14-16 years had sexual intercourse at least once under the likely influence of alcohol or other substances. No significant gender differences were noted.**

Source: Bugeja, R. (2010) Assessing young people's learning needs related to sexuality and relationships on the Maltese islands: a multi-dimensional approach. Unpublished Thesis submitted for the degree of Doctor of Philosophy, University of Southampton, United Kingdom

competence, particularly in relation to the potential contribution that educational programmes may make towards the development of attitudes, values and lifestyles which are believed to be conducive to optimal sexual health, as for example, fidelity and respect.

#### 2.1.iv Sexuality Education

The incidence of adolescents who have received sexuality and relationships education in schools has also been identified as one of the social indicators of sexual health. Sexuality education has been commonly defined as a lifelong learning process starting in childhood, with a potential to promote positive sexuality by enhancing young people's knowledge and understanding (cognitive domain);

Sexuality education has been commonly defined as a lifelong learning process starting in childhood, with a potential to promote positive sexuality

developing or strengthening interpersonal and relationship skills (behavioural domain); explaining and clarifying feelings, attitudes and values (the affective domain) in relation to their sexual development; and increasing comfort with their own developing sexuality.<sup>22, 23, 24 25</sup>

Since its conception at the beginning of the 20th century, sexuality education has provoked numerous debates which have drawn much attention to its controversial moral dimension. Amongst other aspects such as the development of self respect and the development of respect towards other persons, sexuality education also addresses the private and intimate life of the learner and has to do with emotions related to intimacy, pleasure, affection, anxiety, guilt and embarrassment. Therefore it is inescapably a value-laden activity.<sup>26</sup> Values has been defined as principles and fundamental convictions by which people judge beliefs and behaviours to be good, right, desirable or worthy of respect.<sup>27</sup> In comprising such moral dimension the debate

has been persistently characterised by varying levels of agreement and disagreement across individuals, entities, religions, cultures and so on.<sup>28</sup>

Initially, debates about sexuality education focused on whether to teach sexuality education in schools or entrust it exclusively to parents. The major issue arose around the notion that young children have a natural innocence which may be prematurely lost as a result of lessons designed to raise their sexual awareness and thus might cause an ill-effect on their behaviour. Despite the lack of empirical evidence supporting this notion to date, it still dominates some circles of discussion regarding the teaching of sexuality to the young.<sup>29, 30, 31</sup>

Wellings *et al.*<sup>32</sup> had examined the relation between sexuality education and early sexual experience with a sample of 18,876 British participants and concluded that the data provided no significant evidence to support the prevalent concern that provision of school sex education might hasten the onset of sexual experience. Using data from a nationally representative survey among 2019 never-married males and females aged 15–19 years in the United States, Mueller *et al.*<sup>33</sup> found that sexuality and relationships education had effectively reduced adolescent sexual risk behaviours when provided before sexual initiation. A review of 53 studies to

examine the impact of HIV/AIDS education on young people's sexual behaviour concluded that:

*“The overwhelming majority of reports reviewed [...] regardless of variations in methodology, countries under investigation, and year of publication, found little support for the contention that sexual health education encourages experimentation or increases sexual activity.”<sup>34</sup>*

Another recent comprehensive review of studies which explored the impact of sexuality and relationships education on sexual behaviour suggests that comprehensive programmes may actually delay sexual intercourse and increase protection against sexually transmitted infections and unplanned teenage pregnancies<sup>35</sup>. In conclusion, the evidence strongly suggests that comprehensive sexuality education does not hasten the onset or increase sexual activity. Such effective programmes essentially provide the learner with the opportunity to explore and embrace varying values, including abstinence from genital expression of intimacy while exploring other ways of demonstrating affection; as well as being in long-term, loving, mutually faithful sexual relationships.

## 2.2 Behavioural indicators

In the past three decades or so there has been considerable focus on the sexual behaviour and knowledge of young people especially those aged 15 – 24. Behaviour and knowledge are widely considered to be major determinants of conception rates, STIs and HIV transmission, and other sexual health outcomes. Academic and scientific literature reveals a number of key behavioural and knowledge factors commonly used to assess and measure the sexual health of young people.

### 2.2.i Sexual activity and age at first sexual intercourse

Early sexual debut has long been associated with risk behaviours such as substance abuse, multiple partners and unprotected sexual intercourse. These behaviours constitute the most significant factors contributing to STIs and unplanned pregnancies.<sup>36, 37, 38</sup> Therefore, age at first intercourse has been shown to be an important indicator of the possible outcomes of young people's sexual health, and thus young people's learning needs.

#### Facts & Figures

5% of all sexually active Maltese population had more than one sexual partner.

Source: EHIS, 2008

### 2.2.ii Number of sexual partners

The incidence of multiple sexual partnerships has also been addressed in the literature, especially that which explores the sexual health of men and women aged 15-24 years. The evidence indicates an association between having multiple partners and an increased risk of becoming infected with STIs<sup>39</sup>. However further research in this area is indicated.

### 2.2.iii Contraception use

The literature identifies the use of contraception among sexually active adolescents as being a significant determinant of young people's sexual health, not only in terms of prevention of unplanned pregnancies, but also – in the case of barrier methods of contraception– in the prevention of STIs.<sup>40</sup> The scientific literature to date has largely focused on the use of contraception by young individuals engaging in sexual intercourse the first time, and on the consistent use of condoms among sexually active unmarried adolescents. Further research studies regarding the use of contraception is indicated.

## 2.3 Knowledge factors

### 2.3.i Awareness of sexually transmitted infections, including HIV, their modes of transmission and their methods of prevention

The people's knowledge and awareness about sexually transmitted infections and ways of preventing them is another indicator of sexual health within a given community. The prevalence of who correctly identifies STIs, ways of preventing their sexual transmission, and of who rejects misconceptions about sexual diseases is an indicator of sexual health.

#### Facts & Figures

The most commonly used methods of contraception among the sexually active population in Malta are:

- Withdrawal method (20.3%)
- Condom (18.9%)
- Natural Family Planning (5.5%)
- Contraceptive Pill (4.1%)
- 65.3% of the sexually active Maltese population claimed not to have used any contraception at all.

Source: EHIS, 2008

### 2.3.ii Awareness of sexual health screening and treatment services

The prevalence of people's awareness of sexual health services, together with access and use of such services including those for the treatment of STIs, sexual dysfunction, sexual violence and infertility has also been identified as another indicator of sexual health.

### 2.3.iii Awareness of all contraception and fertility awareness methods

Some research studies have shown a significant association between knowledge of contraception methods and safer sexual behaviour.<sup>41</sup> Another body of evidence indicates that knowledge in itself is neither sufficient nor a precursor for the adoption of safer practices, be they abstinence or artificial methods of prevention from STIs and unplanned pregnancy.<sup>42, 43, 44</sup> A threshold has also been suggested beyond which knowledge does not impact on behaviour.<sup>45</sup> It seems that there is still a lot of uncertainty around this issue which merits further research. However, there appears to be a common consensus that people need this kind of knowledge to enable them to make informed decisions about their sexual behaviour.<sup>46</sup>

Downs *et al.*<sup>47</sup> compared knowledge of STIs between adolescent females who had contracted an STI and girls who never did. The findings of this study significantly suggest that the participants who contracted a STI knew more about one's diagnosed specific STI than about other STIs. They also appeared to learn about STIs primarily after diagnosis, when it is too late not only for effective prevention, but also for early detection or prompt treatment of their disease. The researchers argue that if adolescents knew this information earlier, they would be more likely to recognise symptoms earlier, routinely screen for STIs in the absence of symptoms, seek earlier treatment and thus avoid complications, and avoid infecting their partners. Evidence regarding social indicators, behavioural indicators and facets of knowledge arising from and pertaining to the specific context of Malta is still in its infancy. Research activity in this direction is indicated.

# 3

## Monitoring and Surveillance Policies

The social and behavioural indicators identified in Chapter 2 present the areas regarding which a comprehensive systematic audit and review of the situation in Malta is needed. The referred social and behaviour indicators are to be given much importance in attempting to address the sexual health of the population. Coupled with comprehensive exploratory research activity, the indicated audit and review initiatives need to endorse robust methodological approaches. In turn, rigour in the adopted approaches will allow the findings of such audit and exploratory initiatives to serve as the pillars of local strategies and projects related to sexual health in the country.

The social and behavioural factors indicated above also call for the surveillance of domestic violence, substance abuse, adolescent birth rates, sexually transmitted infections, related diseases (such as pelvic inflammatory disease and cervical cancer) and infertility. Furthermore, they also indicate the need for service use surveillance, such as GU clinic yearly attendees and uptake of cervical screening tests.

The planning and commissioning of the indicated research initiatives to an authorised entity, preferably endorsing the contribution of experts in sexual health field, is recommended. Potential entities are the University of Malta, and the Research and Initiative Division, within the Malta Council for Science and Technology

Statutory reporting of the main Sexually Transmitted Infections (Syphilis, Gonorrhoea, HIV and Chlamydia) in Malta was introduced in 2004. Notifications are received at the Infectious Disease Prevention and Control Unit (IDCU) within the Health Promotion and Disease Prevention Directorate. The frequency of such diseases in Malta relies on reported cases by physicians. The numbers notified every year are possibly an underestimation of the true numbers in the general population. Furthermore, the true burden of illness at community level remains unknown since many cases are asymptomatic and hence do not seek medical attention. In addition, cases may not be referred for testing.

# 4

## Legislation

According to WHO estimates there are possibly 13,000 new cases of STIs per year in Malta. The GU clinic issues an annual report which indicates an increasing number of service users over the years since its conception in the year 2000. This may have resulted mainly from the increased awareness and availability of services, and also the increased frequency of infections. The dearth in the availability of empirical evidence to explain the increasing use of the GU clinic strongly suggests the need for research in the area. Moreover, these noted gaps in the data available call for more efficient and effective measures on case notification and a systematic approach at identifying prevalence.

There are a number of direct or indirect references to sexual health in the Maltese legislation. Articles 198 and 201 of the Criminal Code (Cap IX) deal with rape and carnal knowledge with violence, while article 197 deals with prostitution and article 208A deals with pornography.

Abortion is illegal in Malta and punishable at law under Section 241-243A of the same Code. Sexual harassment is also regarded as an offence under Maltese Law and is regulated by the Equality for Men and Women Act (Cap 456) as well as Article 29 of the Employment and Industrial Relations Act (Cap 452).

Furthermore there is the Education Act which indirectly stipulated a mandate for the teaching about sexuality in all schools in Malta, by way of Objective 6 of the National Minimum Curriculum<sup>48</sup> which is a legally binding document.

As with other sexual health indicators, the legislative framework within which sexual health is maintained and enhanced across a population needs to be comprehensively studied, evaluated and revised periodically and accordingly. This policy highlights the need for such an exercise in the context of Malta.

The social and behavioural sexual health indicators identified in this policy call for a number of timely preventive and interventional medical and health services.

### 5.1 Primary prevention services

Effective sexual health education needs to aim at lifelong learning approaches which provide educational programmes aimed at all age groups, and focused programmes targeted at those groups identified as being at risk. Innovative approaches, encompassing the contribution of all related entities within the health, education and social sectors, are required so as to be able to reach specific target populations and especially vulnerable and high risk groups, in the most efficient and effective way possible. The contribution of respective specialist themes, securing the relevant expertise would need to be sought accordingly.

#### 5.1.i Raising Awareness

Sexual health campaigns need to be aimed at raising awareness and increasing knowledge, enabling informed choices and providing opportunities for changes in behaviour. These campaigns should seek to give people correct and appropriate information about their sexual health and the relevant services available. National information campaigns are to provide a backdrop for more targeted local prevention

#### Facts & Figures

- Only 3% of young people aged 14-16 years could correctly identify three STIs (HIV/AIDS, Gonorrhoea and Chlamydia) from a list of common infections. Girls were significantly more knowledgeable than boys.

Source: Bugeja, R. (2010), Unpublished Thesis submitted for the degree of Doctor of Philosophy. University of Southampton: United Kingdom

The milieu, ethics, moral and cultural values, personal choices and prevalent lifestyles in a context need to determine the planning and development of any campaign, since sexual health is influenced by all such factors and facets of a society

efforts. It is imperative that all information, education, communication and skills-based prevention programmes are planned and developed against the specific context in which they would be delivered, that is specific targeted contexts within the wider national context. The transposition of a campaign across different contexts is believed to compromise the efficacy of a noted effective campaign in one context. The milieu, ethics, moral and cultural values, personal choices and prevalent lifestyles in a context need to determine the planning and development of any campaign, since sexual health is influenced by all such factors and facets of a society.

The Health Promotion and Disease Prevention Directorate within the Ministry of Health will seek to enhance its efforts in sexual health promotion. It will maintain its position of responsibility for the planning, managing, delivery and evaluation of such campaigns, in collaboration with the key stakeholders working in this area.

Close collaboration with stakeholders should enhance the establishment of such campaigns directly within the specific environments relevant to the particular age groups, different groups or target populations that they are respectively meant to address.

In essence, such initiatives will aim to:

- empower the population to adopt responsible attitudes and behaviour for its own health and the health of others;
- promote healthy life-styles;
- increase sexual health education among all age groups but especially the young and adolescents;
- increase awareness of when to seek the necessary professional care and support.

#### 5.1.ii Behaviour Change

The Health Promotion and Disease Prevention Directorate in collaboration with the stakeholders in the field will seek to enable people to appreciate and protect their sexual health through responsible behaviour and lifestyles.

Programmes and initiatives will:

- Educate about relationship skills and the dynamics taking place within sexual relationships;
- Address gender issues;
- Increase awareness on personal sexual health and responsibility towards one's sexual health;

- Raise awareness on fertility, conception, child rearing skills and acceptance of individual circumstances;
- Focus on development of risk reduction skills such as sexual assertiveness and discussing and negotiating protection measures.

Health Promotion approaches used will emphasise active learning techniques which aim to:

- Address cognitive, attitudinal and affective factors;
- Build motivation to change or to adopt a health behaviour;

#### Facts & Figures:

- **Condoms are the only contraceptive method proven to reduce the risk of sexually transmitted infections, including HIV**
- **According to the EHIS study in 2008, 8.5% of the sexually active population in Malta used condoms specifically as a way of preventing sexually transmitted diseases**
- **78.2% said they never used condoms as a form of prevention against STIs**

Source: EHIS (2008) Department of Health Information and Research

- Address environmental and/or social barriers that may inhibit change;
- Be sensitive to local culture, diversity, values and context;
- Be based on mainstream peer-reviewed scientific evidence;
- Provide outreach opportunities for all vulnerable target groups as well as minorities;
- Involve face-to-face small group work with peer support;
- Include workshops in different settings and aimed at specific target groups such as school leavers and people living in relative poverty;
- Utilise modern technological tools to provide informal learning opportunities on sexual health issues and concerns.

#### 5.1.iii Including Sexual Health Promotion in Primary Care

Professionals across a range of services, particularly those in primary care settings, can play an important part in providing consistent and integrated information, which needs to be synchronised with the content of all initiatives delivered through the Health Promotion Unit. All initiatives and reforms within primary care in Malta need to be screened in view of embracing this contention.

## 5.2 Secondary/tertiary prevention and curative services

The indicators of sexual health call for other services, such as those pertaining to pregnancy planning and pregnancy/childbirth education, prevention and treatment of sexually transmitted infections initiatives, cervical cytology screening tests setups, and services to prevent and respond to sexual violence.

All services are to address medical, psychological, ethical and social needs in as user friendly a manner as possible, including the development of outreach services for clients, particularly those with special needs. All services are to:

- a. Take client need, as the point of departure in determining service development, provision, monitoring and evaluation;
- b. Be friendly to all various ages, and easily accessible to and all inclusive (non-discriminatory) of all sections of society, taking into account for example all socio-economic inequalities, sexual orientations, people with disabilities, victims of rape, prisoners and detainees, and sex workers;
- c. Be evidence-based, which will include the use of standard national guidelines developed by authorised entities;
- d. Respect client's confidentiality at all times;

- e. Maintain records keeping to a high standard, to provide maximum benefit in client management, to facilitate audit, and secure and record the process of obtaining valid consent;
- f. Continually monitor, audit and evaluate their activities in order to maintain and improve performance.

These services require, as an essential prerequisite, adequate leadership and appropriately trained professional and supporting staff, who must be obliged to maintain their skills and competencies through continuing professional development opportunities. As with most other areas of health, the multiple factors which influence sexual health in any society render it its characteristic transient dynamic nature, which translates into a requisite for all staff to update periodically, in an attempt to remain abreast with the developing nature,

**As with most other areas of health, the multiple factors which influence sexual health in any society render it its characteristic transient dynamic nature, which translates into a requisite for all staff to update periodically, in an attempt to remain abreast with the developing nature, challenges, and facets associated with sexual health**

challenges, and facets associated with sexual health. This in turn obliges the Ministry to secure the provision of the referred continuing professional development opportunities for all staff.

Close collaboration with local and overseas educational and training entities is recommended, in view of the taxing costly nature of the provision and uptake of such opportunities. Participation of staff in exchange programmes is therefore recommended, as is the Leonardo EU programme.

### 5.3 A One-stop-“shop” sexual health service approach

Currently, there are a number of key stakeholders in sexual health care provision within both the public and the private health sectors. These include primary health care, reproductive health care, obstetric/gynaecological care, the urology department, the infectious diseases unit and the genitourinary clinic. A need and feasibility assessment process for the integration and networking of these sectors is indicated in the belief that further complementation of the individual services may enhance the outcomes of the respective individual initiatives, with respect to both effectiveness and efficiency. The evidence supporting the integration of services into a one-stop entity is, as yet, limited but favourable. The efficacy of such entities are still being studied.

This integrative exercise would need to be preceded by a comprehensive evaluation of the prevalent quantity and quality of all the respective individual services. Indicated needs for changes will be carried out accordingly. One possible way forward may be to migrate all the currently prevalent services into a single clinic, which would potentially offer more comprehensive sexual health care services, when the resources and contexts permit so. This sexual health clinic will be easily accessible to all, including through the use of relevant technology, as is the internet

Services from such a *one-stop* clinic will include:

- A genitourinary medicine clinic;
- Contraception advice;
- Protection against sexually transmitted infections;
- Cervical cytology screening tests;
- Referral for testicular examination as clinically indicated;
- On-the-spot pregnancy testing;
- Advice and counselling on sexual issues and responsibilities, with referral as necessary;
- Advice and counselling on STIs, including HIV and referral as necessary;
- Advice and treatment for common clinical sexual problems;
- Referral to other professionals/services beyond the single stop clinic, as indicated.

### 5.4 Training the relevant professions in sexual health promotion

This policy advocates the need for training of professionals across a range of sectors. Opportunities for training in sexual health need to be channelled towards health care professionals, teachers, counsellors, religious workers, psychologists, youth workers, social workers, and others whose work involves the direct addressing of and discussion about sexuality and sexual health. Before reviewing the characteristics of educational programmes, it is important to consider the needs to which these programmes ought to be directed: the development of appropriate attitudes, knowledge, and skills.<sup>49</sup>

#### 5.4.i Attitudes

In order to develop a better understanding of sexual problems, it is necessary for professionals to develop healthy attitudes to sexuality. An understanding by the professional of his/her own sexuality and a rational approach to his/her own sexual problems will help him/her to be better able to deal with the problems of others. It is also necessary for the professional to be aware of and to accept the wide range of variation in sexual behaviour so that he/she can transmit this assurance to clients who seek help for what they consider to be abnormal behaviour in themselves or their partners. The need for change in attitudes is recognized as being particularly important.

#### 5.4.ii Knowledge

In order to approach the topic with confidence, health professionals must themselves have accurate scientific knowledge regarding the facts of human reproduction and human sexuality; they must know what are common sexual problems met are and how to deal with them, and they must know when the solution of a problem is beyond their ability and requires referral to a specialist.

#### 5.4.iii Skills

To enhance his or her ability to help those people who ask for help in the solving of problems related to sexuality, it is essential for the health professional to develop the necessary skills in the art of communication and of good listening. He/she must be able to use the appropriate terminology without embarrassment, must be able to deal with the problem faced by the individual, must be able to develop a good interpersonal relationship and establish rapport with him/her in a non-judgemental way and with sympathy and with sensitivity. An important development in this respect is the attempt to assist the relevant professionals to adopt the appropriate use of language with their clients, consistent with the respective socio-cultural context.

Amongst other factors, the age of the learner is widely held to be one of the central determinants of the nature and content of an educational programme regarding sexual health. There appears to be a general consensus in the literature that holding the ability to appropriately pitch a sexuality and relationships education programme to the respective age/s of a learning audience, is a pre-requisite to favourable learning outcomes of a programme.

Skills appropriate to this area differ only very slightly from those that should be developed during the training of any doctor, nurse or educator. It can nevertheless be pointed out that the general orientation toward specific clinical tasks and techniques in the usual training of health professionals is less appropriate for personnel dealing with sexual problems, where the ability to listen and/or a number of counselling techniques, are to be more predominant.

## 6

# Sexuality and Relationships Education

### 6.1 The purpose and goals of sexuality education

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With the advent of HIV and AIDS in the 1980s the nature of sexuality education gained much attention. Seeking a socially, politically and culturally acceptable *raison d'être* for this education practice continues to provide a significant challenge. One major debate evidenced in recent literature is whether sexuality and relationships education should be driven by moral ideologies, or by scientific approaches showing evidence of effectiveness, regardless of values and morality, or both.<sup>50, 51</sup> The main issue with the latter stand point is that 'what works' and is 'effective' remains debatable.<sup>52</sup> Very often, the success of sexuality education is measured by statistical trends in teenage pregnancies and STIs. It has been widely argued that sexuality education should not be a negative process that attempts to frighten youths, but should take into account the positive aspects of sexual relationships.<sup>53, 54, 55.</sup>

The purpose of sexuality education has also been extended to include learning about psychological well-being by enhancing young people's ability to deal with their emotions. Indeed it has also been suggested that thus sexuality and relationships education ought to be an element within a broader objective of developing 'emotionally intelligent citizens'.<sup>56, 57</sup>

*Emotional intelligence*, which describes more or less the same concept as emotional literacy, has been defined as:

*"the ability to understand ourselves and other people, and in particular to be aware of, understand, and use information about the emotional states of ourselves and others with competence. It includes the ability to understand, express and manage our own emotions, and respond to the emotions of others, in ways that are helpful to ourselves and others."*<sup>58</sup>

The sexuality and relationships education framework prevalent in Malta needs to be timely evaluated against the backdrop of this modern wider and more holistic approach to sexuality education.

The National Minimum Curriculum<sup>59</sup> which is a legally binding document for all Maltese schools, addresses learning needs related to Human Sexuality in Objective 6. This document identifies the knowledge, capabilities and attitudes underpinning a true understanding of human sexuality. This is covered in various subject syllabi at schools including the Personal and Social Development (PSD) lessons, Religious Education lessons, Science or Biology lessons and Home Economics amongst others, imparting knowledge / information, skills, values and attitudes related to sexual health, sexuality and relationships. However, evidence emanating from 16 focus groups with young people in different schools across Malta and Gozo, conducted as part of a local large scale empirical research

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study,<sup>60</sup> indicates that sexuality and relationships education on the Maltese islands remains scanty and uncoordinated across the schools, primarily due to limited and restricted time-table time for its delivery (especially through PSD lessons), a wide-spread lack of preparedness and effective technical skills by teachers and other educational professionals to discuss sexuality and sexual health matters with young people, lack of professional education resources, lack of coordination between the different subject teachers addressing sexuality and sexual health, lack of coordination with parents, and the lack of national policy that outlines the targets and standards of sexuality and relationships education to be delivered in literally all schools across Malta and Gozo. This calls for further research, evaluation, quality assurance and monitoring of sexuality and relationships education practices, locally, in terms of:

- a. The purpose of sexuality and relationships education
- b. Approaches to learning
- c. Methods of teaching and learning
- d. Sources of information and knowledge
- e. Content
- f. Timing of learning
- g. Learning resources

## 6.2 Parental and guardian involvement

Parents and guardians are crucial role models in the upbringing and development of children. These will be directly involved in the provision of sexuality and relationship education to their children. It is therefore imperative that they receive parenting skills training, information and support to fulfil their role. They are the key people to help their children cope with the emotional, social and physical aspects of growing up and preparing them for the challenges and responsibilities that sexual maturation brings. The development of specific educational programmes, both formal and informal, are necessary to secure essential skills in communicating effectively with their children about sexuality and sexual health issues.

Schools are to work in partnership with parents, consulting them on the content of sexuality and relationships education programmes. Parents and guardians need to know that the school's sexuality and relationships education programme will complement and support their role as parents, whilst also giving them the opportunity of furthering their personal knowledge and skills. The prevalent services and initiatives being offered largely through the education and social sectors are to be periodically evaluated and developed further as indicated by the respective structured evaluation and monitoring exercises.

## 6.3 The media

The policy acknowledges the significant influence that the media has on the public in today's world. Against this backdrop, the need for comprehensive educational opportunities in partnership with the media are recommended to positively promote a consistent approach and philosophy towards sexuality, built on the guiding principles of this policy. This is a key component of any strategy aiming to combat possible unfavourable scenarios of having members of the public travel through clouds of partial information, misinformation and exploitation that they may find from the media.

The potential of the media to contribute effectively to optimal sexual health is widely acknowledged and therefore strongly indicates towards the referred partnership with health educational initiatives.

## 7 Research, Evaluation and Quality Assurance Policies

Ongoing research and evaluation is an essential component of any policy or service provision. Research helps to identify new trends and concerns while assessing need for further services and interventions. Therefore, all programmes and interventions carried out with the purpose of enhancing people's sexual health, ranging from health promotion to educational and counselling needs, and from secondary and tertiary prevention interventions to curative medical care, need to be audited and reviewed. Such an exercise will assess their degree of success and effectiveness in achieving pre-established goals and targets. This should in turn guide future interventions and allocation of funds.

Enhanced co-operation with other countries, the EU and the WHO in the context of research initiatives needs to be actively sought and developed. The recommendations pertaining to

research initiatives have been noted along this document. The consolidation of the recommended various research initiatives by one steering entity is being advised, in that such consolidation is believed to maximise efficiency of use of resources in curtailing duplication, repetition and wastage of limited resources available to pursue the noted research initiatives. The terms of reference of the referred steering entity and the members within it are to be determined accordingly, following wider consultation, after the publication of this policy.

Quality service delivery standards and protocols with pre-established targets and objectives need to be introduced for quality assurance in clinical service provision, including for contact tracing and pre- and post- test counselling (such as in genito-urinary clinic service, sexual health clinics, sexual violence / rape response services, etc.) and for sexuality and relationships education provision (such as in schools).

## 8 Future Considerations

Reference has been made already to the characteristic transient and dynamic nature of sexual health. In view of this nature, issues, challenges and facets associated with and arising around sexual health will always be in a state of flux and evolution in the future.

The phenomena of globalisation and increased people migration across countries is increasingly bringing to light the importance of cultural competence across all sectors, including sexual health, and moreover the importance of acknowledging the needs of evolving multicultural societies and addressing them accordingly. For example, Female Genital Mutilation (FGM) is one of many realities arising around sexual health which needs to be addressed more comprehensively in Malta, as a result of an increase in the numbers of residents originating from societies where such practices are known to be prevalent. Government needs to establish

a framework which will be responsible for the detection of the specific needs of minorities within the population of Malta.

In the absence of a rigorous framework and measures which seek to detect the needs, issues and demands of minority groups, the rights of such individuals for optimal health care will be compromised. Complementary legal and regulatory framework of such practices and services, and the training of professionals and supporting staff in skills and knowledge needed to address the demand of minority groups, need to be established accordingly.

Another phenomenon which is bound to have an impact on sexual health is the evolving nature of the health care team across the globe. Scenarios comprising of exclusively doctors and nurses are rapidly being replaced by scenarios consisting of health care teams, varying from

a small number of three or four different professionals to larger teams endorsing a variety of professionals, holding qualifications in varying and narrow specialised fields of practice, as for example are health counsellors as opposed to counsellors. As a result of a booming array of local and overseas educational and training

opportunities, the nature of the health care team in Malta is also gradually changing. In addition, existent professions are continually revising and extending their respective roles. Any policy would need to be periodically calibrated in tune with such evolving contexts, in an attempt to remain relevant.

## Conclusion

In being a first for the specific context of Malta, this sexual health policy seeks to comprehensively determine the pathway that needs to be pursued in an attempt to effectively enhance the sexual health of the population. In summary, the policy identifies the major sexual health indicators, and drawing on evidence, it seeks to establish avenues of addressing the identified indicators.

An avenue comprises a defined beginning and an end point. This policy clearly highlights the end points of the avenues; the sexual health indicators, and recommends constructive ways of

**The indicated research and the noted recommendations within this policy will translate into an effective strategy for the enhancement of sexual health across the nation, now and in the future.**

seeking to reach the noted end points. The next step for the country comprises the determination of the starting points of the respective avenues. In the absence of sound evidence regarding the various facets of sexual health, such as accurate behavioural patterns and prevalence of disease, the need for varied research activity is strongly indicated.

An extensive research exercise which would seek to explore the social and behavioural facets of sexual health of people living in Malta is needed. In addition, an audit research initiative which would seek to elicit evidence regarding the prevalent monitoring and surveillance practices in the country, and the legislative and quality assurance structures within which sexual health medical and education services exist, is strongly called for. All research activity would need to fall under the umbrella of a recognised authoritative national entity, such as the Research Ethics Committee of the University of Malta, and be

steered by the Ministry of Health at the helm of such activity. This would secure the adequate recognisance of the moral, cultural and ethical sensitivity of the nature of subject of the research study, to the specific context of Malta.

In providing an accurate snapshot of the current situation, the collective outcome of such research activity will determine all the referred starting points of the respective avenues identified in this policy. Recommendations for the successful trespassing of the gap between starting points

and end points across avenues are found within the policy. The indicated research and the noted recommendations within this policy will translate into the basis of an effective strategy for the enhancement of sexual health across the nation, now and in the future. The publication of this policy is being complemented by a series of workshops that will be launched and co-ordinated by the Ministry. The contribution of all entities and representatives from across all the population towards the building of a comprehensive sexual health strategy for the specific context of Malta, will be secured through the referred workshops.

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**“A society that fosters an environment that is conducive to persons attaining their maximum potential for health and well-being”**

Our mission is to protect and promote the health of the people of the Islands of Malta. We are working to protect individuals and communities against the spread of disease, injuries, and environmental hazards while promoting and encouraging healthy behaviours and enforcing the laws and regulations pertaining to public health. The Health Division is dedicated to assuring the accessibility, quality and sustainability of the public health services and resources.

The Ministry for Health, the Elderly and Community Care