## Contents

Introduction.................................................................................................... 5  
Topic 1: Sexuality and sexual health ......................................................... 6  
Topic 2: Adolescent sexuality................................................................. 10  
Topic 3: Sexual diversity............................................................................. 16  
Topic 4: Love and intimacy.......................................................................... 22  
Topic 5: Stages of interpersonal relationships ............................................ 28  
Topic 6A: Reproductive health I............................................................... 34  
Topic 6B: Reproductive health II.............................................................. 46  
Topic 7: Contraception and family planning .............................................. 54  
Topic 8: Sexually transmitted infections ................................................... 76  
Topic 9: Human papillomavirus and cervical cancer ....................................... 84  
Topic 10: Teenage pregnancies .................................................................... 90  
Topic 11: Abortion........................................................................................ 96  
Topic 12: Sexuality and relationships education ............................................ 104  
Glossary........................................................................................................ 111  
Sources of help & information.................................................................. 125  
References and bibliography.................................................................. 128
Introduction

The Sexual Health Policy and the Strategy are underpinned by human rights and social justice principles. They aim for optimum sexual health and wellbeing with the capacity for the person to enjoy and control sexual and reproductive health free from fear, shame and guilt associated with false beliefs and misconceptions and free from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.

The Sexual Health Strategy identifies the media as a means to communicate on sexual health in an effective and responsible way. Evidence shows that the media is a useful means to provide information to the general public. The type of media used will depend on the identified target audience. Unbalanced or inaccurate media messages can lead to pressures and confusion over the realities of sex and sexuality particularly for young people. Hence we cannot stop emphasizing the need and importance of the media to be trained on where to seek reliable sources of information and advice.

The media is also able to raise awareness on a particular issue and to reflect back current thinking to users. In addition, media can be useful in shaping attitudes and values. When combined with a range of activities in a multifaceted approach, a positive message through the media can change behaviour. It has been shown that accurate and well-articulated media coverage on sexual health has the potential to improve sexual health and enhance individual lives. In view of the multitude of social and cultural sensitivities that sexuality-related topics carry with them, the presentation of messages on sexual health and sexualities while being clear and factual must also take cognisance of these sensitivities.

The aim of this media pack is to raise the visibility of issues related to sexual and reproductive health based on the principles of individual and social rights and responsibilities, stemming from the values of respect and dignity to human life. This pack contains the correct and evidence-based information which is of relevance to the local situation. The various resources included are designed to help editors, producers, and journalists cover the complex issues that surround sexual and reproductive health. Topics covered in this pack include sexuality and sexual health principles, adolescent sexuality, sexual diversity, love and intimacy, stages of interpersonal relationships, reproductive health, contraception and family planning, sexually transmitted infections, cervical cancer, teenage pregnancies, abortion and sexuality and relationships education.

We encourage all media-related stakeholders to take up and make use of the information provided in this pack which we hope will help impart correct messages which promote and enhance optimum sexual health for all.

Dr Charmaine Gauci
Director, Health Promotion and Disease Prevention

Dr Raymond Busuttil
Superintendent for Public Health
TOPIC 1
Sexuality and sexual health
Human sexuality
Human sexuality is a complex topic. Western civilization has a millennia-long tradition of negative sexual attitudes and biases. But sexuality is much more than just blatant sexual behaviour.

Human sexuality spans and underlies the complete range of physical, intellectual, emotional, social and spiritual dimensions of human experience. It has no single or universal agreed definition, because sexuality also encompasses social and cultural diversity. Thus its definition may vary in different social and cultural contexts. Furthermore, human sexuality cannot be adequately understood unless due consideration is given to the influence that religion and secularisation play on the sexual mores and culture. Therefore, faith and cultural beliefs, together with developing social contexts and processes, influence the ways in which sexuality and sexual practices shape human identity. For these reasons, the concept of sexuality has changed over time, and remains dynamic today.

Sexuality has been largely defined in the literature as a powerful and purposeful aspect of human nature; an essential component of personhood; an important dimension of our humanness and of the human personality which is inextricably woven in the fabric of human existence. It touches on topics such as sexual anatomy and responses, sexual feelings and behaviours, intimate relationships, sexual identity and desires, sexual and reproductive health and sexual wellbeing. However, it is also about the way we individually perceive our sexual selves and build our unique identity. It is about how we interrelate our physiological and psychosocial processes, which are inherent in the way we sexually develop and sexually respond, both to ourselves and to others. Therefore, our sexuality contributes both to our lives and to the lives of other people with whom we interact.

Expressing sexuality
Expressing sexuality is one of the most joyful and enriching aspects of the human experience, and an essential component of the drive to realise our ultimate potential as human beings. In positively expressing our sexuality, we are able to uniquely express and project our personal identity; communicate subtle, gentle or intense feelings; realise sexual pleasure and physical release; emotionally bond with others; achieve a sense of self-worth; and, for many, link with the future through their offspring. Positive sexual expression provides a deep emotional connection with others, through communication and expression of emotions. This deep emotional connection which realizes itself in sensual love making becomes even more important than the physical sexual act itself!

As sexual beings, we are all entitled to the full potential of positive sexual expression, that is, to be able to positively express our sexuality. However, against popular belief, this does not come naturally or instinctively. It is not entirely programmed by nature. Human sexual experience hardly resembles that of non-human animals. As sexual human beings, we have the ability to think and feel. Therefore, humans have an intellectual and emotional investment in virtually everything sexual. This investment infuses people’s sexual interactions with immense joy and passion. Thus, in being able to positively express our sexuality, and to achieve this experience, one would need to achieve a degree of sexual competence.
**Sexual competence**

Sexual competence comes as a prelude to positive sexual expression. Competence refers to the ability, skills or knowledge to attain the desired outcomes, while honouring the rights of all involved. Within the context of sexuality, it is the ability to express our sexual emotions positively and enjoy the benefits of sexual expression highlighted above. Therefore, sexual competence is inextricably linked with emotional intelligence. Emotional intelligence has been defined as the ability to understand 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 positive and helpful to ourselves and others.

A high degree of sexual competence is evidenced when sexual interaction between two persons is consensual, where decisions are made autonomously (that is, not under any form of duress or under the influence of chemical substances) and with no regret. A high degree of sexual competence is evidenced when sexual interactions are based on equality, mutual respect, love, responsibility towards the self and the other, trust, safety and commitment. In more negative terms, positive sexual expression would exclude post-sex worries over contracting a sexually transmitted infection or an unplanned conception and pregnancy. It would exclude having regrets over the nature, the circumstances and the person with whom sexual interaction takes place. It would also exclude having been coerced or acted against one’s will. A good level of sexual competence results in positive sexual expression.

On the other hand, sexual competence is lacking when sexual interactions are based on dishonesty, domination, manipulation, humiliation, coercion, hostility, rage, disregard to self-esteem, physical safety, and negative consequences; or when sexual interaction takes place under the influence of chemical substances such as alcohol and drugs. A low level of sexual competence leads to the experience of fear, shame, regret, guilt and damaged individual self-image. It also leads to negative expectations from future sexual interactions and encounters.

Having a high degree of sexual competence gives us an opportunity to enjoy positive sexual expression, positive sexual and reproductive health and well-being, and helps us reach our full potential as human beings. Sexual competence is enhanced through long-life learning about our own sexuality and sexual health, starting in early childhood, through adolescence to adulthood.

**Sexual and reproductive health**

Within the framework of the World Health Organisation’s definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have responsible, satisfying and safe sexual relationships, and that they have the capability to reproduce and the freedom to decide when and how often to do so.

Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable pre-conception methods of family planning of their choice; the right to access to appropriate health care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant.

As already highlighted above, the sexual development of a person is a process that comprises physical, psychological, emotional, social and cultural dimensions. It is also inextricably linked to the development of one’s identity and it unfolds within specific socio-economic and cultural contexts. Therefore, ‘sexual health’ within this wider and holistic definition, integrates physical, emotional, intellectual and social dimensions of health, and is fundamental to the well-being of all people. Sexual health also goes beyond these domains to require personal awareness, self-acceptance, a positive self-identity and sexual integration – defined as the congruence of a person’s sexual values and behaviours integrated within a person’s wider personality structure and self-definition. Furthermore, there is a communal aspect in the definition of sexual health, reflecting not only self-acceptance and self-respect, but also respect for others in the ability of developing mutually satisfying and considerate relationships.

In summary, sexuality is an important dimension of people’s lives. Sexual well-being can be a source of pleasure and comfort, a way of expressing affection and love, and a means for starting a family. However, in negatively expressing sexuality, people may risk sexual ill-health and adverse social outcomes. Education and learning about sexuality can enhance a person’s sexual competence, and in return enhances one’s potential to positive sexual expression and fulfilment.
TOPIC 2
Adolescent sexuality
In Western societies, in the past sexuality issues seem to have been simpler than now. In the last three decades or so, especially since the advent of HIV and AIDS in the 80s, there has been an explosion of information and research on adolescent sexuality. The same era has seen further changes in social norms, changes in beliefs about sexuality, and increasing levels of tolerance for adolescents’ expression of sexuality and sexual diversity (consistent with changes occurring in adult society).

Adolescence, commonly identified as the period between 10 and 19 years of age, is not only marked by dramatic physiological changes, but also by important and often profound emotional and behavioural changes, social-role development and interpersonal events. Sexual questions, conflicts and crises may begin prior to adolescence, and may certainly continue after this phase of life. But there is no doubt that, for most people, adolescence is a ‘critical period’ in the upsurge of sexual drives, the development of sexual values and the initiation of sexual relationships. During this period adolescents undergo a transitional developmental phase from childhood through to adulthood. The advent of puberty, the power of peer group expectations, and the communication of mixed messages about sex from the adult generation, especially through the media, make dealing with sexuality a difficult but exciting challenge for adolescents. Academic literature has been quite consistent in regarding adolescent sexuality and sexual behaviour as a multidimensional and complex phenomenon.

Today, ideas about ‘right’ and ‘wrong’ adolescent sexual behaviour are less rigid and boundaries are less clear. Of course, teenage sex has always been with us. What is new is the increase in the numbers of young people engaging in this behaviour, and at an increasingly younger age, in the last few decades. In particular, European and American research has shown evidence of a dramatic rise in the number of teenage girls who are sexually active outside marriage over this period. Research findings from the Health Interview Survey of 2008 (Health Information and Research Directorate, Malta), the average age at first intercourse for Maltese young people aged 15 – 24 was 17 years of age. Furthermore, a study of sexual behaviours among 1310 Maltese young people aged 14 – 16 years (Bugeja, 2010) revealed that between 10-15% (12.5% +/- 2.5%) had already practiced sexual intercourse, with the majority having had sex the first time at age 14.
Historically, young boys were more sexually active than young girls. This was also accepted as a ‘double-standard’, which lasted until the 1940s or early 1950s, where sexual activity was tolerated for boys yet prohibited for girls. But the gap between the genders began to narrow, especially with the arrival of the contraceptive pill in the 1950s. The ‘joy of sex’ revolution of the 1960s and 1970s, which was characterised by more permissive attitudes towards sexuality and greater concern for personal fulfilment; and the influence of the demands for equality of sexual expression and sexual fulfilment which were advocated by members of the women’s movement - brought with them a lessening of the prohibition on premarital sex. More recent studies conducted in the 1980s and 1990s confirmed this increase, with some revealing that young girls were as sexually active as their male peers. This is also the case in Malta, where less than 1% difference bridged the gap between the prevalence of boys and girls having sexual intercourse by age 16 (12.6% males and 12.0% females), although boys had significantly more different sexual partners with whom they have had sex than girls (Bugeja, 2010). As a result, there has also been a dramatic rise in teenage unplanned pregnancies outside marriage (see section 10, page 88 for teenage pregnancies).

Many young men and women are now more focussed on establishing a career rather than a long-term relationship. Young people are delaying or dispensing with marriage while at the same time, the age at which puberty begins is decreasing. There has been a significant positive association evidenced between age at menarche (first menstrual period) and age at first intercourse in young girls. This extension of the period between physical maturation and the taking up of traditional roles as in marriage, together with the fact that contraception is widely available, led to the uncoupling of sexuality, marriage and childbearing in the last few decades. The trend towards later marriage may well have contributed since many believe it to be unrealistic to expect young people to abstain from sexual activity until marriage. Initially, premarital sex was more tolerated provided it occurred in a loving, long standing, committed relationship, that was a prelude to marriage. Since then, we have seen a greater tolerance for sex outside of a stable relationship.
It is commonly argued that this have been brought about through the power of a globalised youth culture, shaped largely by the media, facilitated with advanced information and communication technologies. Even in Malta, where premarital sex has long been forbidden and discussions about sexuality taboo, there have been significant changes in young people’s sexual behaviours in the past few decades. The near universal use and much enhanced accessibility of the internet and satellite communications have opened up both positive and negative opportunities for adolescents’ sexual lives. Increasingly, although young people across the globe live in different social, cultural and economic circumstances, their sexual worlds reveal commonalities, as well as differences.

On the other hand, it would be irrational to believe that all teenagers would engage in premarital sex. The way terms such as young people and adolescents are often used in the general literature tend to simplify adolescence and encourage a misinterpretation of the nature of young people’s sexual development and expression in different ways.

First, young people are generally homogenised with habitual characteristics that give little recognition to the diversity among adolescents. Because some young people take risks, all are assumed to do so. Because some young people the present matters more than the future, all are assumed to live in the here and now. And because some young people seek pleasure and thrills, all are assumed to be hedonistic. In assuming that all young people are similar, we are constantly falling back on stereotypes and oversimplifications of who adolescents are.

A significant proportion of young people advocate no sex before marriage, although it is difficult to assess whether this attitude is consistent with behaviour. For example, findings from a survey conducted among 421 Maltese university students (mean age 21 years) by the University Chaplaincy in 2008 (Bartolo, 2009) revealed a very pronounced disparity between religious belief, moral choices, and personal behaviour and practices, particularly in the field of sexuality. The majority (91%) claimed to be Catholics. Just under a quarter (24%) of the participants disagreed with pre-marital sexual intercourse. While 76% saw nothing wrong in pre-marital sexual intercourse, only 44% said they had actually engaged in it up to a year prior to the survey.

Secondly, very often the literature seems to highlight the spontaneity, social immaturity, risk-taking and volatile behavioural patterns of the adolescent, focusing on the abnormal, deviant and spectacular behaviour which young people are often inclined to engage in as they negotiate adolescence. The heavy emphasis on deviance and young people’s perceived vulnerability to risks associated with early sexual debut and unprotected sexual activity - disease and unplanned pregnancy - remain in today’s discourse about adolescent sexuality. Much of the research has placed more emphasis on the negative and problematic perspective on young people’s sexual behaviour. In international literature, young people’s behaviours are often considered as relatively homogeneous, risk-laden, and without any emotion. Thus, adolescents can quickly be perceived as a collection of discrete problems and adolescence depicted as a period that may impact young people’s health in a negative way for the rest of their lives.

But adolescent sexuality need not be defined as problematic behaviour. An alternative perspective is to see adolescence as a time for discovering potentials, endowed with positive life-affirming developmental events, which assist young people in becoming mature and holistic persons. Children develop physically, sexually and emotionally, bringing them to the full physical and behavioural sexual maturity to start forming relationships. Sexual expression that is non-exploitative and safe, from the point of view of mental and physical health, can make a positive contribution to teenage development through increased independence, social competence and self-esteem.

Unlike many of the activities people engage in, expression of one’s sexuality (for the most part) involves a relationship, no matter how limited or brief, with another individual. Sexual expression requires a unique exposure of the self to another. On the one hand there is the possibility of validating one’s sense of self-worth and achieving a deeply satisfying intimate relationship. On the other hand, wrong choices can lead to destructive outcomes, to feelings of anxiety and guilt and to a sense of unworthiness. For adolescents, who are in the process of forming a satisfying and satisfactory sense of their own identity and their place in society, dealing with these issues is a crucial part of their development.

This is not to say that all teenage sexual behaviour is adaptive, healthy and moral. It is true that sexual relationships starting in adolescence can bring significant health and social problems among young adults. Clearly sexual activity can occur too early and in a context that is inappropriate. But sexuality is a normative event in adolescent development, with the potential for both positive and negative
consequences. Through building relationships, young people also start to learn how to relate with others in an intimate way, in an expression of communication, affection and bonding. It also helps them develop sexual values that guide their sexual behaviour.

Thirdly, quite often the literature fails to acknowledge that young people’s sexual drive and expression are not only the result of their physiological and emotional development, but also influenced and shaped by the attitudes, ideas and expectations of both the immediate and the wider socio-religious and cultural context. It has long been recognised that sexuality and sexual behaviour are socially constructed, and not the mere result of biological phenomena. Thus young people’s behaviour can be considered a mirror of a particular society’s norms and attitudes. Thus, youth sexuality cannot be adequately understood unless due consideration is given to the influence that religion and secularisation play on the sexual mores and culture.

One major focus for research on adolescent sexuality is documenting sexual behaviours within a biological framework. How many teenagers are sexually active? What are they doing? Are they using contraception? What is the incidence of teenage pregnancy? These are important questions. But if we are to understand the significance of sexuality during adolescence, we need to consider how the biological fits into the psychological and social aspects of adolescent development.

At the biological level, sexuality is the central feature, marked by the onset of puberty which signals maturation of the reproductive organs, the possibility of becoming a parent and an increasing sex drive. The sexual urges which emerge at puberty must be blended with other aspects of teenagers’ lives. With puberty, changes at the psychological level have to do with readiness for taking on adult roles, including sex and procreation. There is a shift from a primary orientation to one’s family to a reliance on peers for providing guidelines for attitudes and behaviour, as well as a clarification of goals and the development of interpersonal skills and attitudes. This occurs within a context of expanded cognitive skills which allow the adolescent to evaluate alternative points of view. At a broader level, social forces shape adolescents’ sexuality by establishing and re-establishing values and norms relating to sexuality and expectations tied to gender. Recognising those aspects of sexuality that are socially constructed enables us to raise questions about the social context and the ways in which this channels teenagers’ sexual experiences.
TOPIC 3
Sexual diversity
Sexual orientation and gender identity
Sexual diversity

Humankind is a diverse society. The human race is composed of a wide variety of ethnic and religious backgrounds, skin colours and languages. In other words, people are not all the same: there are many ways in which human beings are different from each other. Sexuality is one of the ways that people are different from one another. Although the term “sexual diversity” can apply to many different aspects of sexuality (for example people are diverse in terms of their sexual likes and dislikes), it is often used in the context of sexual orientation and gender identity.

The acronym LGBT is a reflection of sexual diversity within society. It is intended to emphasise a diversity of sexuality and gender identity, and is sometimes used to refer to anyone who is non-heterosexual, or cisgender, instead of exclusively to people who are homosexual, bisexual or transgender. Initially it was LGB (Lesbian, Gay, Bisexual) which itself started replacing the phrase ‘gay community’ beginning in the mid-to-late 1980s. However, many within the gay community felt that LGB did not accurately represent who it referred to. To recognise this inclusion, a popular variant was coined adding the letter T for transgender, hence LGBT; and since the mid-90s the letter Q was added for those who identify themselves as queer and are questioning their sexual identity – hence LGBTQ.

- **L** is for lesbian. Lesbian refers a female person whose primary sexual attraction is toward females.
- **G** is for Gay. Gay refers to a male person whose primary sexual attraction is toward males.
- **B** is for Bisexual. Bisexual refers to a male or female person who is sexually attracted to both males and females.
- **T** is for Transgender and/or Transsexual. Transgender refers to a person whose gender identity is neither exclusively female nor male. Transsexual refers to a person whose gender identity is the opposite of their biological sex.
- **Q** is for Queer or Questioning. Some non-heterosexual people refer to themselves as Queer because they are uncomfortable labelling themselves according to the more traditional categories of gay, lesbian, or bisexual. A person who is Questioning is in the process of arriving at a clearer sense of what his/her sexual orientation is.

These acronyms are not agreeable to everyone that they literally encompass. On the one hand, some intersex people who want to be included in LGBT groups suggest an extended acronym LGBTI. On the other hand, some individuals of one group may feel no relation to the individuals in other groups denoted and find such persistent comparisons offensive.

**Sexual orientation**

Homosexuality, bisexuality and heterosexuality are words that identify one's sexual orientation, that is, to which of the sexes one is attracted socially, psychologically, emotionally and erotically. Attraction to same-sex partners is a homosexual orientation, and attraction to ‘other-sex’ partners is a heterosexual orientation. Bisexuality refers to attraction to both same- and other- sex partners (the use of the term “opposite-sex” is being purposely avoided as it may overstate the differences between males and females; the term “other-sex” is used as an alternative term). The term assexuality or non-sexuality refers to a person's lack of sexual attraction for any gender. (Asexuality is different from someone who abstains from sexual practices with others, such as in celibacy or sexual abstinence, which behaviours are motivated by an individual’s personal choice or religious beliefs). There is an on-going debate in the sociological and psychological scientific arena on whether assexuality ought to be considered
as a sexual orientation, or whether it is the mere absence of a sexual orientation. Asexuals, while lacking in sexual desire for any gender, may also engage in purely emotional romantic relationships.

Homosexuality, heterosexuality, bisexuality and asexuality are only one aspect of a person’s life; therefore they ought to be used more as descriptive adjectives than as nouns that labels a person’s total identity.

In our society, we tend to make clear-cut distinctions between homosexuality and heterosexuality. Actually, the delineation is not so precise. Various research studies has shown that a relatively small percentage of people consider themselves to be exclusively homosexual; while the majority (over 90%) think of themselves exclusively heterosexual. These groups represent the extreme ends of a seven-point spectrum known as the heterosexual-homosexual rating scale, or the Kinsey Scale, named after the American biologist and sexologist Alfred Kinsey who devised it in 1948. Kinsey was the first to perform research on human sexuality, whose work is considered foundational to the modern field of sexology. Individuals between the ends of the heterosexual-homosexual spectrum exhibit varying mixtures of orientation and/or experience, which may also change over time.

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</tr>
<tr>
<td>1</td>
<td>Predominantly heterosexual, only incidentally homosexual</td>
</tr>
<tr>
<td>2</td>
<td>Predominantly heterosexual, but more than incidentally homosexual</td>
</tr>
<tr>
<td>3</td>
<td>Equally heterosexual and homosexual</td>
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<tr>
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<td>Predominantly homosexual, but more than incidentally heterosexual</td>
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<td>Predominantly homosexual, only incidentally heterosexual</td>
</tr>
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<td>6</td>
<td>Exclusively homosexual</td>
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</table>

Bisexuality

According to one definition, a bisexual person is one who can enjoy and engage in sexual activity with members of both sexes, or recognise a desire to do so. Kinsey’s continuum of sexual attraction has been questioned in regard to bisexuality. On Kinsey’s scale, individuals lose degrees of one orientation as they move towards the extreme end of the scales; thus bisexual individuals are seen as a compromise between the two extremes. There is a tendency to use behaviour as the only criterion for sexual orientation and to use the term bisexual to encompass a considerable number of people who fall between exclusive heterosexuality and exclusive homosexuality. However this fails to take into account the context within which the sexual experiences occur and the feelings and thoughts of the individuals involved.

Scholars have described several different types of bisexuality: bisexuality as a real orientation, bisexuality as a transitory orientation, bisexuality as a transitional orientation, or bisexuality as homosexual denial.

Bisexuality as a real orientation means that some people have an attraction to both sexes that begins early in life and continues into adulthood. An individual with this orientation might or might not be sexually active with more than one partner at a time but would continue to be capable of feelings of attraction to both sexes. Some research indicates that women move between straight, bisexual, and lesbian relationships more easily than men; men tend to be more fixed in their orientation.

Bisexuality can be transitory – a temporary involvement by people who are actually heterosexual or homosexual. These individuals will return fully to their original orientation after a
period of bisexual experimentation or experiences. Transitory same-sex behaviour may occur in single-sex boarding schools and prisons, yet the people involved resume heterosexual relationships when the opportunities are again available.

Bisexuality can also be a transitional state in which a person is changing from one orientation to another. This person will remain in the new orientation. It is believed that the majority of bisexuals establish heterosexuality first in their lives and then, over time, include homosexual relationships. Most do not define themselves as bisexual until years after their initial dual attractions.

Finally, bisexuality may sometimes be an attempt to deny exclusive homosexual interests and to avoid the full stigma of homosexual identity. Gay men and lesbians sometimes view the bisexual person as someone who really is homosexual but lacks the courage to identify him or herself as such. For example, a number of people marry to maintain a facade of heterosexuality but continue to have strong homosexual desires or secretive homosexual contacts. One study also found that few bisexual men participate in the gay community.

**What determines sexual orientation?**

This is the first and perhaps the most basic question about sexual orientations. Education on the causes of heterosexuality, homosexuality and bisexuality is greatly needed, as few people really understand the developmental nature of sexual attractions. There are two main theories that have attempted to explain the origins of sexual orientation, particularly homosexuality (although some argue that to pose the question of what causes homosexuality is actually being judgemental towards homosexual people. The purpose of this section is to help dispel common myths propagated in the media about the causes of homosexuality). One is that a homosexual orientation is essentially dictated by genetic or biologic factors, put simply, that people are ‘born gay’. The other theory is that homosexual attractions develop as primarily as a result of psychological and environmental influences and early experiences. Considerable research has been done over the years, much of it contradictory, and there are still no definitive scientific answers. A number of studies published during the 1990s have claimed to offer evidence in favour of a biological or genetic cause for homosexuality. Three of these in particular – a study of brain structure by Simon LeVay; a study of twins by J. Michael Bailey and Richard C. Pillard; and a study of “gene linkage” and “gene markers” by a team led by Dean H. Hamer – attracted considerable media attention and are largely responsible for the popular belief that a “gay gene” has been found. Psychosocial explanations of the development of a homosexual orientation relate to life incidents, parenting patterns, or psychological attributes of the individual.

Some people believe that unhappy heterosexual experiences cause a person to become homosexual. However, research has shown that homosexual and heterosexual groups did not differ in their frequency of dating during high school. The male and female homosexual subjects did, however, tend to feel differently about dating than their heterosexual counterparts; fewer homosexual subjects reported that they enjoyed heterosexual dating. Research indicated that homosexual orientation reflects neither a lack of heterosexual experience nor a history of negative heterosexual experiences.

Some people believe that young women and men become homosexual because they have been seduced by older homosexuals, or they have “caught it” from someone else, particularly a well-liked or respected teacher who is homosexual. In fact, research has also revealed that many people believe that gay men and lesbians should not teach in schools – probably because they believe in the seduction and contagion myth. Contrary to these myths, research indicates that sexual orientation is most often established before school age, and most homosexuals have their first sexual experience with someone close to their own age.

Another prevalent theory has to do with certain patterns in a person’s family background. Psychoanalytic theory implicated both childhood experiences and relationships with parents. Sigmund Freud (1905) maintained that the relationship with one’s father and mother was a critical factor. Freud believed that in “normal” development, we all pass through a “homoerotic” phase. He argued that boys could become fixated at this homosexual phase if they had a poor relationship with their father and an overly close relationship with their mother; the same thing might inversely happen to a woman. Clinical research has attempted to confirm this hypothesis, and although some cases followed this pattern, many homosexual individuals did not fit in these traits, that is, their mothers are not dominant or their fathers emotionally detached. At the same time, many heterosexuals were reared in families where these patterns prevailed. Thus, although male homosexuality may in some cases be related to poor father-son relationships, no particular phenomenon of family life could be singled out as especially consequential for either homosexual or heterosexual development.
Some people believe that choice is a significant factor in same-sex relationships. While some persons are capable of functioning sexually with either sex, other gender related qualities (such as gender-role stereotypes) lead them to find greater satisfaction in same-sex attachments. Researchers argue that women's sexual orientation appears to be more fluid than men's with sexual desire linked to emotional attachment to a particular person while men tend to label themselves as either exclusively gay or straight. Many argue that the idea that same sex attractions are a choice find it extremely offensive and hurtful, especially to those who have these desires. This is because attractions and desires are like feelings; they come from deep within the person and are not a conscious choice on people's part. Promoting the perspective that it is a choice often perpetuates judgemental attitudes towards homosexuals.

Among the biological causes for sexual orientation explored are adult hormone levels, structural differences in the brains, genetic factors, and gender nonconformity as a child. No well-controlled research has found any difference in the circulating levels of sex hormones in adult heterosexual and homosexual males. And even if consistent differences could be identified, it would be difficult to tell whether they were a cause or result of sexual orientation. It would also remain unknown if brain differences developed before birth or during the individuals’ life span. Several studies have found that male and female homosexuality is significantly familiar, which is to say that it appears to run in families. But the mere fact that homosexual tends to be familial does not necessarily mean genetic factors are the cause; the psychosocial influences of a common family environment could just as equally be the source. Researchers continue to search for a genetic marker of homosexuality. Gender non-conformity concerns the extent to which an individual deviates from stereotypic characteristics of masculinity or femininity during childhood; it is measured by asking respondents how traditionally masculine or feminine they were as children and how much they enjoyed conventional boys' or girls' activities. Researchers have found that male and female homosexual adults are more likely to have experienced gender nonconformity during childhood than have heterosexual adults, although it has not been identified as particularly consequential for homosexual development.

In conclusion, research suggests that there is a biological predisposition to exclusive homosexuality. However, the causes of sexual orientation in general, and especially bisexuality, remain speculative and most likely to rely on multiple developmental pathways. It is commonly argued that it seems more appropriate to think of the continuum of sexual orientation as influenced by an interaction of various psychosocial, environmental and biological factors, which may be unique for each person, than to think in terms of a single cause for sexual orientation.

The prevalence of homosexuality
A common question asked is – how many people are heterosexual, homosexual or bisexual? Many studies sought to explore the prevalence of homosexual behaviour with varying results. Researchers argue that the prevalence of homosexuality probably varies over time and across societies, cultures and places. Furthermore, it depends on how the question is asked. In their entirety these studies highlight the difference between homosexual behaviour and homosexual attraction, or as has been commonly distinguished among scholars as homosexual experience, homosexual desire and homosexual identity. These three are different. There are men who have sex with men, and women have sex with women, but who do not necessarily experience homosexual desire or identify themselves as homosexual. The acronyms MSM (men-who-have-sex-with-men) and WSW (women-who-have-sex-with-women) were coined in the 1990s in public health discussions, especially in the context of HIV/AIDS, and refer to persons who engage in sexual activity with members of the same sex, regardless of how they identify themselves. While not all people exhibiting homosexual behaviour actually experience sexual attraction to the same sex, inversely not all persons who experience this attraction exhibit homosexual behaviour. Thus, the levels of prevalence of homosexuality cited in scientific literature are primarily a function of the criteria and definition used.

In an attempt to determine the prevalence of homosexuality in society, Sell et al. (1995) analysed data from the Project HOPE International Survey of AIDS-risk behaviours and found that 8.7%, 7.9%, and 8.5% of males and 11.1%, 8.6%, and 11.7% of females in the United States, the United Kingdom, and France, respectively, had some homosexual attraction but no homosexual behaviour since age 15. When they examined homosexual behaviour separately they found that 6.2%, 4.5%, and 10.7% of males and 3.6%, 2.1%, and 3.3% of females in the United States, the United Kingdom, and France, respectively, had sexual contact with someone of the same sex in the previous 5 years. Laumann et al. (1994) reported same-sex behaviour in the United States in 5% of men and 4% in women; self-identification as homosexual in 2.8% of men and 1.4% of women; and feelings of attraction towards a person of the same sex in 6% of men and 5.5% of women. In a separate study in the United States (Chiang, 2006; 2009), data from the General Social Survey collected over 11 rounds in 17 years (1988 – 2004) with 24,63 people (10,767 men and
13,868 women) revealed that between 1.6% - 4.67% of men and 0.18% - 4.03% women had same-sex sexual behaviour in 12 months prior to the survey. A more recent study among 2753 young adults aged 19 - 26 in Norway (Pedersen and Kristiansen, 2008) found that only about 1% of both genders reported “exclusive” homosexual desire and identity, while one in ten young men (10%) and one of four young women (25%) reported having some homosexual experience, interest or identity. Many researchers argue that the increased reporting of same-sex sexual contact over time may simply be a function of increasing tolerance of same-sex behaviour in society, and not of increased prevalence of actual same-sex behaviour.

Sources of help

The Malta Gay Rights Movement
The Malta Gay Rights Movement was set up in June 2001 with the mission to achieve full equality for LGBT people in Maltese society; a society that enables people to live openly and fully without fear of discrimination based on one’s sexual orientation, gender identity and gender expression. If at any time a person requires support or wishes to express his/her thoughts freely to an understanding person he/she can, send an email on: support@maltagayrights.org

One may also call the National Gay Helpline, run by MGRM
Tel: 2143 0006
Mobile: 9925 5559

Malta Gay Rights Movement (MGRM)
32, Parish Street,
Mosta – MST 2021

Drachma – A Catholic Space for LGBT
Drachma is a group of gay, lesbian, bi-sexual and transgender (LGBT) people who meet to pray. It is a safe place where LGBT people can focus on the love of God for us – no matter who or what we are. Drachma is a place where people search for what brings us together rather than what divides us. Drachma is an inclusive group so any one desiring an experience of prayer can join. Persons who are not LGBT are also welcome to join.

Contact details:
Email: drachmalgbt@gmail.com
Blog: www.drachmalgbt.blogspot.com

Drachma Parents Group
The Drachma Parents’ Group is a Christian organisation established in April 2008 and meets once a month at Mt St Joseph Retreat House, Mosta. The group is committed to encourage and uphold LGBT people and their families in an effort to create more awareness of the difficulties faced because of the stigma society unfortunately attaches to persons with a different sexual orientation.

For more information contact Drachma on:
Mobile: 7944 2317
Email: drachmalgbt@gmail.com

Kellimni.com
Kellimni is a joint effort between SOS Malta, Salesian’s of Don Bosco, Agenzija Zghażagh and Aġenzija Appoġġ, who are seeing the realisation of setting up a local child and adolescent online support service, under the guidance of Child Helpline International.

Kellimni.com offer one-to-one, real-time telephony and online help, support services and counselling to children and adolescents who are suffering from any form of social exclusion, abuse, neglect, and/or psychological difficulties and are in need of immediate emotional, moral and social support.

This project aims that all young people have the opportunity to voice their concerns, express and realize their rights through which medium of communication they would feel most comfortable or available to them.

The service being offered is encompassing mainly on a child and adolescents online support targeting more youths and adolescents through www.kellimni.com. The Kellimni staff can be reached through e mail, chat and forums for support. Kellimni.com is aimed at children and youths who want someone to listen to them and who can provide assistance. It will allow service users to express their concerns and talk about the issues directly affecting them. Young people need to know that they are not alone, that someone outside of their immediate surroundings cares about them, that their life can be free from pain and fear. The service is providing an opportunity to all young people to reach out for help and support through frequently and easily accessible channels of communication.
TOPIC 4
Love and intimacy
Defining love

Love has intrigued people throughout history. Every person's life has been influenced in significant ways by love and people's best and worst moments in life may be tied to a love relationship. Its joys and sorrows have inspired artists and poets, novelists, filmmakers, and has been the inspiration of the greatest works of literature, art, and music in many cultures. Love, intimacy and sexual relationships are important and complex aspects of people's lives. But what is love and how might people define it? This section shall look at these interactions from various perspectives and examine factors that influence the development of intimacy in relationships, and what qualities or behaviours help in sustaining it over the years.

If a hundred people had to be asked to define love, one will probably attain a hundred different answers because love is a personal and individual phenomenon that eludes easy definition or explanation. Love is a special kind of attitude with strong emotional and behaviour components which takes many forms. Social science researchers have attempted to meaningfully measure people's approach to and style of relating to a partner when in a romantic relationship, and develop theories of love that can encompass everyone's individual definitions into an organized set of inter-related categories or types. Many argue that it is simply not possible to measure an emotion such as love. Nevertheless, the conceptualization of love has served as the basis for a great deal of research on intimate relationships.

One of the most respected ambitious attempts to measure love was undertaken by an American social psychologist, lawyer, and author Isaac Michael Rubin (Rubin, 1970, 1973). In his work, Rubin sought to distinguish between feelings of like from feelings of love via “a scale of liking and loving”, which is widely credited as the pioneering psychometric empirical measurement of love. Using responses to a questionnaire administered to several hundred dating couples, Rubin developed a 13-item measurement device that he called ‘a love scale’. On this scale people were asked to indicate whether a particular statement accurately reflects their feelings about another person. As measured by Rubin's scale, love has three components: attachment, caring and intimacy. Attachment is a person's desire for the physical presence and emotional support of the other person. Caring is an individual's concern for the other's well-being. Intimacy is the desire for close, confidential communication with the other.

Theories of love

Amongst the different theories of love, two have received considerable attention and support. The first is known as ‘Styles of Love Theory’ by a Canadian sociologist John Allen Lee (Lee, J.A. 1973, 1977, 1988). Another one is ‘The Triangular Theory of Love’ by an American psychologist Robert Sternberg (Sternberg, R.J. 1986, 1988, 1997, 1998). These conceptualizations of love all reach a common conclusion – that love can take many forms which change over time within the same relationship if it lasts long enough. The two widely discussed types of love present two contemporary models of love. These are passionate love and companionate love.

Passionate love, also known as romantic love or infatuation, is a state between two persons of extreme absorption with and desire for another. It is characterised by intense romantic feelings of tenderness, elation, anxiety, sexual desire, and physical attraction. Generalised physiological arousal, including increased heartbeat, perspiration, blushing, and stomach churning, along with a feeling of great excitement, often accompanies this form of love. Intense passionate love
typically tends to develop rapidly and intensely in the early stages of a love relationship. It sometimes seems as if the less one knows the other person, the more intense the passionate love. In passionate love, people often overlook faults and avoid conflicts. Logic and reasoned consideration are swept away by the excitement. One may perceive the object of one's passionate love as providing complete personal fulfillment.

Not surprisingly, passionate love is often short-lived, declines as the relationship progresses, typically measured in months rather than years. Love that is based on ignorance of a person's full character is bound to change with increased familiarity. However, this temporary aspect of passionate love is often overlooked, especially by young people who may lack experience with long-term love relationships. Many couples, convinced of the permanence of their passionate feelings, choose to make some kind of commitment to each other (becoming engaged, moving in together, getting married, and so forth) while still fired by the fuel of passionate love – only to be disillusioned later. When ecstasy gives way to routine, and the annoyances and conflicts associated with familiarity, especially the security of knowing what pleases the other, the other. This foundation of knowledge and sexual trust can encourage experimentation and subtle communication. Sexual pleasure strengthens the overall bond of a companionate relationship. Although sex is usually less exciting than in passionate love, it is often experienced as richer, more meaningful, and deeply satisfying.

According to Sternberg, the amount of love one experiences depends on the absolute strenght of these three components, and the type of love one experiences depends on their strenghts relative to each other. Different stages and types of love can be explained as different combinations of these three elements. For example, the relative emphasis of each component changes over time as an adult romantic relationship develops. A relationship based on a single element is less likely to survive than one based on two or three elements.

Sternberg's intimacy component does not refer to sexual intimacy but rather to the emotional closeness two people feel, which encompasses feelings of attachment, closeness, connectedness and bondedness. This includes such factors as:
• wanting what is best for the partner
• feeling the partner’s happiness
• holding the partner in very high regard
• feeling able to count on the partner in times of need
• sharing a sense of mutual understanding
• giving and receiving emotional support, and
• being able to share private and personal thoughts and feelings with the partner.

**Passion** is the physical arousal side of relationships, the motivational component that fuels romantic feelings, physical attraction, and desire for sexual interaction. Passion is manifested in an increased heart rate when two partners are together, the partners’ desire to be united together as much as possible, the sexual and romantic attraction two persons feels, the frequency of thinking about one’s partner, and the need to express one’s desire for the partner through touching, kissing, and making love.

The **commitment** component of Sternberg’s model is a more rational aspect of a love relationship, or the cognitive aspect of love. It is determined, in the short term, by the strength of one’s conscious decision to be with and to stay with another, and in the long term, the shared achievements and plans made with that other. It is the chosen desire to be loyal and faithful and to commit to working on creating and maintaining a loving, mutually satisfying, and lasting relationship, in spite of difficulties that may arise.

According to Sternberg, these three components may exist in any combination, from none of them, which is ‘non love’ (absence of love), to all of them, which is ‘consummate love’. Overall, seven possible combinations can help couples see their relationship more clearly and explore what is working well or what might be causing the difficulties they may have been experiencing. The combinations of the components of love are:

- **Intimacy only - Liking**
  A relationship in which two people experience intimacy but do not feel passion or a strong sense of commitment would seem like two people who like each other quite a lot and are probably good friends. Sternberg characterizes such a relationship containing intimacy only as *liking*.

- **Passion only - Infatuation**
  Love based on passion but lacking intimacy and commitment; usually very sexually charged but shallow and devoid of much meaning. Two people may just be bursting with passion and sexual heat for each other but do not feel particularly intimate and are not committed to any sort of short- or long-term relationship. Sternberg characterizes such a relationship containing passion only as infatuation, where two persons are usually very attracted and focused on each other, usually in a sexual way, and may desire to spend all the time together. But the relationship does not go much beyond that. They might know (or care) little about one another, so they do not experience much intimacy and they are not even thinking in terms of a commitment. It is simply a passionate connection that might be fun and sexy, but it exists only in the moment.

- **Commitment only - Empty Love**
  People can be committed to someone without feeling any intimacy or passion. This may happen when attraction is not reciprocated. Sternberg characterizes such a relationship containing commitment only as ‘empty love’. Such empty love relationships are unlikely to have much of a future, unless a person becomes too focused on the other and develops an unhealthy “fatal attraction” or “stalker” sort of obsession. However, not many would define that as love at all. Some couples with children who are experiencing empty love might stay together “for the sake of the kids”, but this is typically an unsatisfactory solution for everyone involved.

- **Intimacy + Passion = Romantic Love**
  This side of the triangle connects intimacy and passion. If one gets to know someone well, establish a deep level of intimacy, and then add passion to that, the result is probably going to feel very romantic. And it will probably feel romantic regardless of whether or not one would have established a commitment with that person. A good example of this is the so-called “shipboard romance”, that short term, intensely romantic relationship that sometimes develop between two people who meet on a cruise or at a resort or have a brief affair outside of their primary relationships. It is more than mere passion because they connect on an emotional and personal level in addition to the physical attraction. But due to the circumstances of the situation or other
involved in their lives, they do not choose to commit to
one another. Sternberg characterises such a relationship as
romantic love.

**Passion + Commitment = Fatuous Love**
Two people can be very physically attracted to each other and
share a strong sexual bond between them. In addition, they
also feel a strong commitment to making the relationship
last over the long term. However, they lack intimacy. They
don’t really like each other all that much, they do not hold
each other in especially high regard, and they have never
achieved close, private, intimate communication with each
other. Sternberg labelled this side of the triangle fatuous
love. Fatuous is a fairly uncommon word that means ‘absurd’,
‘foolish’, or ‘pointless’.

**Commitment + Intimacy = Companionate Love**
Companionate love is a relationship characterised by two
people who are truly in love and are committed to each
other and who enjoy all or most of the characteristics relating
to intimate love or liking. What’s missing is the heat, the
sexual arousal, the physical longing when apart, the passion.
Without passion, it is difficult to see them as lovers, but rather
they are companions, hence why Sternberg coined the term
‘companionate’.

**Intimacy + Passion + Commitment = Consummate Love**
Finally, if a couple are lucky enough to possess all three of
Sternberg’s basic components of love, they will have what he
termed consummate love, meaning the most complete, most
fulfilling, most ideally perfect love that people can achieve.
Sternberg believes – and research has borne him out – that
consummate love is not only rare but also difficult to attain
and perhaps even harder to maintain over time.

**Styles of love theory**
Instead of attempting to describe different patterns or types
of love, John Allen Lee suggests the theory that people follow
various psychological motifs in relating to a love partner. Lee
divided these love patterns into six major categories, using
concepts from Greek mythology and language to name them,
which he called **styles of love**. These are:

**Eros Love** – ‘**Eros**’ is the God of Love in Greek mythology
In his theory of love styles, Lee conceptualised eros love as
erotic, passionate, romantic love. Eros lovers tend to place
great emphasis on romance and physical beauty as they search
for their ideal mate. Romantic, erotic lovers tend to delight in
the visual beauty and feel an urgent sexual desire and strong
physical attraction to their potential partners. They probably
believe in love at first sight and have experienced it often. Eros
lovers desire sexual intimacy earlier in a new relationship than
those embracing other styles, and they value tactile (touch)
sensation above the other senses. This style of love is very
romantic and highly sexually charged, but typically that level of
passion cannot be maintained for long, and relationships based
on eros love tend to burn out quickly.

**Ludus Love** – ‘**Ludus**’ is Greek for ‘play’.
Ludus love is characterised by a game-playing love style. Ludus
lovers enjoy the excitement of forming a relationship more than
the relationship itself – they like the ‘chase’ and the conquest of
a sexual partner with little or no commitment. They see love for
fun, they love to flirt and seduce their partners. They “play the
field”, typically moving rapidly from one relationship to another
or juggling several partners at once. They enjoy the “conquest”
of sex but grow bored very quickly once a relationship
becomes sexual. Ludus lovers are very unlikely to form a lasting
commitment and tend to avoid serious relationships altogether.

**Storge Love** – ‘**Storge**’ is Greek for ‘natural affection’.
A love style characterized by caring and friendship.

**Mania Love** – ‘**Mania**’ is Greek for ‘madness’.
A possessive, dependent, and often controlling style of love.

**Pragma Love** – ‘**Pragma**’ means business in Greek.
A love style in which partners are selected in a businesslike way on the basis of rational, practical criteria.

**Agape Love** – ‘**Agape**’ is the Greek word for ‘brotherly love’ or ‘divine love’.
A style of love focused on giving the partner whatever
he or she may want and need without the expectation of
receiving anything in return.
Relationships remain generally casual and transitory. Often they will end a relationship just when it appears to be at its closest and most satisfying stage; they do so because that is the point at which the relationships seem secure and committed, and they simply do not want security and commitment. At times, they will even begin a new relationship before ending the current one so that they are never without the rush and excitement of the pursuit.

**Storge Love** – ‘Storge’ is Greek for ‘natural affection’.

Storge love is characterised by the central theme of friendship, companionate love style. Those who adhere to this style of romantic relationship usually begin with a close friendship and take a long time to develop feelings of love, affection and commitment. In contrast, to ludus and eros lovers, the sexual side of storge relationships arrives late and tends to take a back seat to the emphasis on friendship. Although passion is not a central feature, storge relationships offer peacefulness, security, and stability - all of which are greatly valued. Storge lovers tend to experience relationships that endure. For storge lovers, more than for any other style, if love ends, the friendship usually remains.

**Pragma Love** – ‘Pragma’ means business in Greek.

Pragma love is appropriately characterised as a practical love.Pragma lovers go about selecting their partners in a businesslike fashion based on rational, practical criteria (such as shared interests) that are likely to lead to mutual satisfaction. You can’t really say that pragma lovers fall in love; rather they decide to love the partner who best fits their requirements, trying to get the best “romantic deal”. These requirements include some of the factors included in most people’s fields of eligibles discussed earlier in this section, but the pragma lover focuses on the most down-to-earth, pragmatic aspects for compatibility, such as educational level, profession, social status, income, religion, common interest patterns, potential as parent, and material possessions. Although on its face this may sound like an effective way to build a strong relationship, it turns out that these partnerships tend to be less mutually satisfying and often unsuccessful. Pragma lovers have a tendency to place too little importance on the emotional aspects of love that are so basic to bonding and forming strong attachments between people.

**Agape Love** – ‘Agape’ is the Greek word for ‘brotherly love’ or ‘divine love’.

Agape love is a selfless, caring, altruistic love, and agape lovers offer their partners self-sacrificing. This means that they strive to give their partners whatever he or she may want or need without any expectation of receiving anything in return. The word agape has often been used to describe the love of God, of saints, and of martyrs. This style of love is patient and non-demanding. As described in 1 Corinthians 13 of the New Testament, agape love “suffers long; is kind; does not envy; does not parade itself; is not puffed up; does not behave rudely, does not seek its own; is not provoked; believes all things; endures all things.” In many ways it is wonderful. But the problem is that although agape love may be wonderful as a way to love “all humankind” or as a way to describe the love between, say, a parent and a child, it turns out to be a rather weak form of romantic love between two adults. Because agape love is all about giving, while romantic love involves a balance of giving and receiving.

**Combining love styles**

Various studies have indicated that different combinations of love styles work better together in a relationship than others. A subjective inventory called the ‘Love Attitude Scale’ has been developed to measure Lee’s six loving styles and investigate the relationship between styles of loving and relationship satisfaction at different stages of life. Findings have shown that in general, people prefer to partner with others who have the same love style as their own. Some combinations of love styles fit together better than others. Some combinations just would not work well at all, and some might be downright dangerous. For example, a storge lover and a pragma lover might get along just fine: one focused on establishing a close friendship and the other finding the perfect qualifications in the partnership. On the other hand, someone who embodies a strong mania style getting together with a pure ludus, where one is manically in love, insecure, and clinging, while the other is playing love games: the end result could be extremely dangerous.

However, research has shown that love relationships are extremely complex, and a couple’s individual love styles tell only part of the overall story of intimacy and overall satisfaction. Therefore, exceptions always exist, and some couples with incompatible love styles may create a successful relationship through skillful communication, clear agreements, and mutual respect.
TOPIC 5
Stages of interpersonal relationships
Initiating relationships

Human interpersonal and sexual relationships present many challenges. To begin, there is the challenge of building positive feelings about oneself, known as self-love. There is the added task of establishing satisfying and enjoyable relationships with family, peers, educators, co-workers, employers, and other people within one’s social network. A third challenge involves developing special, intimate relationships with friends and, when a personal conscious decision that it is the right time is taken by one for oneself, to develop sexual relationships. Finally many people confront the challenge of maintaining satisfaction and love within an ongoing, committed relationship. In most cases, a serious relationship commitment is demonstrated by the decision to marry. However, many couples have long-term committed relationships, either heterosexual or homosexual, that do not involve marriage.

The development of intimacy

The most important foundation for building a satisfying relationship with another person has paradoxically been identified to be self-love. Self-love does not mean conceit, selfishness, or lack of consideration of others; in fact, these qualities are usually indications of personal insecurities. Self-love means a genuine interest, concern, and respect for oneself – the ability of a person to look in the mirror and appreciate the person s/he sees and to feel excited about that person's potential. Eric Ericson (1965) a very famous scholar of human development argued that positive self-feelings are a prerequisite to a satisfying relationship. As people feel secure in their own worth and identity, they are able to establish intimacy with others, both in friendship and eventually in a mutually satisfying sexual relationship based on love.

People commonly enquire how to initiate and maintain intimacy, satisfaction and sexual enjoyment in an intimate relationship or sexual relationship. Today, the study of intimate relationships is commonly known as relationship science and involves several branches of the social sciences, including sociology, psychology, anthropology and social work. The scientific study of relationships distinguishes itself from anecdotal evidence or pseudo-experts by basing conclusions on data and objective analysis.

There is a general progression that many intimate relationships follow as they develop over time, explored by way of an understanding of the development of a relationship and the different aspects or phases of its growth. However, it is important for one to keep in mind that they are simply a convenient scheme; in reality, relationships are fluid, dynamic, and frequently unpredictable. What is presented below is a framework for thinking about a relationship described by Crook and Baur (2010), and should not be considered as a prescription for intimacy.

The first six phases could characterise a variety of relationships, including a good friendship, a parent-child or -sibling relationship. Close nonsexual friendships with members of our own and the other sex can be a very important part of our personal lives. One study found that characteristics of close friendships include enjoying one another's company; mutual trust that each will act in the other's best interest; respecting, assisting, supporting, and understanding one another; confiding experiences and feelings to each other; and being spontaneous in the relationship. This study also found that lover and spouse relationships had these general friendship qualities plus
higher levels of passion, exclusiveness, self-sacrifice, and enjoyment being together. With the foundation of the other phases, genital contact can be the culmination of deep intimacy and emotional closeness. Loving sexual relationships in many ways build on and amplify the positive features of friendly relationships, but they also pose more complications than do friendships. Sexual relationships tend to have less acceptance than nonsexual friendships; they are also characterised by more criticism, conflict, ambivalence, and discussions about the relationship and its problems.

**The stages of a relationship**

**Inclusion** is the first step one person takes in meeting another. It is simply an invitation to relate. Inclusion may take the form of one person making eye contact with another, or smiling at someone, or saying a friendly “hello”. Inclusion continues throughout a relationship, and the nature of inclusion behaviours provides the backbone of a positive relationship. A good-morning kiss, a smile, and hug after a day apart, a sincere “tell me about your day”, a compliment, or an expression of appreciation are some of the kind of inclusions that can nourish an ongoing relationship.

**Response** is the way in which we respond to a gesture of inclusion and may determine whether a relationship even begins. Quickly glancing away from someone’s initial eye contact, or ignoring a smile or a “hello”, may well deter any further friendly overtures. However, responding in kind with a smile and a greeting is likely to encourage the other to initiate further contact. This relates to the principle of reciprocity. Continued gestures of inclusion, as well as warm responses, help to build positive feelings that typically enhance a relationship’s growth. These include listening to the other person and understanding her or his point of view, following through with agreements or plans, or showing enthusiasm about seeing the other person. Positive and consistent inclusions and responses are the foundation for the next important phases – care, trust, affection, and playfulness.

**Care** implies a genuine concern for another’s wellbeing and motivates us to consider another person’s desires and interests. It creates a desire to please and contribute to that individual’s happiness.

**Trust** is essential to both the ongoing development of a relationship and its satisfactory continuance. It contributes to the belief that each partner will act consistently in ways that promote the relationship’s growth and stability and that affirm each partner. Partners trust each other and themselves to be positive and constructive in their inclusions and responses.

**Affection** is characterised by feelings of warmth and attachment. It evokes a desire to be physically close to another and is often expressed by touching, holding hands, sitting close, hugging, and caressing. Affection can be signalled nonverbally by smiles, winks, and tender looks, and verbally by expressions of appreciation, liking, or loving.

**Playfulness** is the phase in the development of an intimate relationship in which each person exhibits delight and pleasure in the other. Exhilaration, abandon, and expansive laughter often accompany playfulness, whether it is a playing peek-a-boo with a child or lovers having a pillow fight.

**Genitality** is the final phase, which extends the relationship to include genital contact. There may have been varying degrees of sexual feeling and expression in previous phases, but in this phase a person has decided to express feelings through genital sex. According to Erich Seligmann Fromm (1965), a German-American social psychologist, sociologist and humanistic philosopher, sex is important both in its role in initial attraction and in its cementing of a relationship through the fulfilment and pleasure it offers.

**Deciding when to say ‘yes’ and the right to say ‘no’ to a sexual relation**

Sexual expression can have many different meanings to different people. It can be a validation of deep intimacy within a relationship. On the other hand, people can choose to be sexual as part of a friendship or as a way of getting to know someone. For some, reproduction may be the primary purpose. For others, reducing sexual tension may be the motivation. Sex can be used as a way of experiencing new feelings, excitement, and risk. It can even be a kind of recreational pastime. People can use sex to try to alleviate feelings of insecurity – to prove their ‘manhood’ or ‘womanhood’ or to please someone or persuade that person to care. People can also use sex to experience the power to attract others or to avenge earlier rejections by enticing partners and then turning them down. Every person has a personal responsibility, and responsibility towards others, of deciding how to express sexuality. But this task is complicated by the fact that many of the old rules that have governed sexual relationships keep changing within a dynamic society. Some people base their decisions about sexuality on clear, pre-existing rules expressed by their family, religion, or peer group. Many others do not have such specific guidelines, or they may disagree with the values they have been taught. These people need to explore their own values before becoming sexually involved, what they value in life and in relationships, such as values of self-respect and respect for others, and what their expectations and needs are.
When sexual attraction exists within a relationship, sex is not necessarily an ‘either/or’ situation. There are progressive stages of intimacy, from holding hands to genital contact, and some people move slowly through these stages to savour and grow comfortable with the increasingly intimate contact. It is perfectly normal for a person to feel sexual attraction and to want a sexual relationship with someone, but feels that it is not yet the time. The ability to delay sexual involvement until both people feel ready can do much to enhance the initial experience. Many people postpone more intimate sexual involvement until they become more comfortable in their relationship. Waiting until familiarity and trust are established, and making sure that personal values are consistent, can enhance not only a relationship but also positive feelings about oneself. The possibility of contracting a sexually transmitted infection, including HIV, may be reduced by taking some time to assess the risk status of a prospective partner before beginning sexual relations. Gratification may be greater when the progression towards intimacy is gradual rather than when it is rushed.

Others may take an alternate course, moving quickly to sexual intimacy. In some cases, this may deepen a relationship. However, this result is certainly not assured. In fact, when a relationship becomes sexual without going through the phases described above, the individuals may actually experience a reduction in feelings of emotional closeness. Research evidence has also revealed that the nature or quality of relationships is strongly linked to the speed of beginning sexual relations. People who are quick to have sex are more likely to have brief relationships of a month or less, whereas people who wait are more likely to have lasting relationships. It is reasonable to suspect that some people have attempted to justify their sexual behaviour by deciding they are in love. Indeed, it is likely that some couples enter into premature commitments such as going steady, moving in together, becoming engaged, or even getting married to convince themselves of the depth of their love and thus the legitimacy of their sexual involvement.

Social expectations of ‘instant sex’ can present a challenge to those who want to move gradually into a sexual relationship. Movies, television programs, and novels often portray couples who meet, fall into lust, and quickly commence sexual relations within days (or even hours) of first contact. This media-perpetuated stereotype, which may pressure some people to get to sex quickly, is not the social norm. Research evidence continues to reveal that it is relatively unlikely that sexual relationships will occur among couples who have known each other for less than one month, albeit popular anecdotal beliefs. Relationship studies have also revealed that most young people believe themselves to be much slower than their peers to initiate sex. This finding suggest that while many people are considerably more conservative in their movement towards sexual relations than the popular media and common perceptions imply, most may not be aware of this fact. Consequently, many dating relationships begin amid a false perception by both partners that their peers are having sex much more quickly than they are.

Research also indicates that men and women have somewhat different ideas about how long a couple should wait before commencing sexual relations. Women tend to expect to wait longer than men in a relationship before sexual relations begin. Furthermore, traditionally research has indicated that women tend to associate sexual relations with love to a greater extent than men, while men find it easier to have sexual intercourse for pleasure and physical release, without an emotional commitment (although more recent research seems to indicate a convergence in gender differences with more men reporting finding it difficult to have sex without love). These differences between the sexes may produce some conflict when couples confront a phase when only one partner, usually the man, expresses a readiness to engage in sexual relations. What can one do to let the partner know s/he is not yet ready for sex, or that s/he wants the relationship to progress slowly? It is often helpful for one to begin indicating to the partner that s/he finds him/her very attractive. One may acknowledge the desire for greater sexual intimacy, yet be definite about not being ready. Finally, one can let the partner know what kind of physical contact is desired at a given point in the relationship, thus help avoid misunderstandings and reassure the other person.

Maintaining relationships - what makes sexual relationships last?

Ingredients in lasting love relationships include self-acceptance, appreciation of one another, commitment, good communication, realistic expectations, shared interests, and the ability to face conflict effectively. These characteristics are not static. They evolve and change and influence one another over time. Often, they need to be deliberately cultivated. The efforts that partners make towards preservation are probably more important to relationship stability today than in the past, when marriage as an institution was sustained more strongly by culture, religion, law, and the extended family. A review of research on marital satisfaction revealed that successful marriages that remain strong over many years often exhibit certain other characteristics, listed as follows:

- Parents of both spouses had successful, happy marriages
- Spouses have similar attitudes, interests, and personality styles
Growth and change are important in maintaining vitality in a relationship. Each person’s growth can provide an opportunity for the other partner to develop. Partners can draw on emotional, artistic, intellectual, spiritual and physical dimensions of growth, to enrich each other’s mutual enjoyment. At times, this dynamic of growth and change occurs without deliberate effort; at other times, it requires direct attention. Couples who maintain satisfactory levels of growth typically do not let love diminish by choosing to withdraw their energy from the relationship at the first sign of strain or boredom. Rather, they confront the difficulties and attempt to overcome them.

Each person brings her or his strengths and weaknesses into relationships, and a relationship itself has its own combination of strengths and weaknesses. A couple is rarely fully prepared for the myriad issues that arise from this combination. It is often helpful to view problems and dissatisfactions as challenges to overcome or differences to accept, rather than as sure signs that the relationship is about to fail. Couples need to be prepared to negotiate and renegotiate what they want out of life and out of their relationship, knowing that the arrangement they work out one day may become untenable the next. At the same time, partners in a committed relationship often recognise that their love for each other means accepting one another as unique human beings. These attitudes give a couple options for shaping a relationship uniquely suited to their individual and collective wants and needs.

Being in a committed relationship can itself be a source of growth. Such a relationship can make urgent demands on individuals so that they mature in directions and with a rapidity that would not otherwise occur. The experience of confronting oneself intensely and learning to accept another deeply, as sometimes occurs within an intimate relationship, can facilitate individual growth.

Seeking variety in sexual relationships

Many people have a strong desire to seek variety and enrichment in life’s experiences such as in seeking friends, recreational activities, food and other interests. Unfortunately, many people enter into a committed relationship and settle for routine sex lives, thinking that intense sexual excitement will always follow naturally when two people are in love. But the initial excitement must eventually be replaced by realistic and committed efforts and emotional investment to maintain the vitality and rewards of a working relationship.

For some individuals it may be necessary to seek variety in other ways. But not every couple feels the need for sexual variety. It should not be implied that all people must have active, varied sex lives to be truly happy. Many partners may feel quite comfortable and find contentment with established familiar patterns of sexual interaction and have no desire to change them. Others may consider sex relatively unimportant compared with other aspects of their lives and may choose not to exert special efforts in pursuing its pleasures. However, for those who consider the expression of sexuality through intimacy as an important source of pleasure in life, here are some suggestions by which couples may develop more variety in their sexual relationship.

Communication is critical – the couple can talk about their needs and feelings. They can share the desire to try something different, explore new experiences.

Actively working to defeat routine - such as in times, places and frequency in all shared activities, including love making. Some of the most exciting sexual experiences may be those that take place on the spur of the moment with little or no planning. It is easy to see how these encounters might occur frequently during courtship. It is also true that they

• Both spouses are satisfied with their sexual sharing
• The couple have an adequate and steady income
• The woman was not pregnant when the couple married.

Research has also shown that the most frequently named reasons for an enduring and happy marriage was seeing one’s partner as one’s best friend. Qualities that individuals especially appreciated in a partner were caring, giving, integrity, and a sense of humour. Successful couples, while being aware of flaws in their partners, they believe that the likeable qualities are more important. Many claim that their partners had become more interesting to them over time. They prefer shared rather than separate activities, which appears to reflect the richness in the relationship.

Another key is the belief in marriage as a long-term commitment and a sacred institution. Most successful couples are generally satisfied with their sex lives, and for some the sexual passion becomes more intense over time. However, few believe that good sexual relations keep the marriage together. Maintaining frequent positive interactions is crucial to continued satisfaction in a relationship. Little gestures count, and these behaviours are often so small that one may not really notice them. However, when couples do fewer things to make one another feel loved, the deficit is often experienced as a lack of love. Continuing affectionate and considerate interaction helps maintain a feeling of love. Enjoyment with and appreciation of one another in nonssexual areas typically enhance sexual interest and interactions. Often couples report a lack of desire for sexual intimacy when they are not feeling emotionally intimate.

The importance of individual and relationship growth

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may become distant memories after couples settle into the demanding daily schedules of living together. Maintaining the spontaneity will stand the couple in good stead as the relationship is nurtured over months or years.

**Planning for intimate time** – be it sexual and nonsexual (non-genital) intimacy, can also help maintain closeness. For example, making a commitment to place one’s energy and time towards the relationship, such as making “dates” with one another, and consciously continue the romantic gestures that came naturally early in the relationship.

**Enriching one’s sexual repertoire** – too often people refrain from experiencing something new because they feel that different activities are abnormal. In reality, only individual persons can judge what is normal for them, as long as it gives pleasure and does not cause emotional or physical discomfort or harm to either partner. The only right standard for a couple is to have intimate moments and experiences as often as both partners desire. Emotional comfort is an important variable because “discomfort” and conflict rather than intimacy and satisfaction can result if behaviours are tried which are too divergent from personal values and attitudes.

**Seek help and support** – learning can be sought from reading reliable books dealing with sexual relationships and attending talks, seminars and courses offered from time to time about interpersonal relationships. Discussing a particular written suggestion or discussing with others can often open up new possibilities of sexual sharing. Such opportunities sometimes provide the necessary information and support for trying something new.

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**Source of help and support with relationships**

**Cana Movement**  
Cana Movement is an organisation of people who have the family at heart. It is a voluntary organisation within the Catholic Church of Malta. Cana Movement provide a counselling service in a Christian perspective that accompanies people on their journey towards their fulfilment as individuals and members of healthy families and communities. The objectives of this service are:  
- to help couples prepare for marriage;  
- to help couples or individuals who are facing difficulties in their relationships  
- to help couples strengthen their marriage and their family.

More often than not, people seek help when they feel that they have outdone all their resources in managing a situation by themselves. However, this might be too late in the day as therapy works best when the problems are not so entrenched that it would be difficult to work through them.

The counsellors are trained to deal with relationship issues. At various point throughout the lifespan of a relationship, difficulties may arise. Couple who are deciding to get married might wish to iron out certain difficulties that they might have before they go along with the marriage plans. Once the couple get married, they might need help to adjust to married life and perhaps learn how to be husband and wife. Eventually should the couple have children, they might need help to go through that transition in order to maintain their marital relationship alive despite the transition to parenthood. Of course, couples may face other problems such as infidelity, the death of a spouse or child, infertility, financial problems etc. that would necessitate counselling. Should the unfortunate circumstance happen that the marriage breakdowns, persons who are undergoing separation may also access Cana services to get help to come to terms with the loss and pain and to adjust to their new reality.

One may access the service by phone on 21238942 or 21238068. A receptionist will answer the phone and gives an appointment with one of the counsellors. Alternatively one can drop in at Cana at the Catholic Institute, Floriana and make a booking with reception in person.

The opening hours for Cana are Monday to Friday 9.00am – 1.00pm and 4.00pm – 7.00pm. However some counsellors also offer their services on a Saturday. In addition, a counselling service is also provided at Cana house in Paola for people who would find it more convenient to access the service there. The Cana counselling service is free of charge. However clients are invited to make a voluntary contribution that goes towards Cana Movement funds.

**Cana Movement**  
Catholic Institute, St Publius Street, Floriana FRN 1441  
Tel: 2123 8942, 2123 8068, 22039300  
Email: info@canamovement.org  
Web: www.canamovement.org
TOPIC 6A
Reproductive health I
Health and function of the reproductive systems
The major function of the reproductive system is to ensure survival of the species. Both the male and female reproductive systems play a role in pregnancy. Within the context of producing offspring, the reproductive system has four functions:

- to produce gametes (egg cells in females and sperm cells in males)
- to transport and sustain these cells
- to nurture the developing offspring in the female
- to produce hormones.

These functions are divided between the primary and secondary (also known as accessory) reproductive organs. The primary reproductive organs consist of the testes in males and ovaries in females. Together, these are called the gonads. The gonads are responsible for producing the sperm cells in males and egg cells (or ova) in females. The sperms and ova are called the gametes. Furthermore, the gonads are responsible for the production of hormones. These hormones function in the development of sexual characteristics, the maturation of the reproductive system, and the regulation of the normal physiology of the reproductive system. All other organs, ducts and glands in the reproductive system are considered secondary, or accessory, reproductive organs. These structures transport and sustain the gametes (sperms and ova) and nurture the developing foetus in the early stages of pregnancy.

Problems with these systems can affect fertility and the ability in both males and females to have children. There are many such problems in men and women. Reproductive health problems can also be harmful to overall health and impair a person’s ability to enjoy a sexual relationship. Reproductive health is influenced by many factors. These include a person’s age, lifestyle, habits, genetics, use of medicines and exposure to chemicals in the environment. Many problems of the reproductive system can be corrected.

**The male reproductive system**

The male reproductive system, like that of the female, consists of those organs whose function is to produce a new human being, i.e. to accomplish reproduction. This system consists of a pair of testes, accessory glands (seminal vesicles, the prostate, and the bulbourethral glands), a network of...
Sexual Health

The male reproductive system

The scrotum consists of skin and subcutaneous tissue. A vertical partition made of subcutaneous tissue in the centre, called a septum, divides the scrotum into two parts, each containing one testis. Tiny muscle fibres in the subcutaneous tissue contract to give the scrotum its wrinkled appearance. When these fibres are relaxed, the scrotum is smooth. Another muscle controls the position of the scrotum and testes. When it is cold or a man is sexually aroused, this muscle contracts to pull the testes closer to the body for warmth.

Each testis is an oval structure about 5cm long and 3cm in diameter. Inside the testis there are interstitial cells, called cells of Leydig, which produce male sex hormones.

The sperm

Sperm are produced by a process called spermatogenesis, inside the testis. At puberty, hormones stimulate cells lying dormant within the testes since early embryonic development (known as spermatogonia) to begin dividing, a process known as mitosis. The spermatogonia contain 46 chromosomes (23 pairs) each. After a series of cell division processes, they become cells with half the number of chromosomes, i.e. 23 chromosomes. Spermatogenesis in males is identical to oogenesis in females (the process producing ova in the female), both resulting in cells (sperm and ova) having only half the number of chromosomes than a normal cell. When the sperm cell unites with an egg cell, the full number of chromosomes is restored, i.e. 46 chromosomes (23 pairs).

In the final stage, the sperm cells mature and forms a head, midpiece (or neck), and tail. The head holds the 23 chromosomes. The midpiece or neck contains energy producing cells used to activate the tail, or the locomotor, for locomotion. At the end of the process, the sperm leaves the testes and are stored in the epididymis where they undergo their final maturation stage and become capable of fertilising a female gamete. Each epididymis is about 6 metres long, but is very tightly coiled. Mature sperm are stored in the lower portion of the epididymis, near the beginning of the vas deferens.

Two glands in the male reproductive system produce a thin, milky coloured and alkaline liquid that enhances the motility of the sperm. These are the prostate gland and the bulbourethral glands, also known as Cowper’s glands. The prostate gland is a firm, dense structure that is located just inferior to the urinary bladder about the size of a walnut. The paired Cowper’s glands are smaller, about the size of a pea, and located near the base of the penis. In response to sexual stimulation, these glands secrete alkaline mucus-like fluid. This fluid neutralizes the acidity of the vagina and the acidity of some residual urine in the urinary duct, and provides some lubrication for the tip of the penis during intercourse.

During ejaculation the vas deferens contracts, forming peristalsis (like the movement of intestines), forcing the...
sperms out of the human body, passing through the vas deferens, the ejaculatory duct, and the urethra. The urethra extends from the urinary bladder to the external urethral orifice at the tip of the penis. It is a common passageway for sperm and fluids from the reproductive system and urine from the urinary system. While reproductive fluids are passing through the urethra, sphincters contract tightly to keep urine from mixing with semen and entering the urethra.

There are usually between 50 million and 150 million sperm per millilitre of semen, therefore between 75 million and 900 million sperms in one ejaculate. Sperm counts below 10 million to 20 million per millilitre usually present fertility problems. Although only one sperm actually penetrates and fertilises the ovum, it takes several million sperm in an ejaculation to ensure that fertilisation takes place.

In response to sexual stimulation, the male achieves an erection of the penis and an orgasm, accompanied by ejaculation of semen. This sexual response produces many changes in the human body, such as an increase in pulse rate and blood pressure, muscular contractions, glandular secretions, and many other signs of mounting excitement until, eventually, the tension is released in pleasurable, seizure-like reaction known as orgasm. Orgasm is followed by a variable time period during which it is not possible to achieve another erection. While this response is never exactly the same in any two individuals, or even in the same person on different occasions, its basic physiological pattern is shared by all men and women.

Sperm production begins at puberty and continues throughout the life of a male. The entire process of sperm production takes about 74 days. After ejaculation, the sperm can live for about 48 hours in the female reproductive tract. Some sperms will live longer, up to 5 days.

As sperms are forced out of the epididymis during ejaculation, they are mixed with the secretions produced by the accessory glands (the prostate and the Cowper’s glands) forming the seminal fluid, commonly known as semen. Semen is a slightly alkaline mixture of sperm cells and secretions. The volume of semen in a single ejaculation may vary from 1.5 to 6.0 ml.

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The penis, the male copulatory organ, is a cylindrical pendant organ located anterior to the scrotum and functions to transfer sperm to the vagina. The penis has a root, body (shaft), and glans penis (head of the penis). A loose fold of skin, called the prepuce, or foreskin, covers the glans penis.
The organs of the female reproductive system produce and sustain the female egg cells, or ova, transport these cells to a site where they may be fertilised by sperm, provide a favourable environment for the developing foetus, move the foetus to the outside world at the end of the development period, and produce the female sex hormones. The female reproductive system includes the (paired) ovaries, (paired) Fallopian tubes, uterus, vagina, accessory glands, and external genital organs. Four hormones have major roles in regulating the functions of the female reproductive system. These are the follicle-stimulating hormone, luteinising hormone, oestrogen and progesterone.

The primary female reproductive organs, or gonads, are the two ovaries. Each ovary is solid, ovoid structure about the size and shape of an almond, about 3.5cm in length, 2cm wide and 1 cm thick. The ovaries are located in shallow depressions one on each side of the uterus, in the lateral walls of the pelvic cavity. They are held loosely in place by ligaments.

The Fallopian tubes transport the egg (or ova) from the ovary to the uterus (the womb). There are two Fallopian tubes, or oviducts, each associated with every ovary. They have small hair-like projections called cilia on their inner lining. These tubal cilia are essential to the movement of the egg through the tube into the uterus. These tubes bear the name of Gabrielle Falloppio, a 16th Century Italian physician and one of the greatest surgeons of the age.

The uterus is a muscular organ that receives the fertilised oocytes and provides an appropriate environment for the developing foetus. Before the first pregnancy, the uterus is about the size and shape of a pear, with the narrow portion directed downwards. After childbirth, the uterus is usually larger, then regresses after menopause. The uterus is lined inside with the endometrium, which sloughs off during menstruation. More information about menstruation is given further down.

The vagina is a muscular tube, about 10 cm long, that extends from the neck of the uterus (also known as the cervix) to the outside. It is located between the rectum and the urinary bladder. Because the vagina is tilted posteriorly as it ascends, and the cervix is tilted anteriorly, the cervix projects into the vagina at nearly right angle. The vagina serves as a passageway for menstrual flow, receives the erect penis during intercourse, and is the birth canal during childbirth.

The external genitalia are the accessory structures of the female reproductive system that are external to the vagina. They are also referred to as the vulva or pudendum. The external genitalia include the labia majora, mons pubis, labia minora, clitoris, and glands within the vestibule. The clitoris is an erectile organ, similar to the male penis, which responds to sexual stimulation. Posterior to the clitoris, the urethra, vagina, paraurethral glands and greater vestibular glands open into the vestibule.

Female reproductive cells, or gametes, develop in the ovaries - a process called oogenesis. The sequence of events in oogenesis is similar to the sequence in spermatogenesis in males, but the timing and final result are different. Early in foetal development, primitive germ cells in the ovaries start dividing rapidly to form thousands of cells, called oocytes, which have a full complement of 46 (23 pairs) of chromosomes. The two ovaries together contain approximately 700,000 oocytes at birth. This is the lifetime supply, and no more will develop. These cells remain in a
dormant state until puberty, although the number of cells would have reduced to about 400,000. This is quite different from the male in which spermatocytes continue to be produced throughout the reproductive lifetime.

At puberty, when the ovaries and the uterus are mature enough to respond to hormonal stimulation, certain stimuli cause the brain (the hypothalamus) to start secreting a hormone (gonadotropin-releasing hormone). This hormone enters the blood and goes to the anterior pituitary gland (which is at the base of the brain) where it stimulates the secretion of two other hormones: the follicle stimulating hormone and the luteinising hormone. These hormones, in turn, affect the ovaries and uterus and the monthly cycle begin (menarche).

When the first menstrual cycle (menarche) starts under the influence of hormones (follicle stimulating hormone), several primary oocytes start to grow again, and thereafter each month. One of them outgrows the others and resumes to become a mature cell, while the other cells degenerate. The large cell undergoes a cell division process resulting in a

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**Normal ovary**

- Developing primary follicle
- Secondary oocyte
- Follicular cells
- Follicular fluid
- Stroma
- Mature (graafian) follicle
- Ruptured follicle
- Ovum released (ovulation)
- Corpus albicans
- Atretic follicle
- Corpus luteum fully formed
- Early corpus luteum
single cell with 23 chromosomes (the rest degenerates). After about 10 days of growth during every menstrual cycle, the oocyte will be ready for ovulation.

Ovulation is prompted by a hormone called luteinising hormone released from the anterior pituitary gland under the brain. A mature follicle at the surface of the ovary ruptures and releases the oocyte, or the egg cell, into the peritoneal cavity close to the fallopian tube. Once inside the Fallopian tube, the oocyte is moved along the rhythmic muscle in the wall of the tube. The journey through the Fallopian tube takes about 7 days. But because the oocytes is fertile for only 24 -48 hours, fertilisation usually occurs in the Fallopian tube. If fertilised by a male sperm, the cell continues the journey to the uterus. If not fertilised, the oocyte will degenerate.

A woman’s reproductive cycles last from menarche (when the menstrual cycles begin in puberty) to menopause (when the menstrual cycle ends, generally in the late 40s early 50s). The menstrual cycle begins with menstruation.

The mammary glands

Functionally, the mammary glands produce milk; structurally they are modified sweat glands. Mammary glands are located in the breast overlying the chest muscles and are present in both males and females, but are functional only in the female. Externally, each breast has a raised nipple, which is surrounded by a circular pigmented area called the areola. The nipples are sensitive to touch, due to the fact that they contain smooth muscle that contracts and causes them to become erect in response to stimulation.

Mammary gland function is regulated by hormones. At puberty, increasing levels of oestrogen in girls stimulate the development of glandular tissues in the female breast. Oestrogen also causes the breast to increase in size through the accumulation of fatty tissue. During pregnancy, oestrogen and progesterone enhance further development of the mammary glands. Another hormone, prolactin, stimulates the production of milk within the glands, and oxytocin causes the ejection of milk from the glands.
The menstrual cycle is the process by which a woman’s body gets ready for the chance of a pregnancy each month. The average menstrual cycle is 28 days from the start of one cycle to the next, but it can range from 21 days to 35 days. In Malta just over a third of girls (35%) start menstruating at the age of 12, a quarter (25%) start menstruating at age 11 while just over a fifth (22.5%) start at age 13. Thus the majority of Maltese girls (just over 80%) start menstruating between ages 11 – 13. About 1 in 10 Maltese girls start menstruating at age 9-10, and another tenth start at age 14-15. But girls can start menstruating between the ages of 8 and 15. If a teenage girl does not get her first period (menarche) by her 16th birthday, she should be seen by a medical practitioner.

In the beginning of the menstrual cycle, levels of oestrogen rise, causing the lining of the uterus to grow and get thicker. An egg starts to mature in one of the ovaries. Around the middle of a 28-day cycle, the egg leaves the ovary, a process called ovulation. Ovulation day varies in shorter or longer cycles.

The egg begins to travel down the fallopian tubes to the uterus. If the egg becomes fertilised by a sperm cell and attaches to the uterus, the woman becomes pregnant. If not, the uterus does not need the extra thick lining and it begins to shed. This shedding of the uterine lining through the vagina is menstruation.

Menstruation is the part of a woman’s monthly menstrual cycle in which blood and tissue are discharged from the vagina. It is also commonly called a period or menstrual period. Bleeding from the vagina is the primary sign of menstruation. Most menstrual periods last from three to five days.

Some women have other symptoms around the time of menstruation, including:
• cramping, bloating, and sore breasts
• food cravings
• mood swings and irritability
• headache and fatigue.

Placing a heating pad on the abdomen, taking a warm bath, and taking over-the-counter pain relievers may help lessen the symptoms. If these symptoms are severe, it might be a sign of premenstrual syndrome (PMS). PMS usually occurs one or two weeks before menstruation. PMS may affect a woman of any age who has menstrual periods. If the symptoms disrupt a woman’s lifestyle, she may need to seek medical attention.

Menstrual irregularities
Sometimes women have problems in their menstrual cycle – called menstrual irregularities or menstrual problems. Signs indicating that there is something wrong with the menstrual cycle include when a woman:
• stops getting her periods (amenorrhoea), unless the woman is pregnant
• when a menstrual period is skipped
• get periods too frequently
• have unpredictable menstrual bleeding or the cycle becomes irregular (oligomenorrhoea)
• have very painful periods (dysmenorrhoea)
• starts bleeding between the periods (spotting)
• have very heavy bleeding.

When not caused by pregnancy, menstrual irregularities are usually a sign of a larger condition or problem. It is very important that when a woman experiences these symptoms she talks to her private medical practitioner immediately, as diagnosing some problems and treating them early could result in more positive outcomes.

There are many conditions that can cause menstrual irregularities. Eating disorders such as anorexia nervosa and bulimia nervosa, excessive physical exertion, psychological / emotional stress, tumours and hormonal problems may also cause amenorrhoea (stop a woman from getting her periods).

Anorexia
Treatment for amenorrhea depends on the underlying causes. Sometimes lifestyle changes can help if weight, stress, or extreme physical activity is causing the problem. Other times, medications and oral hormonal pills can help control the problem.

Other common conditions causing menstrual irregularities are uterine fibroids, endometriosis, and Polycystic Ovarian Syndrome or Polycystic Ovary Syndrome (PCOS) which are described in further detail below.

**Uterine fibroids**

Uterine fibroids are the most common, non-cancerous tumours in women of childbearing age. The fibroids are made of muscle cells and other tissues that grow within and around the wall of the uterus. Women who are overweight or obese for their height are at a greater risk, while women who had given birth are at a lower risk. Many women with uterine fibroids have no symptoms. Symptoms of uterine fibroids can include:
- heavy or painful periods, or bleeding between periods
- feeling ‘full’ in the lower abdomen
- urinating often
- pain during sex
- lower back pain
- reproductive problems, such as infertility, miscarriages or early (premature) labour.

Most women with fibroids do not have problems with infertility and can get pregnant. Some women with fibroids may not be able to get pregnant naturally. But advances in treatments for infertility may help some of these women get pregnant.

Women who have uterine fibroids, but show no symptoms, may not need any treatment. Some women with fibroids have heavy menstrual periods, and some may bleed in between periods. Medications can often offer relief from many of the symptoms of fibroids, such as pain, and can even slow or stop their growth. There are also several types of surgery that can remove the fibroids.

**Endometriosis**

Endometriosis occurs when tissues that usually grow inside a woman’s uterus grow on the outside too, such as surfaces of organs in the pelvis or abdomen, where they are not supposed to grow. It is one of the most common gynaecological conditions in women. Estimations of the incidence of endometriosis range from 1 in 10 non-symptomatic women to 40% of infertile women. About 30% to 50% of women with endometriosis are infertile, making it one of the top three causes of female infertility. Endometriosis may cause pain before and during the first few days of the menstrual period. Women with endometriosis may also have very heavy periods.

The two most common symptoms of endometriosis are pain and infertility. Other symptoms may include:
- pain before or after menstrual periods, as well as during or after sex
- lower back, intestinal, or pelvic pain
- heavy menstrual periods, or spotting and bleeding between periods
• painful bowel movements or painful urination during menstrual periods
• infertility.

In most cases, the symptoms of endometriosis become milder after menopause because the growths begin to get smaller.

There is currently no cure for endometriosis. But a variety of treatment options exist, and there are ways to minimise the symptoms caused by the condition. There are several ways to treat pain, including pain medication to relieve symptoms, hormone therapy to control the growth of endometriosis, and surgery to remove growths or control the size of very large endometriosis and to relieve pain. There are also some treatments for infertility associated with endometriosis, including hormone treatments and surgery.

**Fertility and pregnancy**

Pregnancy is the term used to describe when a woman has a growing foetus inside of her. In most cases, the foetus grows in the uterus. Human pregnancy lasts about 40 weeks, or just over 9 months, from the start of the last menstrual period to childbirth.

Preconception care is the care a woman is recommended by health care providers before she considers becoming pregnant, or in between pregnancies. This is different than prenatal care, which is the care a woman gets during a pregnancy. Getting early and regular prenatal care is important for the health of both mother and the developing baby. Both preconception care and prenatal care help to promote the best health outcomes for mother and the baby.

**Menopause**

Menopause occurs when a woman’s reproductive cycles stop. Strictly speaking, the word menopause refers to a woman’s last menstrual period, which typically occurs around the late 40s or early 50s. However, the menopause more commonly describes the ‘change in life’ – all the hormonal changes and resulting symptoms that happen in the years leading up to, and beyond, the final menstrual period. Many women naturally experience a decline in fertility at age 40; this age may also mark the beginning of irregularities in the menstrual cycle that signal the onset of menopause.

In the years leading up to the menopause, the ovaries function less efficiently, resulting in irregular and heavy periods. Blood levels of oestrogen go up and down giving rise to hot flushes, night sweats and a multitude of other symptoms.
symptoms. Eventually, the ovaries cease functioning and the period stops. Most of these symptoms settle within a few years of the period stopping completely.

Symptoms of the menopause:
- anxiety
- changes to skin and hair
- depression
- difficulty sleeping
- dry vagina
- fatigue
- headaches
- hot flushes and night sweats
- irregular periods
- irritability
- joint and muscle pains
- loss of interest in sex
- pain on intercourse
- palpitations
- poor concentration
- poor memory
- urinary problems
- weight gain.

Most women adjust to these changes without problems and some enjoy a new-found freedom, free from the burden of the monthly 'curse' and the fear of an unplanned pregnancy. Others do not have it so easy, and in spite of benefiting from self-help treatments, a few may need medical support. The menopause has taken on much greater importance over recent years, particularly in the Western society as, with life expectancy of more than 80 years, many women can expect to be post-menopausal for nearly a third of their lives.

Although the symptoms of the menopause are not life-threatening, the long-term effects of oestrogen deficiency can be. Research has shown that oestrogen keeps the bones strong and healthy, and protects against heart attacks and strokes. After the menopause, as the protective effect of oestrogen is lost, the risk of fractures (especially of the hip, wrist and spine), heart attacks and strokes increases. While these conditions do not always result in death, they lead to a significant reduction in quality of life, for both individuals affected and their relatives.
TOPIC 6B
Reproductive health II
Sexual and reproductive health problems
Infertility
An apparently healthy couple both under the age of 35 who have had no success starting pregnancy after more than a year of conscious effort may be well advised to seek professional help for infertility. Infertility is the term health care providers use for women who are unable to get pregnancy, and for men who are unable to impregnate a woman, after at least one year of trying; or six months, if a woman is 35 years of age or older. Women who can get pregnant but are unable to stay pregnant full term (until childbirth) may also be infertile.

Infertility is a common and complex problem. It does not have a single cause because getting pregnant is a multi-step chain of events. An estimated 1 in 10 women aged 15-44 years in the United States having difficulty getting pregnant or staying pregnant. But infertility is not always a woman's problem. Both women and men can have problems that cause infertility. About one-third of fertility problems between couples are due to the man. The other cases are caused by a mixture of male and female problems, from unknown factors, or a combination of factors. The causes of infertility may range from simple sexual inexperience to poor diet, psychological difficulties, and problems of the male or female reproductive systems.

Most often, infertility becomes a source of frustration and great unhappiness to men and women whose sense of self-esteem is somehow tied to their ability to become parents. Fortunately, the advances of modern medicine have made it possible to help many of them. A careful medical examination of both partners by a specialist can often discover the reason for their failure. Sometimes, the diagnosis as well as the therapy are very simple indeed. For example, there have been couples who remained childless just because they never had sexual intercourse on the woman's fertile days. At other times, the problem may prove to be extremely complicated and require extensive treatment involving psychological counselling, hormone replacement, or surgery. One of the more recent and increasingly popular methods of treating infertility is artificial insemination or assisted conception, although this approach is not fool proof. In some cases, fertility cannot be established in spite of all available medical measures. However, these couples may still find fulfilment as parents through adoption.

Infertility in men
A physician who tries to diagnose the reason for a couple's infertility will usually first examine the man. Not only is the male reproductive system simpler, but quite often the root of the problem can indeed be found in the male. Infertility in men is most often caused by factors that cause a man to make too few sperms, or none at all. A man's infertility may result from three major causes.

It may, of course, result from certain congenital defects, when a man is born with the problems that affect his sperm. A common cause of infertility or subfertility (insufficient or low fertility) may be a low sperm count. In this case the man produces live sperm, but in quantities insufficient for a successful impregnation. It has already been mentioned above that while it is true that only one sperm cell is needed to fertilise the female egg, or ovum, usually at least 200 million sperm have to be ejaculated at one time in order to give this one cell a statistical chance to reach its destination. In some cases, the sheer number of sperm cells is insufficient, or their proper development or their ability to move is impaired. Most often, however, a low sperm count, or...
malformed sperms that affect their motility are found to occur together. One congenital defect is called a varicocele - this happens when the veins on a man’s testicle(s) are too large. This heats the testicles. The heat can affect the number or shape of the sperm. Obviously, these conditions do not have to affect a man’s sexual desire or performance at all. He is just unable to cause pregnancy in a fertile woman. In other words, such a man is not “impotent”, but infertile.

Male infertility may start later in life due to increasing age, changes in health and lifestyle, wounds, illness, injury or exposure to environmental toxins and conditions. Certain injuries can damage the reproductive organs themselves. Injuries that damage the reproductive system, such as cross-bar injuries in cyclists, can damage the epididymis or vas deferens and block the sperm. Injuries to the neck or spine may lead to the loss of control over parts or all of the body, to a point where sexual intercourse becomes difficult or impossible. Heavy alcohol use, recreational drugs, tobacco smoking, environmental toxins, including pesticides and lead may all cause male infertility. Certain illnesses such as testicular cancer, kidney disease, cystic fibrosis or hormone problems can affect a person’s response or weaken the body, while certain medicines and treatments, including radiation treatment and chemotherapy for cancer, are known to cause male sterility too.

Male infertility may also be acquired, usually as a complication of certain infections and diseases. For example mumps in adulthood, or a sexually transmitted infection such as gonorrhoea can produce sterility.

However, there are also some men who are infertile because they are "impotent", or suffer of a sexual dysfunction. They cannot cause a pregnancy in spite of their normal sperm production because their inability to have or hold an erection prevents them from even performing coitus. Sexual Problems and Sexual dysfunctions are described further down on page 49.

Infertility in women
As mentioned above the cause of a couple’s infertility may lie with the man or the woman, or both. If medical tests prove the man to be fertile the examining physician will start a new series of tests on the woman. In women, the term infertility is used to describe those who are of normal child bearing age, not those who cannot get pregnant because they are near or past menopause. Women who are able to get pregnant but who cannot carry a pregnancy to term (birth) may be considered infertile, or subfertile.

Pregnancy is the result of a process that has many steps. Infertility can happen if there are problems with any of these steps. To get pregnancy:
• a woman’s body must release an egg from one of her ovaries (ovulation)
• the egg must go through a fallopian tube towards the uterus (the womb)
• a man’s sperm must meet and join with (fertilise) the egg along the way (fertilisation)
• the fertilised egg must attach to the inside of the uterus (implantation)

A woman’s fertility also decreases with increasing age. A woman’s chances of having a baby decrease rapidly every year after the age of 30. Many women are waiting until their 30s and 40s to have children. In fact, just under a third of Maltese women in 2010 had their first pregnancy between ages 30 and 44. Furthermore, 42% of all first and second maternities in 2010 were to women aged 30 - 44 years (National Obstetrics Information Systems (NOIS), Department of Health Information and Research). These figures, of course, do not include couples with infertility problems trying for a baby. About one-third of couples in which the woman is older than 35 years have fertility problems.

Figure 7: 1st and 2nd Maternities by Age of Mother - Malta, 2010

Aging decreases a woman’s chances of having a baby in the following ways:
• her ovaries become less able to release eggs
• she has a smaller number of eggs left
• her eggs are not as healthy
• she is more likely to have health conditions that can cause fertility problems
• she is more likely to have a miscarriage.

In some cases of infertility, there simply is no egg or ovum to be fertilised because there is no ovulation. In fact, most...
causes of female infertility are caused by problems with ovulation. Some signs that a woman is not ovulating normally include irregular or absent menstrual periods. Ovulation problems are most often caused by polycystic ovarian syndrome (PCOS) which is a hormone imbalance problem which can interfere with normal ovulation. Another cause of ovulation problems is Primary ovarian insufficiency (POI) which occurs when a woman's ovaries stop working normally before she is 40. POI is not the same as early menopause. These two conditions are described in further detail below.

vaginal fluids are hostile to the sperm and kill it. Sometimes women develop antibodies which appear in the vagina and produce immunity to all sperm or to the sperm of a particular man. It can also be the result of certain acquired internal sexually transmitted infections especially gonorrhoea and chlamydia which lead to Pelvic Inflammatory Disease, damaging and permanently block the Fallopian tubes, thus making fertilisation impossible. These infections damage the small hair-like projections called cilia inside the Fallopian tubes (described above) whose function is essential to the movement of the egg through the tube into the uterus. The egg may not get “pushed along” normally but may stay in the tube. Infection can also cause partial or complete blockage of the tube with scar tissue, physically preventing the egg from getting to the uterus.

In other women, there is ovulation, but the ovum is impeded from meeting the sperms either because of certain congenital defects of the Fallopian tubes (disruption of the normal architecture of the ducts, such as kinking) or tumours of the Fallopian tubes, or the cervical mucus is too thick to be penetrated by sperm. In certain women, the cervical and

Furthermore, any process that damages the Fallopian tube or narrows its diameter increases the chance of an ectopic pregnancy. An ectopic pregnancy is a condition in which a fertilised egg settles and grow in any abnormal location other than the inner lining of the uterus. The vast majority of ectopic pregnancies are so-called tubal pregnancies and occur in the Fallopian tube (98%) (however they can occur in other locations, such as the ovary, cervix and abdominal cavity). An ectopic pregnancy occurs in about one in 50 pregnancies. The major health risk of ectopic pregnancy is rupture of the fallopian tube leading to internal bleeding. Failure to seek early medical attention and surgery could lead to maternal mortality. Ectopic pregnancy remains the leading cause of pregnancy-related death in the first trimester of pregnancy. Surgery on the Fallopian tubes due to a previous ectopic pregnancy may also permanently block the tubes, and increases the risk for future ectopic pregnancies. In other cases, fertilisation does take place but the fertilised egg invariably fails to attach itself to the uterine wall. In such cases the fertilised egg disintegrates.

In other instances, both fertilisation and implantation occur, only to be followed by early spontaneous abortions (miscarriages). The reason for this may be some abnormality of the uterus or cervix.

Other common causes of fertility problems in women also include Endometriosis and Uterine fibroids, which both have already been described above.

There are then many lifestyle factors and behaviours can change a woman’s ability to have a baby. These include:
• tobacco smoking
• excess alcohol use
Sexual Health

- stress
- poor diet
- athletic training
- being overweight or underweight

Some health problems also increase the risk of infertility in women. So, women should talk to an obstetrician if they have:
- irregular periods or no menstrual periods
- very painful periods
- endometriosis
- pelvic inflammatory disease
- more than one miscarriage.

It is always a good idea for any woman to talk to a health professional before trying to get pregnant. They can help a woman get her body ready for a healthy baby. They can also answer questions on fertility and give tips on conceiving. Another cause of female infertility are female sexual dysfunctions, which are described further down.

Polycystic Ovarian Syndrome (PCOS)

PCOS is a condition in which a woman’s ovaries and, in some cases the adrenal glands, produce more androgens (a type of hormone) than normal. High levels of these hormones interfere with the development and release of eggs as part of ovulation. As a result, fluid-filled sacs or cysts can develop on the ovaries.

Women with PCOS often have menstrual irregularities such as amenorrhea (they do not get menstrual periods) or oligomenorrhea (they only have periods now and then). Because women with PCOS do not release eggs during ovulation, most women with PCOS have trouble getting pregnant. In fact, it is the most common cause of female infertility. Although it is hard for women with PCOS to get pregnant, some do get pregnant, naturally or using assistive reproductive technology. Women with PCOS are at higher risk for miscarriage if they do become pregnant.

In addition to infertility, women with PCOS may also have:
- pelvic pain
- hirsutism, or excess hair growth on the face, chest, stomach, thumbs or toes
- male pattern baldness or thinning of hair
- acne, oily skin, or dandruff
- patches of thickened and dark brown or black skin.

Also, women who are obese are more likely to have PCOS. Women with PCOS are also at higher risk for associated conditions, such as:
- diabetes
- metabolic syndrome – sometimes called a precursor to diabetes (this syndrome indicates that the body has trouble regulating its insulin)
- cardiovascular disease – including heart disease and high blood pressure.
- The condition is usually diagnosed by way of a pelvic examination to feel for cysts on the ovaries, an ultrasound and blood tests.

Premature Ovarian Failure (POF)

Sometimes a woman starts experiencing a decline in fertility before the age 40, sometimes even in the teens. This condition is commonly termed primary ovarian insufficiency or premature ovarian failure (POF). In the past, this condition was called premature menopause, but this term is an inaccurate description of what happen in a woman with premature ovarian failure. A woman who has gone through natural menopause will rarely ever have another period. A woman with POF is much more likely to have periods, even though they might not come regularly. There is virtually no chance for a woman who has gone through menopause naturally to get pregnant; in some cases, a woman with POF can still get pregnant. POF affects approximately:

- 1 in 10,000 women by age 20
- 1 in 1,000 women by age 30
- 1 in 250 women by age 35
- 1 in 100 women by age 40.

The most common first symptom of POF is having irregular periods. Woman should pay close attention to their menstrual cycles, so that they can alert their family doctor when changes occur in periods. Health care professionals sometimes dismiss irregular or skipped periods (called amenorrhea) as being related to stress; but a woman's

Ovaries with PCOS
monthly cycle is actually an important sign of her health, in the same way that blood pressure or temperature are signs of health. If a woman starts having irregular periods or skip periods, she should talk to her medical practitioner so that the cause of these symptoms is determined. Other symptoms associated with POF are:

- hot flashes
- night sweats
- irritability
- decreased interest in sex
- pain during sex
- drying of the vagina
- infertility.

Sexual dysfunction, sexual disorders or sexual problems

“Sexual Disorders” or “Sexual Dysfunctions” are common medical terms, very often incorporated in formal psychological or medical diagnosis. These terms may imply very serious conditions! They might also be perceived as incurable and can even put off people and discourage individuals having such issues from seeking professional help.

“Sexual problems” is a better term, believed to lessen stigma and fear associated with these health issues. Nearly all sexual problems are readily treatable. No one should endure chronic, long term sexual difficulties in silence because of fear and stigmatisation. Sexual problems are no different from most other difficulties in life. There are solutions to most sexual problems too.

Sexual problems are defined as difficulty during any stage (desire, arousal, orgasm, and resolution) of the sexual act, which prevents the individual or couple from enjoying sexual activity. Sexual problems may begin early in a person’s life, or they may develop after an individual has previously experienced enjoyable and satisfying sex. A problem may develop gradually over time, or may occur suddenly as a total or partial inability to participate in one or more stages of the sexual act. The causes of sexual difficulties can be physical, psychological or both.

Emotional factors affecting sex include both interpersonal problems and psychological problems within the individual. Interpersonal problems include marital or relationship problems, or lack of trust and open communication between partners. Personal psychological problems include depression, sexual fears or guilt, or past sexual trauma.

Physical factors contributing to sexual problems include:

- nerve damage from injuries to the back (as in spinal cord injuries).
- an enlarged prostate gland in males
- certain chronic conditions (such as diabetes, cardiovascular disease, multiple sclerosis, cancer, and rarely, tertiary syphilis)
- drugs, such as alcohol, nicotine (hence smoking), narcotics, stimulants, anti-hypertensives (medicines that lower blood pressure), antihistamines, and some psychotherapeutic drugs (used to treat psychological problems such as depression)
- treatment for certain cancers (e.g. treatment of prostate cancer in males)
- endocrine disorders (thyroid, pituitary, or adrenal gland problems)
- heart failure
- hormonal deficiencies (low testosterone, oestrogen or androgens)
- problems with blood supply
- some birth defects (congenital defects)

Sexual problems or disorders are generally classified into four categories: sexual desire disorders, sexual arousal disorders, orgasm disorders, and sexual pain disorders.

Sexual desire disorders (decreased libido) may be caused by a decrease in the normal production of oestrogen (in women) or testosterone (in both men and women). Other causes may be aging, fatigue, pregnancy, and some anti-depressant medications are well known for reducing desire in both men and women. Psychiatric conditions, such as depression and anxiety, can also cause decreased libido. Fear of an unplanned pregnancy, especially when no methods of birth control are used, can also lead to a sexual desire disorder.

Sexual arousal disorders were previously known as frigidity in women and impotence in men. These have now been replaced with less judgmental terms. Impotence is now known as erectile dysfunction or erectile problem, and frigidity is now described as any of several specific problems with desire, arousal, or anxiety.

For both men and women, these conditions may appear as an aversion to, and avoidance of, sexual contact with a partner. In men, there may be partial or complete failure to attain or maintain an erection, or a lack of sexual excitement and pleasure in sexual activity.

There may be medical causes for these disorders, such as decreased blood flow or lack of vaginal lubrication. Chronic disease may also contribute to these difficulties, as well as the nature of the relationship between partners. As the success
of drugs used to treat erectile problem attests, many erectile disorders in men may be primarily physical, not psychological conditions.

**Orgasm disorders** are a persistent delay or absence of orgasm following a normal sexual excitement phase. The disorder occurs in both women and men. Again, certain antidepressants are frequent culprits - these may delay the achievement of orgasm or eliminate it entirely.

**Sexual pain disorders** affect women almost exclusively, and are known as dyspareunia (painful intercourse) and vaginismus (an involuntary spasm of the muscles of the vaginal wall, which interferes with intercourse). Dyspareunia may be caused by insufficient lubrication (vaginal dryness) in women. There may also be abnormalities in the pelvis or the ovaries that can cause pain with intercourse. Vulvar pain disorders can also cause dyspareunia and inability to have intercourse due to pain.

Poor lubrication may result from insufficient excitement and stimulation, or from hormonal changes caused by menopause or breast-feeding. Irritation from contraceptive creams and foams may also cause dryness, as can fear and anxiety about sex.

It is unclear exactly what causes vaginismus, but it is thought that past sexual trauma such as rape or abuse may play a role. Another female sexual pain disorder is called vulvodynia or vulvar vestibulitis. In this condition, women experience burning pain during sex which may be related to problems with the skin in the vulvar and vaginal areas. The cause remains unknown.

**When do sexual problems start in life?**
Sexual problems are most common in the early adult years, with the majority of people seeking care for such conditions during their late 20s through 30s. The incidence increases again in the peri- and post-menopausal years in women, and in the elderly population, typically with gradual onset of symptoms that are associated most commonly with medical causes of sexual problems.

Sexual problems are more common in people who abuse alcohol and drugs. It is also more likely in people suffering from diabetes and degenerative neurological disorders. Ongoing psychological problems, difficulty maintaining relationships, or chronic disharmony with the current sexual partner may also interfere with sexual function.

**Can sexual problems be prevented?**
Open, informative, and accurate communication regarding sexual issues and body image between parents and their children may prevent children from developing anxiety or guilt about sex, and may help them develop healthy sexual relationships.

Reviewing all medications, both prescription and over-the-counter, for possible side effects that relate to sexual problems can help a person avoid taking medications that could lead to sexual problems. Avoiding drug and alcohol abuse will also help prevent sexual problems.

Couples who are open and honest about their sexual preferences and feelings are more likely to avoid some sexual problems. One partner should, ideally, be able to communicate desires and preferences to the other partner. People who are victims of sexual trauma, such as sexual abuse or rape at any age, are urged to seek psychiatric advice. Individual counselling with an expert in trauma may prove beneficial in allowing sexual abuse victims to overcome sexual difficulties and enjoy voluntary sexual experiences with a chosen partner.

**What are the common symptoms of sexual problems?**
Common symptoms experienced by both men or women alike include:
- inability to feel aroused
- lack of interest in sex (loss of libido)
- pain with intercourse (much less common in men than women).

Common symptoms experienced by men only include:
- delay or absence of ejaculation, despite adequate stimulation
- inability to control timing of ejaculation
- inability to get an erection
- inability to keep an erection adequately for intercourse.

Common symptoms experienced by women include:
- burning pain on the vulva or in the vagina with contact to those areas
- inability to reach orgasm
- inability to relax vaginal muscles enough to allow intercourse
- inadequate vaginal lubrication before and during intercourse
- low libido due to physical/hormonal problems, psychological problems, or relationship problems.
What happens when someone reaches out for help about a sexual dysfunction?
The health care provider will investigate any physical problems and conduct tests based on the particular type of sexual problem the person experiences. In any case, a complete medical history is taken to:

- identify possible fears, anxieties, or guilt specific to sexual behaviours or performance
- identify predisposing illness or conditions
- uncover any history of prior sexual trauma

A physical examination may also be done, but is not always necessary.

How are sexual problems treated?
Treatment depends on the cause of the sexual problem. Medical causes that are reversible or treatable are usually managed medically or surgically. Physical therapy may prove helpful for some people experiencing sexual problems due to physical illnesses or disabilities.

Certain drugs may be helpful for men who have difficulty attaining an erection. These medications increases blood flow to the penis. These must be taken 1 to 4 hours before intercourse. Men who is taking treatment for coronary heart disease should consult his medical specialist before taking medications used to treat erectile problems.

Mechanical aids and penile implants are another option for men who cannot attain an erection and find that medications are not helpful.

Women with vaginal dryness may be helped with lubricating gels, hormone creams, and - in cases of premenopausal or menopausal women - with hormone replacement therapy. In some cases, women with androgen deficiency can be helped by taking testosterone. Certain physical exercises, known as Kegel exercises, may also increase blood flow to the vulvar/vaginal tissues, as well as strengthen the muscles involved in orgasm.

Vulvodynia (a chronic pain syndrome affecting the vulvar area) can be treated with numbing cream, biofeedback, or low doses of certain antidepressants that also treat nerve pain. Surgery has not been successful in treating this problem. Behavioural treatments involve many different techniques to treat problems associated with orgasm and sexual arousal disorders. Self-stimulation and the Masters and Johnson treatment strategies are among the many behavioural therapies used.

Simple, open, accurate, and supportive education about sex and sexual behaviours or responses may be all that is required in many cases. Some couples may benefit from joint counselling to address interpersonal issues and communication styles. Psychotherapy may be required to address anxieties, fears, inhibitions, or poor body image.

What is the likely outcome of treatment for sexual problems?
The outcome depends on the type and nature of sexual problem. In general, the probable outcome is good for physical sexual problems resulting from treatable or reversible conditions. It should be noted, however, that some organic causes do not respond to medical or surgical treatments. Prolonged physical dysfunction in the body can also create sexual problems.

In functional sexual problems resulting from either relationship problems or psychological factors, the prognosis is generally good for temporary or mild dysfunction associated with temporary stress or lack of accurate information. However, those cases associated with chronically poor relationships or deep-seated psychiatric problems typically do not have positive outcomes.

What are the complications of sexual problems?
As it has already been described above, some forms of sexual problems may cause infertility. Persistent sexual problems may cause depression in some individuals. The importance of the disorder to the individual (and couple, when applicable) needs to be determined. Decreased sexual function is important only if it is a cause of concern for the couple. Sexual problems that are not addressed adequately may lead to conflicts or potential breakups.
TOPIC 7
Contraception and family planning
**Introduction**

Family planning has been gaining increased acceptance in Malta over the years. Under the Press Law of 1974, the ban on the advertisement of contraceptives was lifted. In the following year, the prohibition of the importation of contraceptives was repealed. Today Maltese people can freely seek information and professional advice about contraception and family planning from government Health Centres, private family doctors (General Practitioners), gynaecologists and health professionals (pharmacists, nurses and midwives) in the community.

Contraception not only provide women protection against unplanned pregnancies, but also gives women power over their bodies. In earlier days in Britain, contraception was not available to non-married women until the late 1960s. Contraception gives women the opportunity to choose when to conceive or not, to space their pregnancies, allowing them the chance to develop their lives through education and careers. However, this also creates dilemmas: by having highly effective contraception, women now have to decide when to conceive, and sometimes there never seems to be a right time to do this! Many women leave trying to conceive till late into their thirties, and then find they have difficulty becoming pregnant. It has also been documented in scientific literature that some women have contraceptive failures which may subconsciously stem from their desire to become pregnant. Contraception has developed dramatically over the last two decades or so with the launch of longer-term yet reversible methods of contraception such as intra-uterine hormonal contraceptive systems. These methods give an excellent alternative to sterilisation, which is considered permanent, and offer a wider choice to all women.

All methods of contraception can be classified into four main types. These are:
- natural family planning methods
- barrier methods
- hormonal methods
- surgical methods.

**Contraception efficacy**

The performance of a contraceptive method is measured by its failure rate, or the number of unplanned conceptions (irrespective of pregnancy outcome) occurring in people using the method for a year. It is sometimes represented as a percentage, but more accurately as the number of pregnancies per 100 woman-years. One woman-year is a unit that represents 12 months of a woman’s exposure to the chance of becoming pregnant.

The basis for many failure rate calculations is known as the Pearl pregnancy rate, or a Pearl Index, calculated as:

\[
\text{Failure rate} = \frac{\text{Total unplanned pregnancies} \times 1200^*}{\text{Total months of exposure}}
\]

\*1200 being the number of months in 100 years

The average pregnancy rate for a couple who are sexually active and do not use contraceptives is equivalent to 85 pregnancies per 100 woman-years. A contraceptive method that results in a pregnancy rate of fewer than 10 pregnancies per 100 woman-years is considered highly effective. The efficacy of a contraceptive method reflects failure rates in **perfect use** (i.e. method failure) or **in typical use** (i.e. user failure or provider failure). Thus methods of contraception fail for three main reasons: due to the method, the user, or the provider.
**Method failure** is defined as pregnancy occurring despite the method of contraception being used correctly (or fitted correctly in the case of implants, copper intrauterine devices and the levonorgestrel-releasing intrauterine system). Method failure also includes failure due to physiological differences in women, such as weight and age.

**User failure** is defined as pregnancy occurring because the method is not used, or is used incorrectly by the user.

**Provider failure** is defined as pregnancy occurring because the provider (health care professional) erred, for example by giving incorrect information on use or perforating the uterus while inserting a contraceptive intrauterine device.

Contraceptive failure rates are higher in day-to-day practice than in clinical trials, because of higher user failure rates. For user-dependent methods of contraception (e.g. the natural family planning methods, the condom and the contraceptive pill) failure rates are highest in the first 12 months of use. Long term users obviously tend to be those who use the method efficiently and also include those of lower fertility.

**Natural family planning methods**

Natural family planning methods have been used widely in the past especially among Roman Catholic faith communities. They involve the observation of certain body changes which denote ovulation. From this information a couple may choose to either abstain from sexual intercourse and use it as their family planning method, or use this fertile period to have sexual intercourse promoting pregnancy, known as fertility awareness.

Natural family planning methods have been referred to previously as **periodic abstinence**, the **safe period** and the **rhythm method**. It is only more recently that it has been promoted to women as fertility awareness method,

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage of women experiencing an unplanned pregnancy within the first year of use</th>
<th>Percentage of women using the method 1 year after starting it</th>
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<tbody>
<tr>
<td>No method</td>
<td>85%</td>
<td>-</td>
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<tr>
<td>Natural family planning</td>
<td>25%</td>
<td>1–9%</td>
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<tr>
<td>Contraceptive Pill combined oral contraceptives progestogen-only pill</td>
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<td>0.30%</td>
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<td>Injectable medroxyprogesterone (Depo-Provera)</td>
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<td>0.30%</td>
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<td>Etonogestrel implant</td>
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<tr>
<td>Combination contraceptive patch</td>
<td>8%</td>
<td>0.30%</td>
</tr>
<tr>
<td>Combined contraceptive patch</td>
<td>0.96 <strong>Pearl Index</strong>†</td>
<td>0.64 <strong>Pearl Index</strong>†</td>
</tr>
<tr>
<td>Copper intrauterine device (IUD: ParaGard (Tcu 380A))</td>
<td>0.80%</td>
<td>0.60%</td>
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<td>Levonorgestrel-releasing intrauterine system (IUS)</td>
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<td>Diaphragm plus spermicide</td>
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<td>6%</td>
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<td>-</td>
</tr>
<tr>
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<td>5%</td>
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<tr>
<td>Withdrawal</td>
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</tr>
<tr>
<td>Female sterilization</td>
<td>0.50%</td>
<td>0.50%</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>0.15%</td>
<td>0.10%</td>
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| **Pearl Indices (number of pregnancies per 100 woman years of use) are the only efficacy data available for the combined contraceptive vaginal ring currently, suggesting comparable efficacy with that known for combined oral contraceptives [ABPI Medicines Compendium, 2009b].**

and as more women are delaying pregnancy, this has become a popular choice. Women seeking help on natural family planning methods are usually advised to use fertility awareness kits. Recently research has increased in this area producing personal contraceptive systems and urinary dipsticks. The temperature method has benefited from electronic and digital thermometers by increasing accuracy and decreasing the time clients need to take their temperature.

The main natural family planning methods
There are four main natural family planning and fertility awareness methods:
- the temperature method
- the cervical mucus method (previously known as the Billings method)
- the calendar method
- combination of methods, also known as the symptom-thermal method or double-check method.

These methods help a woman to recognize when ovulation takes place. This usually occurs between days 12 and 16 before the next menstrual period. The ovum remains capable of being fertilized for 12-24 hours, whilst sperm are capable of fertilizing the ovum for 3-5 days, although on occasions it has been found that sperms may survive up to 7 days in utero.

Efficacy
The efficacy of natural family planning methods is 75% with typical use and up to 91%-99% with careful use, depending on method used. The sympto-thermal is the most effective method as it uses a combination of methods. In theory the efficacy of the sympto-thermal method can be as high as 99%; however, with this and any natural family planning method the range of effectiveness of the method is dependent on the level of motivation and commitment the couple give to the method. Many men and women use this method to space their pregnancies, and as a result may be prepared to take more risks. However, couples who are using the method to avoid a pregnancy are more likely to be highly motivated and conscientious; they are less likely to take risks so the user failure rate will be lower and the efficacy higher. Lastly the level and expertise of the teaching of this method will influence the efficacy of the method, which is why it is vital that his method is taught by a health professional trained in natural family planning.

Disadvantages
- Requires motivation
- Needs to be taught by a specialist in natural family planning
- Requires the observation and recording of changes in the body
- May take time to learn so may require a period of abstinence.

Advantages
- Once learnt its use is under the control of the couple
- Inexpensive (except in the personal contraceptive method)
- Can be used to promote pregnancy
- Increases couple’s knowledge of changes in the body and fertility
- No physical side effects
- More acceptable to the Roman Catholic community.

The temperature method
The temperature method involves the woman taking her temperature every day to record her basal body temperature. Following ovulation the basal body temperature (BBT) will drop slightly and then rise by 0.2-0.4°C where it will stay until the next period. The woman will be advised to take her temperature at the same time each day before getting out of bed. If she works night shifts she should do this after sleeping in the evening. She should take her temperature first before drinking or eating as these will affect the basal body temperature. The thermometer should be an ovulation thermometer which is calibrated in tenths of a degree between the range of 35 and 39°Celsius. A digital or electronic thermometer may be used which takes about 45 seconds to give a reading. Using traditional mercury-in-glass thermometers, the temperature can be taken orally which
Cervical mucus method
The cervical mucus method involves a woman observing her cervical mucus every day. The mucus varies throughout the cycle. Following menstruation there is little cervical mucus and this is often described as ‘dry’. There may be an absence of cervical mucus or it may appear sticky and if stretched between two fingers will break. This mucus is known as infertile mucus. As the ovum begins to ripen, increasing amounts of hormones (oestrogen) cause an increase in cervical mucus. This marks the beginning of the fertile phase. Oestrogen levels continue to rise prior to ovulation and the cervical mucus becomes abundant, clear and stretchy; if held between two fingers it can stretch easily without breaking - described as having a marked Spinnbarkeit (a German biomedical term meaning spin-ability) - which refers to the stringy or stretchy property found to varying degrees in cervical mucus.

This kind of mucus has been described as looking like raw egg white and is called fertile mucus. It helps to capacitate sperm and provides an optimum environment for them to proceed to the upper tract. The last day of this type of mucus is known as peak mucus day; which can only be identified retrospectively. Four days following peak mucus day the mucus becomes thick, scanty, sticky and opaque and is known as infertile mucus. This mucus is impenetrable and hostile to sperm. This change in the mucus occurs because the ovum has been released and the level of oestrogen has dropped. The woman is taught to observe and record her cervical mucus several times a day either by collecting some on the toilet paper or by inserting two fingers into her vagina to check its consistency and appearance.

Research has shown a method failure rate of 1.5 per 100 users and a user failure rate of the method of 15.9 per 100 users at 21 months. This would seem to illustrate how vital training and motivation of the client and her partner are in ensuring efficacy.

Disadvantages
- Requires commitment
- Needs to be taught by a specialist in natural family planning
- Can take 2-3 cycles to learn the method
- Vaginal infections can make it difficult to identify fertile mucus
- Some drugs used for treatment of colds etc. can inhibit cervical mucus production
- Involves touching the body which some women may dislike
- Requires abstinence.

Advantages
- Under the control of the woman
- Gives the woman an opportunity to explore and feels more comfortable with her own body
- Increases awareness of body changes
- Predicts fertile mucus thus enabling pregnancy
- Can be used to prevent pregnancy.

Calendar method
The calendar method involves a woman detecting when her fertile period is, which is usually 12-16 days before the first day of her next menstrual cycle. This is based on looking retrospectively over the woman’s menstrual cycle for a period of 6 – 12 months of recorded cycles. This method is no
Contraception and family planning

longer recognized as reliable on its own, but may be taught alongside another method as in the combination of methods.

**Disadvantages**

- Unreliable as it does not take into account irregular cycles
- Stress, illness and travelling can affect the menstrual cycle
- Requires motivation
- Requires menstrual cycle to be recorded for 6 – 12 months prior to use.

**Advantages**

- Under the control of the woman
- Increases knowledge about fertility
- Can be used in conjunction with another method.

**Combination of methods**

This is often referred to as the symptom-thermal method or double-check method and combines the temperature, calendar and cervical mucus methods, which is why it is more effective as a contraceptive. Women are also encouraged to observe changes in their cervix such as consistency, position, and whether their cervical opening is open or closed. During the beginning of the cycle when the hormonal levels (oestrogen and progesterone) are reduced, the cervix is positioned low in the vagina and can be easily felt. The cervical opening is closed, and the cervix feels firm to the touch. As oestrogen levels increase the cervix changes and at peak mucus day feels soft. The opening is now open and the cervix has risen higher into the vagina, making it harder to locate. Following ovulation the cervix returns to its former state, positioned lower, and feels firmer when closed. Checking the position and consistency of the cervix, along with the cervical mucus method, can easily be performed by either partner. Women are encouraged to observe and record mood changes and breast tenderness which usually occur in the latter part of the cycle. She may be aware of ovulation pain (known as “mittelschmerz”) and / or mid-cycle bleeding. All these indicators help to confirm changes in the cycle.

**Disadvantages**

- Requires motivation
- Needs to be taught by a specialist in natural family planning
- Requires daily commitment.

**Advantages**

- Detects beginning and end of fertile phase
- Can be used to promote pregnancy
- Higher contraceptive efficacy than any other single natural family planning method.

**Personal contraceptive systems**

Personal contraceptive systems are electronic home kits and devices intended to assist women predict fertility. These devices may analyse changes in hormone levels in urine (luteinising hormone monitors), basal body temperature (thermal monitors), electrical resistance of saliva and vaginal fluids (electrolyte monitors), or a combination of these methods. Some monitor brands are specifically marketed only to assist in pregnancy planning, while other brands are marketed for both pregnancy planning and as a method of birth control.

With careful and consistent use, these systems are between 93% and 99% effective in preventing an unplanned pregnancy; the efficacy stated is the result of ongoing prospective research. These devices monitor hormones in urine through urinary test sticks, or monitor basal body temperature through temperature sensors. Information is stored on a database inside the device’s electronic memory which in turn tells the woman, when the fertile period commences and ends, and whether she is fertile or not. Urine tests should be performed on an early morning urine sample and then inserted into the machine. Usually this needs to be performed eight days a month, but in the first month it will need to be done 16 days of the month to provide the database with information about a woman. These systems involve the purchase of the device and a starter pack once, then test sticks for every month.

**Disadvantages**

- Expensive
- Can only be used by women whose menstrual cycle falls within the range of 23 – 35 days.

**Advantages**

- No systemic effects
- Under the control of a woman
- Can be used to plan pregnancy
- Easily reversed.
- Absolute contraindications for hormone monitors
- Unsuitable for women whose menstrual cycle does not fall in the range of 23 – 35 days
- Unsuitable for women breast feeding
- Unsuitable for women using hormone treatments
- Unsuitable for women with kidney or liver disease
- Unsuitable for women with menopausal symptoms
- Unsuitable for women with polycystic ovarian syndrome.
A male natural method of birth control

The choice of contraception available to a man is limited compared with that available to women. Most research has been aimed at female clients because it is the woman who will become pregnant and because it is easier to stop a monthly ovulation rather than a continuous sperm production process.

Coitus interruptus

Coitus interruptus is where a man withdraws his penis from the vagina before ejaculating during sexual intercourse. It is the oldest method of contraception, being also referred to in the Bible (Genesis 38: verse 9) and the Koran. Coitus interruptus is widely accepted and used in Muslim and Christian communities as a method of contraception. The name coitus interruptus is rarely used by men and women – instead it is usually referred to as withdrawal, although there are many other euphemisms such as ‘being careful’ or ‘he looks after things’.

Many couples choose to use this method because of its accessibility. This may be because they have no other contraception available at the time of intercourse or because they feel that other choices are unsuitable or unacceptable to the couple. Coitus interruptus is often chosen as a method by couples for its religious acceptability. For many couples this may be a highly acceptable form of contraception which is under their influence and easily reversible. They have the power to revoke their decision and have ‘unprotected’ sexual intercourse if they wish to conceive at any time.

The efficacy of coitus interruptus is variable but it can with careful and consistent use be as high as 96% effective in preventing pregnancy. However, the figure may be as low as 73% with less careful and committed use. Another reason why this method may fail is the presence of sperm in pre-ejaculate.

However this method of contraception may raise sexual frustration and anxiety. The man may feel anxious over the responsibility placed upon him to successfully withdraw his penis before ejaculation. This may reduce his enjoyment during sexual intercourse and may lead to erectile problems. The woman may experience anxiety over her partner’s ability to use withdrawal and the risk of pregnancy; as a result she may complain of loss of satisfaction during intercourse.

Disadvantages

- Low efficacy
- No protection against HIV and other sexually transmitted infections
- May inhibit enjoyment and is highly interrupts sexual intercourse
- May lead to sexual dysfunction
- Absolute contraindication
- Men experiencing premature ejaculation.

Advantages

- Easily available
- Requires no consultations with health professionals
- Acceptable to certain religions
- No financial cost
- Under the control of the couple.

Barrier methods of contraception

All ‘barrier methods’ of contraception help prevent pregnancy by acting as a barrier, stopping sperm and ovum from meeting and fertilisation or conception occurring. Therefore, they do not induce abortion, otherwise known as non-abortifacient. An abortifacient is a substance or method of contraception that can induce abortion, by either stopping a fertilised ovum to successfully implant in the uterus – which is the process by which a dividing fertilised egg becomes embedded in the lining of the womb, or by terminating a pregnancy after implantation would have taken place.

Condoms

Condoms are one of the first forms of contraception invented. They were made of many unusual materials and initially were seen as a protection against sexually transmitted infections rather than pregnancy. Egyptian men in ancient Egypt were first reported to use condoms to protect themselves against infection back in 1350-1220B.C. Later in AD 1564 an Italian anatomist called Gabrielle Fallopius proclaimed to have invented a condom made of linen in an effort to protect against syphilis. During Casanova’s era in the 1700s, condoms were being used not only to protect against infection but also pregnancy. In the past, condoms have been made of animals’ bladder and intestines, oiled silk, paper and leather.

With the discovery of AIDS in 1981 condoms have been widely advertised and promoted to prevent transmission of HIV. Research has confirmed that condoms are highly effective in preventing the transmission of HIV. For many
years, health promotion specialists have tried to promote the use of the male condom in the prevention of sexually transmitted infections and HIV but with limited effect; there is still the belief that ‘it won’t happen to me’, and as long as this exists the widespread use of condoms is impeded.

Condoms can be bought from pharmacies, supermarkets and vending machines available in public places. There is no legal age limit requirement which restricts the sale of condoms, which gives condoms both a wide and young user age range. Condoms are a highly effective method and one of the few contraceptives available to men.

Today condoms are generally made from a latex sheath which is applied and covers the length of an erect penis. It is disposable and should only be used once, and comes in a variety of colours, flavours (suitable for oral intercourse) and features (contoured, flared, plain ended, straight and ribbed). Flared and contoured condoms are designed to give more space to the head of the penis, thus alleviating tightness around the glans penis during intercourse. Contoured condoms are anatomically shaped to hug the glans, so that they are less likely to slip off whilst still increasing sensitivity. Ribbed condoms are straight condoms with extra bands of latex which are designed to heighten sensitivity for a woman. Straight condoms come in designs with or without a teat (the teat is to retain ejaculate). Condoms with teats such as straight, flared or contoured should be used for internal lubrication. Internal lubrication, or ‘gel charging’, involves putting water-soluble lubricant into the teat of the condom. As the gel liquefies around the glans, sensitivity increases.

Condoms also vary in thickness and thus strength. Stronger condoms are thicker, thus safer. They are suitable for men who experience premature ejaculation or wish for other reasons to delay ejaculation. Thicker condoms are more suitable for anal intercourse, which requires the use of extra water-based lubricants. Condoms which are thinner are designed to increase sensitivity but clients need to be aware of the need to apply these carefully.

Many condoms contain the spermicide Nonoxynol-9 which may give rise to increased local irritation. If a partner complains of local irritation to a condom, then a condom using a non-spermicidal lubricant should be used, once genitourinary infections have been excluded. Some persons may also be allergic to latex. There are male condoms made from polyurethane. Polyurethane condoms are less likely to be affected by fat-soluble products, do not suffer from “latex rot”, and are suited for users who have an allergic reaction to latex – also known as hypoallergenic condoms. They also have the advantage of being stronger and more durable. The efficacy of the condom is variable. With careful and consistent use it can be high as 98% or as low as 85% in preventing an unplanned pregnancy. Research has shown that the lower efficacy is more likely to occur in young men and women, who are more fertile, and with less experience using this method. Research has also shown that condom mishaps are more likely to happen at the beginning of a new relationship and decrease as the relationship continues because regular condom use leads to the development of techniques which reduce breakage and slipping of condoms. This means that new and transient relationships are most at risk of unprotected sexual intercourse.

**How to wear a condom**

1. Place the condom on the erect penis, with the tip pointing upwards.
2. Squeeze the teat and slowly insert the condom onto the penis.
3. Put the teat of the condom inside the vagina or anus, and squeeze it to release any air.
4. Once fully inserted, stop squeezing the teat and use the same hand to hold the condom in place.

**Common problems leading to condom failure**

Often change to another method is exacerbated by a user failure such as burst or split condom, or condom coming off during sexual intercourse. Usually a condom bursts or splits because the user has either put the condom on inside out, or not expelled any air, or because the condom has come into contact with a fat-soluble product, such as petroleum jelly or baby oil which causes the condom to break. Various substances and preparations, including all oil-based products, affect the efficacy of the condom. These include intra-vaginal medications for fungal (such as thrush) or other infections.

Other common condom failures are due to condoms being torn while opening the aluminium packet or while being put on with ragged finger nails and jewellery. Thus, when opening the condom packet, the condom ought to be pushed out of the way by squeezing it to the side to avoid tearing it. The condom packet should then be squeezed helping the condom to slip out, and not pulled out using the finger nails. If a condom is ripped whilst it is being applied due to ragged nails or rings, a new condom must be applied at all times.
Another common mishap is condoms slipping off inside the vagina following loss of erection after sexual intercourse. Condoms slip off during intercourse or remain in the inside of the vagina when the penis is removed following intercourse because the man loses his erection and fails to hold onto the condom when he removes his penis from the vagina, leaving the condom inside the vagina. The condom can also easily slip off when applied inside out. Thus a condom should be applied before the penis comes into contact with the vulva. The condom should be placed on the erect penis and unrolled carefully along the whole length of it. Using the other hand, the person using it should squeeze the condom at the head of the penis to expel any air. Once ejaculation has taken place the penis should be withdrawn holding the condom onto the base of the penis to ensure that it is not left in the vagina.

Some couples find difficulty applying the condom, complaining that it’s either too small or too big. Many men and women also stop using condoms because of complaints of loss of sensitivity. It is believed that one reason why men complain of loss of sensitivity with condoms is because they find them too tight. Few people know that condoms come in different sizes, and can be bought to accommodate different sizes of penis. All condoms are able to expand so should not be too small. Furthermore, flared condoms are more suitable for men who complain that the condom is too small, and thus may help alleviate the problem of condom tightness. Contoured condoms are more suitable for men who find condoms too big. There are also extra large sized and small sized condoms.

Good quality condoms must conform to the British Standards Institution specification (BS 3704 1989) and good quality condoms sold in the European Community must conform to the new single European condom standard. Only condoms carrying the BSI kitemark and the European Standard Logo, also known as the European CE mark ensure they comply with and have met recognised quality standards and reliability criteria. Therefore, people are to be encouraged to check that the condom has the BSI kitemark and CE logo, and that the packet has not expired!

For many men and women condoms are a convenient and easily accessible form of contraception. They allow men to share and take the responsibility for preventing an unplanned pregnancy. Condoms can increase enjoyment by “giving permission” to the couple to touch and explore the penis. They can also use the condom as part of a safe form of foreplay by applying it together, creating equality in the relationship. This can give couples the opportunity to talk about their sexual needs and desires. But there are other perceptions regarding the use of condoms. Studies in the United States have shown that many men believe that using a condom ‘shows you care’, however at the same time it may give other messages, e.g. ‘that you have AIDS’ or ‘that you think that your partner has AIDS’. These anxieties cause dilemmas for men and women, and illustrate how difficult it is to talk to a new partner about sexual intercourse and safer sex. The embarrassment this causes may be the reason why so many couples have unprotected sexual intercourse.

Disadvantages
- Perceived as messy
- Perceived as interrupting sexual intercourse
- Requires forward planning
- Loss of sensitivity
- Cannot be used in conjunction with oil-based lubricants such as petroleum jelly.

Advantages
- Under the control of the couple
- No systemic effects
- Easily available
- Protection against most sexually transmitted infections, including HIV
- May protect against cervical cancer.

Contraindications
- Allergy to latex or spermicide
- Erectile problems such as failure to maintain an erection.

Female barrier methods
For thousands of years women sought to block the cervix to prevent pregnancy. Various cervix-shaped devices were used across different cultures towards this end, ranging from oiled paper cones to lemon halves, or have made sticky mixtures that include honey or cedar rosin to be applied to the cervical opening. The rubber diaphragm, which is held in place by way of a spring in its rim rather than being hooked over the cervix and the cervical cap were introduced into the European market in 1882 which gave women more freedom over their bodies. The cervical cap has not been as widely chosen as the diaphragm because it is only suitable for a certain type of cervix. These contraceptive devices have also given women opting to use them more confidence with their own bodies.
Contraception and family planning

Advantages

• Gives women control and choice over their own sexual health
• It very rarely splits
• Less loss of sensitivity when compared with male condom
• Is made from hypoallergenic material and is safe to use with people who are allergic to rubber latex
• Females condoms are not dependent on the penis being erect for insertion and does not require immediate withdrawal after ejaculation.
• Unlike the male condom, it is not tight or constricting.
• Protects against sexually transmitted infections and HIV
• Can be used in conjunction with oil-based products for lubrication (except with female condoms made from latex)
• No systemic side effects.

Contraindications

• Present vaginal, cervical or pelvic infections which must be investigated and treated first
• Inability by client to touch genital area

The female condom

The female condom (Femidom)

Disadvantages

• Perceived as noisy
• Is not aesthetically pleasing to many women and their partners
• Requires motivation
• May be perceived as interrupting sexual intercourse.

They gave the woman permission to investigate her vagina, allowing her to touch areas that may have seemed forbidden. Often women have little or no knowledge of this area of their body and have built up their own ideas about their vagina. Through lack of knowledge men and women can create very strong images of their bodies which can be frightening and strange.

The female condom

The female condom was first used in the 1980s and originally made of lubricated polyurethane, which is stronger than latex rubber. These have been heavily criticised by users due to reported “rustling” sounds during intercourse which can turn off some potential users, as did the visibility of the outer ring which remains outside the vagina. In order to address these issues, a second generation female condom (FC2) was made from synthetic nitrile between 2005 and 2009. The newer nitrile condoms are less likely to make potentially distracting crinkling noises. Another reason for poor sales of the female condom was that inserting them inside the vagina requires skill that has to be learned, and that female condoms tend to be significantly more expensive than male condoms.

The female condom is a thin, soft, loose-fitting sheath and comes in various sizes. It has an inner and an outer ring. The inner ring, which is situated at the closed end of the condom, is used to aid insertion. The outer ring is situated at the open end of the condom and lies flat against the vulva and covers part of the external genitalia, therefore giving more protection against sexually transmitted infections than the male condom. The female condom prevents sperm from entering the vagina by acting as a barrier. The female condom is similar to the male condom in its effectiveness in preventing pregnancy. There have only been a few studies researching the efficacy of the female condom, but these indicate that the efficacy ranges from 79% for typical use to 98% for perfect use.

The diaphragm

The diaphragm is a latex rubber or silicone dome which is inserted into the vagina. It covers the cervix, acting as a barrier to sperm and therefore helping it to prevent pregnancy. Diaphragm could be left inside the vagina for a minimum of 6 hours after sexual intercourse but not more than 24 hours to avoid the risk of toxic shock syndrome and pressure ulcers forming. The application of spermicidal cream or gel is indicated with the use of the diaphragm. This will give contraception protection for 3 hours. After 3 hours if no sexual intercourse has taken place more spermicidal will need to be inserted, such as in vaginal pessary form.
The diaphragm is intended for multiple use, however must be taken care of by washing with mild soap and water, and dried before bent back into shape and kept in its case following use. Talcum powders, detergents and perfumes should be avoided as these will affect the natural flora in the vagina leading to infections. The diaphragm should be kept away from direct sunlight and heat sources as these may cause the diaphragm to perish. It should also be checked regularly for holes as this will reduce its effectiveness. The diaphragm has to be renewed every year. It must also be renewed in the event of a vaginal infection to prevent re-infection.

With careful consistent use the diaphragm is 94% effective when used with a spermicide in preventing pregnancy in the first year. With typical use where a woman does not use this method carefully the efficacy is 84% effective with used with a spermicide in preventing pregnancy in the first year. Failure rates for the diaphragm depend on how effectively the woman uses it, such as whether it has been used consistently and whether it was placed correctly covering the whole cervix. Other factors which influence the failure rate of all methods are a woman’s age and how often she is having sexual intercourse. For example if a woman is aged 40 and uses a diaphragm as a contraceptive she is less fertile than a woman aged 25 so a diaphragm is a more effective contraceptive for her. The use of spermicide with a diaphragm has been debated amongst researchers as some claimed not to make a significant different. But current guidelines indicating the use of spermicide remain.

There are three main types of diaphragm. The first is known as a flat spring diaphragm suitable for women with an anterior or midplane positioned cervix. The second is a coiled spring diaphragm suitable for women with a shallow symphysis pubis, and the third is an arcing spring diaphragm suitable for women with a posterior positioned cervix, or where a woman has difficulty feeling her cervix. A woman wanting to use the diaphragm would need to first have a vaginal examination and then be taught how to use it for the first times by a health professional. Routine visits and examination by a professional are indicated every 6 months. The number of women using diaphragms has dropped significantly since the 1960s with the introduction of the hormonal pill and modern intra uterine devices in the market, from one-third of American couples in the 1940s to 0.2% in 2002.

Disadvantages
- Requires motivation
- Needs to be used carefully and consistently inserted for optimum efficacy
- Needs to be used with a spermicide which may be perceived as messy
- May increase the risk of cystitis and urinary tract infections.
- No protection against HIV.

Advantages
- Under the control of the woman.
- May give some protection against cervical cancer and some sexually transmitted infections.
- No systemic side effects
- Provides vaginal lubrication
- Can be used during menstruation
- Gives a woman permission to touch and explore her body.

Contraindications
- Pregnancy
- Undiagnosed genital tract bleeding which must be investigated and treated first.
- Poor vaginal muscle tone or prolapsed
- Abnormalities of the vagina or the cervix existing since birth (congenital)
- Allergy to rubber or spermicide
- Present vaginal, cervical, or pelvic infection which must be investigated and treated
- Recurrent urinary tract infections
- Past history of toxic shock syndrome
- Women who feel unable to touch their genital area because of personal or religious reasons.

Side effects
- Urinary tract infection
- Toxic shock syndrome – associated with diaphragms being worn for more than 30 hours
- Vaginal irritation.

The Cervical Cap
Closely related to the diaphragm, there is the cervical cap, which is smaller and made from rubber or hypoallergenic silicone, covering the cervix only and held by suction. The
The cervical cap helps to prevent pregnancy by acting as a barrier, stopping the sperm and ovum from meeting. There are three types of cervical caps, which are the vault cap suitable for women with short cervices; the cervical cap suitable for a woman with a long parallel-sided cervix; and the vimule cap which is a combination of a vault and cervical cap which adheres to the vaginal wall.

The cap is fitted in a similar way to the diaphragm. A woman wanting to use the cap would need to first have a vaginal examination and then be taught how to use it for the first times by a health professional. Routine visits and examination by a professional are indicated every 6 months. The cap could be left inside the vagina for a minimum of 6 hours after sexual intercourse but not more than 48 hours to avoid the risk of toxic shock syndrome and pressure ulcers forming. The application of spermicidal cream or gel is indicated with the use of the cervical cap. This will give contraception protection for 3 hours. After 3 hours if no sexual intercourse has taken place more spermicidal will need to be inserted, such as in vaginal pessary form.

With careful and consistent use the cervical cap is 80% effective in women who have had given birth in the past and 91% in women who had never given birth, when used with a spermicide, in preventing pregnancy in the first year of use. With typical use where a woman does not use this method carefully, the efficacy is 68% effective in women who have had given birth in the past and 84% in women who had never given birth when used with a spermicide in preventing pregnancy in the first year.

Disadvantages
- Requires motivation
- Needs to be used carefully and consistently for optimum efficacy
- Needs to be used with a spermicide which may be perceived as messy
- May be harder to insert and remove than a diaphragm
- No protection again HIV.

Advantages
- Under the control of the woman
- May give some protection against cervical cancer and some sexually transmitted infections
- No systemic side effects
- Provides vaginal lubrication
- Can be used during menstruation
- Gives a woman permission to touch and explore her body
- No increase in urinary symptoms and cystitis.

Contraindications
- Inability of the client to locate her cervix
- Unsuitable cervix e.g. shape, position
- Pregnancy
- Undiagnosed genital tract bleeding which must be investigated and treated first
- Abnormalities of the vagina or the cervix existing since birth (congenital)
- Allergy to rubber or spermicide
- Present vaginal, cervical or pelvic infections which must be investigated and treated first
- Past history of toxic shock syndrome
- Women who feel unable to touch their genital area because of personal or religious reasons.

Spermicides
Spermicides such as Nonoxynol-9 (or N-9) has long been used as a method of contraception, even though there is little information on the true efficacy of spermicides used on their own. They are available in various forms – cream, foam, gel, film and pessaries. It is not known whether contraceptive effectiveness differs according to formulation or dose. They are usually used with another method of contraception such as the diaphragm and the cervical cap. They are also applied to certain makes of condoms, although there is no evidence that condoms lubricated with N-9 are more effective in preventing pregnancy than lubricated condoms without N-9. Spermicides inactivate sperm by causing changes in the cell membrane of the spermatozoa. They are believed to be of only moderate efficacy as a contraceptive. Limited evidence suggests that the contraceptive effectiveness of the diaphragm and cervical cap may be moderately more effective when used with a spermicide than without.
Spermicide can be bought from a pharmacy over-the-counter without a doctor’s prescription. Originally Nonoxynol-9 was thought of as a breakthrough in the prevention of HIV because it was capable of “killing” (damaging) the virus. However, recent research has shown that the use of Nonoxynol-9, which is a kind of detergent, can irritate and disrupt the cell lining (epithelium) of the vagina and rectum that is present to help protect against diseases. This can cause small cuts, eroding the body’s own protective layers, further leaving a person open to HIV and other sexually transmitted pathogens. Therefore, it can also increase the risk of sexually transmitted infections including HIV infection.

Therefore, while being very effective at helping to prevent an unplanned pregnancy, spermicide is recommended for women who are in a monogamous relationship, and it is only recommended for once a day use at most. Those who are not in a monogamous relationship should use condoms for better protection against pregnancy, HIV and other sexually transmitted infections. Nonoxynol-9 should not be used rectally in the form of a cream, foam, gel, film and pessaries.

Sex workers who are at high risk for sexually transmitted infections as well as HIV should not use spermicide as they typically have sex several times a day with multiple partners. There is good evidence that N-9 does not reduce the risk of sexually transmitted infections or HIV infection among sex workers. What was once thought to empower sex workers (prostitutes) to protect themselves when clients refused to wear a condom is now known to actually contribute to the transmission of sexually transmitted infections in the sex industry.

### Disadvantages
- Perceived as messy
- Local allergic reaction
- Only of moderate contraceptive efficacy on its own.

### Advantages
- Provides lubrication
- Easily available
- May provide protection against sexually transmitted infections and HIV
- Can be used in conjunction with the barrier methods of contraception.
- Absolute contraindication
- Allergic reaction to spermicides.

### Side effect
- Local irritation.

### Intra-Uterine Device (IUD) or Intra-Uterine Contraceptive Device (IUCD)
An intrauterine device is an object inserted through the cervical canal by a medical practitioner and placed in the uterus to prevent pregnancy. It has threads which hang down into the vagina, which a woman can feel using her fingers to make sure that the device is correctly positioned. Different IUDs are licensed to be left inside the uterus for periods ranging from 3 years to 8 years (depending on the type of IUD). It prevents pregnancy by impairing the viability of the sperm and ovum through the alteration of the fallopian tube and uterine fluids. This reduces the chances of the ovum and sperm from meeting, thus impeding fertilisation. The IUD also causes a foreign body reaction which irritates the lining and wall of the uterus, making it hard for an embryo to implant. It is difficult to find the origin of intrauterine devices. Arabs are believed to have inserted stones into the uteruses of their camels to stop them becoming pregnant whilst on long journeys across the desert. The first IUD, made by Dr Richard Richter in 1909 in Germany, designed to prevent conception, was a ring made of silkworm gut. In the 1920s Ernst Graefenberg developed a silver ring known as the Graefenberg ring and in 1962 the first plastic IUD was introduced, called the Lippes Loop. In many countries contraception was illegal during this time, and antibiotics had not been developed to treat pelvic infection. It was not until 1965 that IUDs became available to women in the UK through Family Planning Clinics, and in 1969 copper wire was added (coiled around) to the plastic IUD which was found to increase the efficacy of the device – hence why it is commonly known as the coil.

There are over 10 different kinds of copper IUDs available. Recently a new IUD system has been introduced known as
Contraception and family planning

an intra-uterine system (IUS) which works with a hormone (progestogen), has fewer side effects, increased efficacy and lasts up to 10 years. These are described further down in a section dedicated to hormonal contraception. The decision of which IUD to insert will depend on the woman and the size of her uterus.

An IUD may be removed at any time if a woman does not mind becoming pregnant. An IUD is removed by a medical practitioner who visualises the IUD threads in the vagina and gently pulls out the IUD. It is usually advised that IUDs are removed 1 year after the menopause, because there is concern that an IUD may cause pus in the uterus.

**Efficacy**
The IUD is from 98% to nearly 100% effective in preventing pregnancy, depending on the device. Newer IUDs have failure rates of less than 1 per 100 after 1 year of use.

**Disadvantages**
- Heavy and prolonged menstrual periods
- Excessive menstrual pain
- Slightly increased risk of ectopic pregnancy if there is an IUD failure
- Increased risk of pelvic infection
- Expulsion of the IUD
- Perforation of the uterus, bowel and bladder
- Malposition of the IUD
- Pregnancy caused by expulsion, perforation, or malposition.

**Advantages**
- Effective immediately
- No drug interactions
- Reversible and highly effective
- Does not interfere sexual intercourse.

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**Advantages**
- Effective immediately
- No drug interactions
- Reversible and highly effective
- Does not interfere sexual intercourse.

**Absolute contraindications**
- Pregnancy
- Undiagnosed genital tract bleeding
- Previous ectopic pregnancy
- Pelvic or vaginal infection; once treated an IUD may be fitted
- Abnormalities of the uterus existing since birth (example a bicornuate uterus)
- Allergy to components of the IUD, e.g. Copper
- Wilson’s disease
- Heart valve replacement or previous history of bacterial endocarditis because of increase risk of infection
- HIV and AIDS because of reduced immune system and increased risk of infection.

**Relative contraindications**
- History of pelvic infection
- Excessive menstrual pain and/or heavy and prolonged menstrual periods
- Fibroids and endometriosis.

**Hormonal methods**
Hormonal methods of contraception can be classified in various ways. They can be classified by the hormonal active ingredients, such as:
- oestrogen-free methods (or progestogen-only) and
- combined methods (those containing oestrogen and progestogen).

They can also be classified by their ‘mode of delivery’, or the way by which the steroid hormone reaches the female body, such as:
- oral (taken orally as pills)
- injectable (taken as a depot injection – one which releases its active compound in a consistent way over a long period of time)
- dermal (through the skin using patches)
- sub-dermal / implantable (sub-dermal implants inserted under the skin)
- intra-uterine (via controlled-hormone-release devices inserted in the uterus)
- intra-vaginal (via devices inserted inside the vagina such as vaginal rings).

**Oral contraceptives**
Oral contraceptives were first explored in the late 1930s, and became available to American women in 1957, followed by the British in 1961. The convenience, effectiveness and reversibility of action of birth control pills have made them the most popular form of birth control in the western world.
Contraceptive pills include the combined pill which contains the hormones oestrogen and progestogen, and the progestosterone-only pill which contains the hormone progestogen. These are abbreviated to the COC and POP by professionals, and referred to by women in the case of the combined pill as ‘the pill’ and to the progestogen pill as the ‘mini pill’.

There is a wide range of contraceptive pills and with increasing media attention focusing on this area women have a greater knowledge of the types and makes of pill available. However, this knowledge often does not extent to guidelines over missed pills, so these cannot be emphasised too much by health care professionals.

Any sort of hormonal contraceptive requires a consultation with and careful assessment by a medical professional before it can be prescribed. Hormonal contraceptives cannot be purchased from a pharmacy over-the-counter. Hormonal contraceptives require a medical prescription.

Once the contraceptive pill or any other hormonal form of contraception has been prescribed, a thorough medical consultation is recommended every six months.

The combined contraceptive pill
The combined oral contraceptive pill contains two hormones – oestrogen and progestogen. It is today one of the most widely used methods of contraception.

It prevents pregnancy by:
- Inhibiting ovulation
- Making the endometrium unfavourable for implantation
- Making the cervical mucus impenetrable to sperm.

There are four types of combined pills:
- Monophasic pills
- Biphasic pills
- Triphasic pills
- Every day (ED) pills.

Monophasic pills are the most widely used combined pill, which means that it contains the same amount of oestrogen and progestogen throughout its 21 days of pills.

Biphasic pills are 21-day pills which contain the same amount of oestrogen throughout the packet but have pills with two different levels of progestogen in them. These are usually coded in different colours.

Triphasic pills are 21-day pills which contain varying amounts of oestrogen (usually two different levels) throughout the packet but have three different levels of progestogen in them, which are colour coded.

Every day (ED) pills are either monophasic or triphasic but are 28-day pills. Twenty-one of these pills contain oestrogen and progestogen and seven of these pills are inactive pills containing no hormones. The aim of the ED pill is to improve compliance.

The combined 21-day pill should be commenced on the first day of the woman’s menstrual cycle, that is the first day of the woman’s period, when bleeding (menses) starts.

When started on the first day of the period, no additional contraceptive measures need to be taken. This applies to all 21-day pills whether they are monophasic, biphasic or triphasic. If the pill is commenced at any other time in the cycle, additional precautions (such as using a condom) are required for 7 days. The pill ought to be taken at the same time each day. Once 21 days of pills have been taken, then a woman should have a 7-day break where no pills are taken; this is known as the pill-free week, during which the woman will experience bleeding (menses). This is known as a ‘withdrawal bleed’. Following the 7-day break, the woman should restart the pill on day 8. Each packet of pills will always be commenced on the same day of the week the first packet is commenced.

Efficacy
With careful use the combined pill is 99% effective in preventing pregnancy; however with less careful use the efficacy may be as low as 92%.

The combined pill’s effectiveness is reduced by:
- missed pills – if a woman forgets to take her pill or is more than 12 hours late
- vomiting – if a woman vomits within 3 hours of taking the pill
- severe diarrhoea
- drugs which are either enzyme inducers or affect the absorption in the bowel
- taking antibiotics at the same time.

What to do when a pill is missed, a woman vomits, or have severe diarrhoea
If a woman forgets a pill, but it is within 12 hours from when she normally takes it, then she should take it immediately and no additional precautions are required.
If the pill is forgotten more than 12 hours from when it is normally taken, then there are certain actions and precautions to be taken, depending on the type of pill taken (monophasic, biphasic, triphasic or Every Day pill) and the specific day on which the pill was missed. In such a situation, it is very important that a woman seeks advice from her pharmacist, family doctor, or another designated health care professional such as a nurse or midwife, on what actions and extra precautions will be required to ensure that it would be safe to have intercourse without the risk of getting pregnant.

If a woman vomits within 3 hours of taking the pill, or suffers from severe diarrhoea, then the pill will not be effective and additional actions and precautions will be required. These depend on how long a woman suffers from bouts of vomiting or diarrhoea. In such circumstances, it is very important that a woman seeks advice from her pharmacist, family doctor, or another designated health care professional such as a nurse or midwife, on what actions and extra precautions will be required to ensure that it would be safe to have intercourse without the risk of getting pregnant.

Women are safe to have sexual intercourse in the 7-day pill-free week, as long as they do not lengthen this gap. If a woman lengthens this gap then she is at risk of ovulating and pregnancy. If she forgets the last pill of her packet she should count that as the first day of the pill-free week and only have a further 6 pill-free days.

If a woman forgets to restart her next packet on time and has had an 8-day pill-free interval, then her pills will not be contraceptively effective until she has taken 7 days of pills; in the meantime she will need to use additional contraceptive precautions, such as using condoms.

If ever in doubt about what to do, a woman should ALWAYS contact a family doctor, a pharmacist, or another designated health care professional such as a nurse or midwife for advice.

Disadvantages
- Needs to be taken regularly, carefully and consistently.
- No protection against STIs and HIV
- Increased risk of circulatory disorders such as hypertension, arterial disease and venous thromboembolism
- Increased risk of liver adenoma, cholestatic jaundice, gallstones
- Effect of COC on breast cancer
- Unsuitable for smokers over the age of 35.

Advantages
- Reliable and easily reversible
- Relief of excessive menstrual pain and heavy / prolonged menstrual periods
- Reduces risk of anaemia
- Reduces the risk of benign cysts in the breast and ovaries (ovarian cysts)
- Relief of premenstrual symptoms
- Fewer ectopic pregnancies
- Less pelvic inflammatory disease
- Protects against endometrial and ovarian cancer.

Absolute contraindications
- Pregnancy
- Breastfeeding
- Undiagnosed vaginal or uterine bleeding
- Past or present venous thrombosis
- Past or present arterial thrombosis
- Cardiovascular and ischaemic heart disease
- Lipid disorders
- Focal and crescendo migraines
- Cerebral haemorrhage
- Transient ischaemic attacks
- Active disease of the liver
- Breast cancer
- Four weeks before major surgery or leg surgery
- Obesity (body mass index (BMI) over 35kg/m²)
- Severe diabetes mellitus with complications
- Smokers over the age of 35
- Family history of arterial/venous disease in a first degree relative below the age of 45
- Other medical conditions either related to previous use of the combined pill or affected sex steroids.

Side effects
- Nausea
- Breast tenderness and swelling
- Breakthrough bleeding
- Depression
- Changes in libido
- Contact lenses may become uncomfortable – this is usually associated with hard lenses and high dose pills.

When commencing oral contraception, the risks along with the benefits should be discussed fully with a medical doctor, so that one is able to fully understand and weigh up the risks and benefits of the contraceptive pill.
A woman experiencing any of the following problems while taking the contraceptive pill should seek medical attention immediately:

- Pain and swelling in the calf of the leg
- Chest pain
- Shortness of breath
- Increasing headaches
- Headaches with speech or visual disturbances
- Pain, tingling or weakness in an arm or leg
- Jaundice
- Severe abdominal pain
- Bleeding after intercourse or any prolonged bleeding.

The Progestogen Only Pill

The Progestogen-only pill (POP) is commonly referred to as the ‘mini-pill’, which tends to give women the impression that it is of a low contraceptive efficacy. The POP have many advantages over other methods that are often underestimated. It prevents pregnancy in a number of ways, namely by:

- Thickening the cervical mucus, hindering sperm penetrability
- Suppressing ovulation in some cycles
- Rendering the endometrium unreceptive for implantation
- Reducing fallopian tube function.

The effectiveness of the POP is between 96% and 99% in preventing pregnancy. If used consistently and correctly the efficacy will be higher, but for typical use the efficacy will be lower; this may be due to women not taking their pills on time. Research has also shown that if a woman is heavier than 70kg there is a trend that indicates that failure rate is higher.

When a woman commences the POP, she should return for a follow-up visit in 3 months if there are no problems, then she should be seen for a thorough examination every 6 months.

When commencing oral contraception, the risks along with the benefits should be discussed fully with a medical doctor, so that one is able to fully understand and weigh up the risks and benefits of the contraceptive pill.

Disadvantages

- To be effective needs to be taken carefully
- Irregular menstrual cycle
- A small number of women develop functional ovarian cysts
- If POP fails may have possible increased ectopic pregnancy rate
- Effect of POP on breast cancer.

Advantages

- Does not inhibit lactation so suitable for breast feeding mothers
- No evidence of increased risk of cardiovascular disease
- No evidence of increased risk of venous thromboembolism
- No evidence of increased risk of hypertension
- Does not need to be stopped prior to surgery
- Is not affected by broad spectrum antibiotics taken at the same time
- Suitable for women with diabetes or focal migraines
- Reduction in excessive menstrual pain
- May relieve pre-menstrual symptoms
- Suitable for women unable to take oestrogen.

Absolute contraindications

- Pregnancy
- Undiagnosed genital tract bleeding
- Past or present severe arterial disease
- Severe lipid abnormalities
- Recent trophoblastic disease
- Serious side effects occurring on the COC which are not due to oestrogen
- Previous ectopic pregnancy
- Present liver disease, liver adenoma or cancer.

Side effects

- Functional ovarian cysts
- Breast tenderness
- Bloatedness
- Depression
- Fluctuations in weight
- Nausea
- Irregular bleeding
- Absence of periods.
Emergency contraception: 71

Emergency contraception refers to any intervention or method to prevent pregnancy in women who have had unprotected sex, or when other birth control methods have failed – such as when a condom breaks, a diaphragm slips out of place or a woman forgets to take her birth control pill. The term ‘Plan-B’ has also been coined to refer to emergency contraception. Other terms referring to emergency contraception are post-coital contraception, post-conceptional or contraceptive agent.

The first emergency contraception attempted in the ancient past to prevent pregnancy after unprotected intercourse was vaginal douches, and remains in use today. But these are not successful, and should not be used. Douches are devices and preparations used to introduce a stream of water mixed with antiseptic chemicals to ‘clean and irrigate’ the vagina. A range of pessaries and douches have been described over the years, including wine and garlic with fennel, used in Egypt as early as 1500BC; ground cabbage blossoms in the 4th century, and culminating in the Coca-Cola modern mythology in some developing countries even today.

However, this method is doomed to frequent failure as a method of contraception since sperm have been found in cervical mucus within 90 seconds following ejaculation. Furthermore, many professionals argue that douching is unhealthy and risky, as it interferes with both the vagina’s normal self-cleaning process, the natural pH of the vagina, and with the natural bacterial culture (natural flora) of the vagina. Thus it can lead to irritation, introduce or spread infections such as bacterial vaginosis, and pelvic inflammatory disease. Douching may also wash bacteria into the uterus and Fallopian tubes, causing fertility problems.

For these reasons, the practice of douching is now strongly discouraged except when ordered by a medical doctor for specific medical reasons.

The history of more effective emergency contraception methods began in the early 60s. Today emergency contraception refers to two main methods: hormonal contraception and intrauterine contraception. Hormonal contraception refers to a drug containing oestrogen and progestogen. There are several emergency contraception pills, also commonly known as ‘emergency pill’ or the ‘morning-after pill’ - although the latter term has created many problems because people have mistakenly believed that they may only take emergency contraception the day after unprotected sexual intercourse, when in fact it can be taken within a much longer time period.

The ‘morning-after pill’ is available in either a single dose, or two separate doses taken 12 hours apart, that must be taken within 72 hours of unprotected sexual intercourse. The sooner this is started, the more effective it is. The latter method of emergency contraception is known as the Yupze regimen, after the Canadian Professor Albert Yuzpe who published the first studies demonstrating the method’s safety and efficacy in 1974.

Emergency contraceptive drugs, irrespective of type, are not licensed in Malta, and therefore cannot be bought from Maltese pharmacies. The action of the hormonal emergency contraception will depend on when in relation to ovulation they are administered. Morning-after pills are high-dose hormonal birth control pills that work by stopping or delaying ovulation (the eggs) being released from the ovaries, inhibiting sperm to prevent fertilisation, or preventing the implantation of a fertilized egg. The ethical debate on this issue centres on whether a pregnancy begins at fertilization or at a later stage of the reproductive cycle, such as at implantation. The Catholic Church regards any mechanism that blocks or inhibits the implantation of a fertilised ovum an abortion, therefore the morning-after pill is considered as an abortifacient. In view of its potential abortifacient mode of action, and in view of the fact that, in Malta, abortion is a criminal offence, the morning-after pill is not licensed locally.

Efficacy

The efficacy of the Yuzpe regimen varies between 95 - 100% in preventing pregnancy, with the lower efficacy rate applying to mid-cycle unprotected intercourse which has the greatest risk of pregnancy. However, not all episodes of unprotected sexual intercourse result in pregnancy. Research trials estimated that this regimen’s efficacy reduces the probability of pregnancy by 75%. Although this is a great reduction in the risk of pregnancy, it is not considered as an adequate replacement for effective ongoing method of birth control.

Advantages

- By definition it is non-intercourse-related, it does not disrupt the sexual act
- It is highly effective
- The method can be applied well after exposure to the risk with a good chance of success.
- The method is safe in the absence of underlying contraindicated conditions. No deaths have been reported.
- The method is under the woman’s control.
- There is no age limit to use.
Disadvantages
It may cause the following side-effects:
• abdominal pain
• changes in menstrual bleeding (next menstrual cycle may start earlier or later than usual and the next menstrual flow may be lighter or heavier than usual)
• fatigue
• headache
• dizziness
• nausea and vomiting
• breast tenderness.

Absolute contraindications
• Pregnancy
• Present focal migraines
• Jaundice
• Sickle cell crisis
• Current active arterial disease
• Active porphyria.

Relative Contraindications
• Past history of arterial disease
• Past history of venous thrombosis
• Previous ectopic pregnancy
• Breast feeding
• If more than 72 hours has elapsed since unprotected sexual intercourse.

An alternative to hormonal emergency contraception is the insertion of a copper-releasing intra-uterine device, or IUD, already described in a previous section. The IUD operates here mainly by blocking implantation, since it is usually inserted after ovulation; though if applied earlier in the cycle it an also block fertilisation. It must be inserted by a health care professional within 5 days of having unprotected sex. For the IUD method the failure rate is very low, usually quoted at that of about 1/100 woman-years. It can be removed after the next menstrual period, or the woman may choose to leave it in place to provide ongoing birth control.

The morning-after pill should not be taken if a woman thinks she might have been pregnant before having intercourse, or if she had vaginal bleeding for an unknown reason. Emergency contraception should not be used as a routine birth control method, because it is actually less effective at preventing pregnancies than most types of other methods of birth control.

The Intra-Uterine System
In 1995, a new method of contraception, known as an intrauterine system (IUS) was launched in the market. An IUS has a hormone cylinder that releases a synthetic progestogen called levonorgestrel (thus a Levonorgestrel-releasing intrauterine system), meaning that it is a progestogen-only method. The term IUS is used to distinguish the hormonal intrauterine contraceptive from copper-based intrauterine devices (IUDs). The IUS is used both as a method of contraception as well as a treatment heavy periods, very painful periods and endometriosis.

The IUS has a plastic T-shaped frame similar to the copper IUD, but with a steroid reservoir. The device is 32mm in length and 4.8mm in diameter. It is inserted through the cervical canal into the uterus, where it sits releasing the hormone 24 hrs a day for a recommended duration of use of 5 years. The amount of synthetic hormone delivered by the IUS is only a fraction of the daily dose received through oral contraceptives, so the side effects should be smaller with the IUS than with oral methods. The IUS can only be fitted by a qualified medical practitioner. During the procedure, which only lasts a few minutes, the cervix is dilated and the IUS is fitted using an insertion device. Removal of the IUS is the same as removing an IUD, and fertility returns immediately. The IUS prevents pregnancy by the suppression of the endometrium, making it unfavourable to implantation. In some women the IUS reduces ovarian function. It also causes the cervical mucus to thicken, making it impenetrable to sperm.

Efficacy
The IUS has a mean failure rate of less than 0.2 per 100 women years for up to 5 years.

Disadvantages
• Total absence of menstrual periods
• Irregular bleeding
• Dilatation of cervix is required which is uncomfortable, and for some women painful
• Expulsion of the IUS
• Perforation of the uterus, bowel or bladder
• Malposition of the IUS
• Pregnancy causing expulsion, perforation, or malposition
• Slightly increased risk of ectopic pregnancy if there is an IUS failure.

Side effects
• Some women may develop functional ovarian cysts
• Breast tenderness
• Acne
• Headaches
• Bloating
• Mood changes
• Nausea
• Irregular bleeding
• Total absence of menstrual period.
Advantages

- Reduction in heavy and prolonged menstrual periods
- Reduction in excessive menstrual pain
- Infrequent or absent menstrual periods
- High efficacy
- Reversible
- Unrelated to sexual intercourse.

Absolute contraindications

- Pregnancy
- Undiagnosed genital tract bleeding
- Heart valve replacement
- Congenital or acquired uterine anomaly which distorts the fundal cavity
- Suspected or confirmed uterine or cervical malignancy
- Recent trophoblastic disease
- Serious side-effect occurring on the COC which are not due to oestrogen
- Present liver disease, liver adenoma or cancer
- Present thrombophlebitis or thromboembolic disorder.

Relative contraindications

- Chronic systemic disease
- Risk factors for arterial disease
- Past or present severe arterial disease
- Severe lipid abnormalities
- Recurrent cholestatic jaundice
- Sex steroid-dependent cancer, e.g. breast cancer
- Functional ovarian cysts which have required hospitalisation
- Previous ectopic pregnancy.
- Medicines which may interfere with intrauterine system efficacy (seek a pharmacist’s or doctor’s advice if taking other medications).

Permanent surgical methods of contraception

Male sterilisation

Male sterilisation has become a popular choice of permanent contraception in various countries. The surgical procedure is known as vasectomy and may be performed under local or general anaesthetic. One or two incisions are performed on each side of the scrotum so that the vas deferens may be located. A vasectomy involves cutting the vas deferens, which is the tube that transports sperm from the epididymis in the testes to the seminal vesicles. Then either cautery or a ligature will be applied. Full recovery will be attained within a week from the procedure, during which the person will be instructed to take things gently and avoid heavy lifting, strenuous exercise and sexual intercourse.

By cutting the vas deferens sperms are unable to be ejaculated and a man will become infertile once the vas deferens is clear of sperm, which takes about 3 months. Therefore alternative contraception will be required for about 3 months following the procedure. Once two consecutive negative sperm counts have been obtained, then the use of another form of contraception may be ceased. A vasectomy is highly effective form of contraception. Its immediate failure rate is 1 in 1000; the late failure rate is between 1 in 3000 and 1 in 7000. Although very rare, vasectomies can fail, and is thought to be due to re-canalisation of the vas deferens. Vasectomy requires counselling, preferably with both partners, as this is a decision which will permanently affect both parties. As this is a permanent method of contraception the couple should be sure of their decision, and aware that this is very difficult to reverse. Reversal of a vasectomy is easier than reversal of a female sterilisation. However it may only be 50% successful in achieving a pregnancy, and may be lower if the reversal operation is performed more than 10 years after the original vasectomy operation. Couples during counselling are often asked to consider certain scenarios, e.g. how they would feel if their partner died, would they want to have children with someone else? Or if one of the children died, would they want to have more? If they have not had children is there a likelihood they will change their mind? Sometimes couples have not considered major life events and their effects, and during counselling decide to delay such permanent decision.

Men are often concerned about their ability to maintain erections and have sexual intercourse following a vasectomy. Some men see a vasectomy as similar to castration, and become anxious that their ability to function as a man will be impaired. However vasectomy does not affect libido, erections, or orgasm, and the ejaculate will look exactly the same, except it will no longer contain sperm. After vasectomy some men may experience signs of grief over their loss of fertility and perceived loss of sexuality. This will depend on how the man feels about his decision; if he feels forced or coerced into the decision then he may feel anger and sadness over his loss. On the other hand, some men see a vasectomy as their opportunity to do something, especially after their partner has had children. This can enhance their relationship and bring them closer, reducing anxiety over further pregnancy.

Disadvantages

- Alternative contraception is required until two consecutive clear sperm counts are obtained
- A minor surgical procedure required
- Local or general anaesthesia required
- Not easily reversible.
Female sterilisation should be considered irreversible. Successful reversal will depend on the type of procedure used when the woman was initially sterilised and the number of years since the procedure was performed. The success in achieving pregnancy following reversal can be between 50% and 90%. However, following reversal a woman is at a higher risk of ectopic pregnancy, with 3-5% of pregnancies being ectopic.

Counselling for the couple prior to the procedure is very important as it is considered a permanent method. This will also reduce post-operative grief over the loss of fertility which some women experience. Often a pregnancy-scare precipitates a request for sterilisation. Hence, during counselling, a number of issues have to be considered with the couple such as how would they feel if something happens to the present partner - whether they would want children with a new partner; and whether they are certain of not wanting any more children.
Contraception in Malta

Figure 8: Frequency of contraception used amongst the sexually active population, 2002 and 2008

Figure 9: Most common contraceptive methods used in the sexually active population

Figure 10: Contraceptive use on those having multiple partners
TOPIC 8
Sexually transmitted infections
Sexually transmitted infections (STIs)

Sexually transmitted infections, or STIs are primarily spread through person-to-person sexual contact, from one infected person to another through genital sexual practices (oral sex, vaginal sex, anal sex and mutual genital rubbing). Several, in particular HIV and syphilis, can also be transmitted from mother-to-child during pregnancy, childbirth or during breastfeeding from an infected mother. They can also be transmitted through infected blood products and tissue transfer. Sexually transmitted infections are among the commonest cause of illness in the world. They can lead to serious complications and consequences too. The good news about sexually transmitted infections is that many (although not all) can be completely cured with medications. Even more importantly, they are ALL preventable – with responsible sexual behaviour.

There are more than 30 different sexually transmissible bacteria, viruses and parasites. The most common conditions they cause are gonorrhoea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, human immunodeficiency virus (HIV) infection and hepatitis B infection. Some of the most common infections are listed below.

Common bacterial infections
- *Neisseria gonorrhoeae* (causes gonorrhoea or gonococcal infection)
- *Chlamydia trachomatis* (causes chlamydial infections)
- *Treponema pallidum* (causes syphilis)
- *Haemophilus ducreyi* (causes chancroid)
- *Klebsiella granulomatis* (previously known as *Calymmatobacterium granulomatis* causes granuloma inguinale or donovanosis).
- *Bacterial Vaginosis*
- *Cystitis.*

Common viral infections
- Herpes simplex virus type 2 (causes genital herpes)
- Human papillomavirus (causes genital warts and certain subtypes lead to cervical cancer in women)
- Hepatitis B virus (causes hepatitis and chronic cases may lead to cancer of the liver)
- Cytomegalovirus (causes inflammation in a number of organs including the brain, the eye, and the bowel).
- *Human immunodeficiency virus* (causes AIDS).

Fungal infection

Parasites
- *Trichomonas vaginalis* (causes vaginal trichomoniasis)
- *Pubic lice* (also known as crabs)
- *Scabies.*

*Note – these infections are not necessarily sexually acquired or transmitted, but sex can make symptoms worse or can be the cause of transmission due to the close intimate contact with the infected person.

The World Health Organisation estimates that around a million people acquire a sexually transmitted infection, including HIV, every day in adults aged 15-49 years. The highest rate of infection is found among 20-24 year olds, followed by 15 – 19 year olds. The incidence and prevalence of STIs is highest in developing countries. Their complications rank in the top five disease categories for which adults seek health care.
The problem is costly to individuals and healthcare systems. It is estimated that for women aged 15-44 years the STIs, excluding HIV, are the second commonest cause of healthy life lost after maternal morbidity and mortality. The advent of HIV infection in the 80s has highlighted the importance of infection spread by the sexual route.

STIs disproportionately affect women and adolescent girls. The World Health Organization established that one in 20 adolescent girls gets a bacterial infection through sexual contact, and the age at which infections are acquired is becoming younger and younger. It has been calculated that a single act of unprotected sex with an infected partner, teenage women have a 1 per cent chance of acquiring HIV, a 30 percent risk of getting genital herpes, and a 50 per cent chance of contracting gonorrhoea.

Like many other medico-social conditions the explanation of the increase in sexually transmitted infections is multifactorial.
- The age of sexual maturity has decreased, the age at which people have sexual intercourse for the first time is lower
- More people have premarital sexual intercourse than previously. None of these indicate promiscuity, but it must be a factor.
- The increasing use of the oral contraceptive pill and intrauterine devices has removed the protective effect of barrier techniques such as the male condom.
- Since populations are now more mobile internationally, certain groups (tourists, professional travellers, immigrants)

resources for both good treatment facilities and services, and coordinated research.

The incidence of sexually transmitted infections in Malta
The incidence reports of sexually transmitted infection shown here emanate from reports published by the Infectious Disease Prevention and Control Unit (IDCU) within the Ministry for Health, the Elderly and Community Care, which is the centre in Malta dealing with surveillance of infectious diseases. This unit receives reports of infections from doctors, laboratories and the Genito Urinary (GU) clinic. However, these figures need to be interpreted with caution. Data from the IDCU relies substantially on the notification of any infectious diseases reported to the centre. As with many other infectious diseases, the data is the tip of the iceberg as many patients with
potential STIs may not refer to a doctor or the GU Clinic and even some who may refer may not get reported. Apart from this many cases are asymptomatic and hence never refer for help. Therefore, the true prevalence and incidence of STIs in Malta is unknown.

The IDCU also performs contact tracing and partner notification of specified notifiable sexually transmitted infections reported to track down the source of the infection. This is another individual (a sexual partner) with whom the person would have had sex. Public health officials then attempt to get in touch with the partner(s) and bring them in for testing and treatment. The goal of contact tracing and partner notification is to find and treat any person that the initial case may have infected before s/he can pass the infection onto others. This is a technique used by public health authorities to try to limit the spread of infections and diseases.

There are six sexually transmitted infections and diseases that are statutory notifiable to the Superintendent of Public Health. These are HIV & AIDS, Gonorrhoea, Chlamydia, Hepatitis B and Syphilis. Notification is mandatory by law for all doctors in both public and private sectors. In terms of Article 27 (a)(i) of the Public Health Act, the Superintendent has declared the list of notifiable diseases. This notice was issued in the Government Gazette No. 17,533 dated 27th January 2004 (Pg 406). Thus, notification of the specified sexually transmitted infections have been recorded since 2004 (except for HIV/AIDS and Hepatitis B, for which notifications date back to 1986). Reports of deaths directly attributed to notifiable infectious diseases are provided by the Department of Health Information and Research, which processes all death certificates.

The data presented below includes infections of persons of foreign nationality who were diagnosed with the respective infection or disease in Malta, irrespective of these being local residents or non-residents.

In a ten year period between 1st January 2000 and 31st December 2010, a total of 19,367 clinic attendances by 13,557 patients were registered at the GU clinic. Over two-thirds (70%) of these visits were new cases. Follow up appointments at the GU clinic are only offered to patients when strictly necessary to allow more time for new consultations. New consultations included patients attending for the first time, or past patients presenting with a new ailment.

**Signs and Symptoms of STIs**

*Signs* of STIs are what the individual or the health-care provider sees on examination, while *symptoms* are what the person infected with an STI feels prior to an examination.

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**Percentage cases of AIDS in Maltese residents by transmission category**

- Other/Undetermined
- Injecting drugs users
- Mother to Child
- Homo/Bisexual contact
- Blood transfusion
- Heterosexual contact
- Homo/Bisexual men (MSM)

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**Figure 15: Reported cases of HIV infections and deaths from AIDS in Malta - 1986 - 2011**

- **Notifications**: 5 2 7 0 1 7 4 5 3 4 2 4 1 3 0 4 2 1 3 7 2 8 2 6 6
- **Deaths**: 4 2 4 1 2 3 5 4 1 8 2 3 1 2 0 2 1 1 2 4 0 1 0 0 0

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Infectious Disease Prevention and Control Unit, Malta; Department of Health Information and Research, Malta.
such as pain or irritation. **STIs often exist without any symptoms, particularly in women.** For example, up to 70% of women and a significant proportion of men with gonococcal and/or chlamydial infections experience no symptoms at all. Both symptomatic and asymptomatic infections can lead to the development of serious complications, described below. Thus, men and women with sexual partners who have STI symptoms should seek medical care regardless of a lack of signs.

The three commonest presenting symptoms are genital ulceration, urethral discharge, and vaginal discharge with or without vulval irritation. Other symptoms that persons may have include rash, pain or a burning sensation while passing urine (dysuria), pain during intercourse (dyspareunia) and intermenstrual spotting, that is, the appearance of a blood-stained discharge from the vagina between menstrual periods in women. Some of these symptoms are easily recognisable and consistent. For example, a discharge from the urethra in men can be caused by gonorrhea alone, chlamydia alone or both together. Finally, sexually transmitted infections are not always acute; many chronic conditions of the genital tract may require long term care – for example, pelvic pain, recurrent herpes genitalis, and vaginal candidiasis. The most common complaints patients have presented themselves with at the local GU clinic were genital ulcerations ("lumps"), itchiness/soreness, dysuria (or pain while passing urine), urethral discharge and vaginal discharge.

**The main symptoms of common STIs**

- Urethral discharge
- Genital ulcers
- Inguinal swellings (a swelling in the groin)
- Scrotal swelling

- An unusual / abnormal vaginal discharge
- Lower abdominal pain
- Neonatal eye infections (conjunctivitis of the newborn)
- Genital warts.

Genital warts are caused by genital Human Papillomavirus (HPV) infections, which is the most common viral infection of the reproductive tract. Infection is extremely common in young women in their first decade of sexual activity. Genital warts are perceived as unsightly and are associated with psychological morbidity and feelings of shame. Most people will seek treatment. However treatment is not straightforward. There are a variety of therapies in use. Management of genital warts can require long periods. Infection with certain types of the human papillomavirus can lead to the development of genital cancers, particularly cervical cancer in women. More information related to HPV and cervical cancer can be found in section 9, page 84.

**Complications of STIs**

Complications from sexually transmitted infections can cause grave health and social problems. They can ultimately lead to premature loss of life.

Sexually transmitted infections are important causes of fallopian tube damage that leads to infertility in women. The fallopian tubes (also called oviducts or uterine tubes) are a pair of ducts opening at one end into the uterus and at the other end, over the ovary. Each tube serves as the passage through which the female egg cell (the ovum) is carried to the uterus, and through which male sperm cells move out towards the ovary. STIs remain the main preventable cause of infertility, in both men and women. For example, 10-40% of women with untreated chlamydial infection develop symptomatic pelvic inflammatory disease. Fallopian tube damage resulting from infection is responsible for 30 – 40% of cases of female infertility.

Failure to treat traditional infections such as gonorrhoea, chlamydia and syphilis can have a deleterious effect on pregnancy and the newborn, such as ectopic pregnancy, miscarriage, premature delivery of the baby, congenital and neonatal infections and blindness. For example, in pregnant women with untreated early syphilis, 1 in 4 pregnancies (25%) result in stillbirth and 14% in neonatal death – an overall perinatal mortality of about 40%.

Up to 35% of pregnancies among women with untreated gonococcal infection result in spontaneous abortions and premature deliveries, and up to 10% in perinatal deaths. In the absence of any treatment to prevent the condition (prophylaxis), 30-50% of infants born to mothers with untreated gonorrhoea and up to 30% of infants born to mothers with untreated chlamydial infection will develop a serious eye infection (ophthalmia neonatorum), which can lead to blindness if not treated early. According to the World Health Organisation, worldwide between 1000 and 4000 newborn babies become blind every year because of this condition, especially in developing countries where medications are scarce.

The presence of untreated STIs (both those which cause ulcers or those which do not) increase the risk of both acquisition and transmission of HIV by a factor of up to 10. Prompt treatment for STIs is thus important to reduce the risk of HIV infection. Controlling STIs is important for preventing HIV infection, particularly in people with high-risk sexual behaviours, such as people with multiple sexual partners,
people whose partners have had multiple partners, especially those who have sexual intercourse without the use of condoms.

**Prevention of STIs**
The most effective means to avoid becoming infected with or transmitting a sexually transmitted infection is to abstain from sexual intercourse (i.e. oral sex, vaginal sex, or anal sex) or to have sexual intercourse only within a long-term, mutually monogamous relationship with an uninfected partner. Male condoms, when used properly and consistently, can be highly effective in reducing the transmission of HIV and many other sexually transmitted infections, including gonorrhoea, chlamydial infection and trichomoniasis. It is not surprising to note that three out of four (75%) of patients presenting at the GU clinic with symptoms of sexually transmitted infections claimed to have never used a condom. However, condoms are not fool-proof either, and do not offer a high level of protection against ALL STIs. In fact, between 10-15% of patients attending the GU clinic over a ten year period were contacts of other patients seen in the clinic. The GU clinic report states that this shows that in Malta there is a substantial reservoir of infection that is untreated, and infecting others. Thus, the actual prevalence of disease therefore remains an unknown quantity with most of the disease, especially gonorrhoeal disease, remains undiagnosed in the community.

Neither hormonal contraceptives, such as the contraceptive pill, nor intrauterine contraceptive devices known as IUDs (or IUCDs) offer protection against HIV or other sexually transmitted infections. Protection against both unplanned pregnancy and STIs including gonorrhoea, chlamydial infection and trichomoniasis. It is commonly believed that Maltese citizens under the age of 18 cannot be seen by a doctor without the parents’ consent. This is not the case. Minors can be seen without parents’ consent and are entitled to confidentiality. The Medical and Kindred Professions Ordinance, Chapter 31 Sec 7(1)(a), provides:

“It shall be the duty of every medical practitioner … to practise his profession where he is so required in cases of urgency, whether by day or by night, and without any wilful delay to render his aid and prescribe the necessary remedies.”

As the Medical Council of Malta (2000) attests, by this provision it is clear that on being requested by a person to be examined, the doctor’s first and foremost consideration is to examine that person and have the necessary treatment provided without delay. Other considerations, such as the consent or knowledge of the parents of the patient, the latter being a minor, are subordinate to the first. Certain provisos however apply. The minor must be given the option to have a parent present. If the minor declines, examination and treatment can proceed provided the practitioner is satisfied that the minor is mentally competent and mature enough to provide informed consent and that abuse is not involved. Therefore, young people under the legal age of consent, that

Whenever an infection is diagnosed or suspected, effective treatment should be provided promptly to avoid complications. The partner notification process, which is an integral part of STI care, informs sexual partners of patients about their exposure to infection so that they can seek screening and treatment too. Partner notification can prevent reinfection and reduce the wider spread of infections – thus it is an important public-health protection measure. Unfortunately in Malta only 9% of patients attending the GU clinic over a ten year period were contacts of other patients seen in the clinic. The GU clinic report states that this shows that in Malta there is a substantial reservoir of infection that is untreated, and infecting others. Thus, the actual prevalence of disease therefore remains an unknown quantity with most of the disease, especially gonorrhoeal disease, remains undiagnosed in the community.

**Screening and treatment of STIs**
In Malta and Gozo there is one Genito Urinary Clinic, also known as the GU clinic, which delivers a specialist medical service in the treatment of sexually transmitted infections as part of the National Health Service programme. Thus, screening, treatment and counselling is given FREE to ALL (Maltese and tourists) at the Out-patients Department, Mater Dei Hospital.

Services delivered at the clinic include:
- diagnosis and treatment of Sexually Transmitted Infections
- counselling and testing for HIV
- other genital conditions not necessarily sexually acquired.

Unlike other clinics patients do not need a doctor’s referral ticket. Patients can refer themselves to the GU clinic by phoning the clinic for an appointment (Tel. 21227981), without having to be referred by a family doctor. About 80% of patients who attend the GU clinic are self-referrals. The clinic operates on the essential factor of ABSOLUTE CONFIDENTIALITY. No information is given to ANYBODY without the patient’s EXPRESS (and written) permission. All patients are given a unique code number, and only this number appears on all request forms. Patients can therefore confidently leave their contact details.

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is 18 years according to Maltese Laws, can still be considered for examination and treatment without being accompanied by the parents/guardians.

There are other private sexual health clinics that deal with sexually transmitted infections on the island.

Reducing the risk of contracting a sexually transmitted infection

- Abstain from risky sexual practices
- Avoid multiple partners, prostitutes and other people with multiple sex partners
- Avoid sexual contact with people have symptoms or lesions (e.g. urethral discharge, warts, ulcers)
- Avoid genital contact with oral “cold sores”
- Use condoms
- Have regular check ups at the Genito Urinary (GU) Clinic at Mater Dei Hospital, Out-patients Department (Level 1) if at high risk of sexually transmitted disease. To book an appointment call telephone no. 2122 7981.

Sources of help

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Telephone no. 21227981.

Infectious Disease Prevention and Control Unit
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The objectives of the IDCU are:
• To undertake surveillance of communicable diseases in Malta.
• To improve reporting of notifiable diseases by creating methods that would encourage early notification.
• To disseminate relevant, accurate and timely information.
• To undertake responsibility for the control of infection through timely investigation and management of incidents of communicable diseases.
• To undertake epidemiological research.
• To provide advice on communicable diseases to health professionals and the general public.
• To contribute to training in communicable disease control.

The Director
Health Promotion and Disease Prevention Directorate,
5B, The Emporium,
Triq C. De Brocktorff,
L-Imsida MSD 1421

Phone: During office hours 2326 6112
Out of office hours 21332235
Email: disease.surveillance@gov.mt
TOPIC 9
Human papillomavirus and cervical cancer
The human papillomavirus (HPV) causes genital warts, and is one of the most serious sexually transmitted infections. Infection with certain types of HPV can lead to the development of genital cancers in both men and women, but particularly more cervical cancer (cancer of the cervix) in women aged 15-44. The risk of developing cervical cancer increases with age and reaches a peak at about 35 to 55 years of age in unscreened populations. There is consistent and convincing evidence that cervical cancer is a rare consequence of infection of the genital tract by some types of HPVs. Although many women become infected with HPV, in most cases the body's immune system (the body's mechanism that fights off infections) suppresses the virus before cancerous cells develop.

More than 100 types of HPV have been identified and known to infect the skin and mucous surfaces of the body. Common warts, such as those found on the hands and feet, are caused by certain types of HPV. Over 40 types of HPV are known to infect the human genital tract, namely the glans penis (or the head of the penis) and the foreskin in males, and the vulva and cervix (or the neck of the uterus) in females. Transmission of genital HPV types usually occurs during sexual intercourse, although penetration of the penis is not necessary. Transmission has been shown to also occur via genital skin-to-skin contact, as in mutual genital masturbation practices, that is, genital rubbing without penetration. HPV can also cause anal warts in people who practice anal sex, especially men who have sex with men (MSM). Lesbians too can spread HPV by genital-to-genital contact, finger-vaginal (fingering) practice, or finger-anal contact. There is anecdotal evidence suggesting that sex toys can play a role in the spread of HPV, if a device is used by more than one person, or is not cleansed thoroughly between partners. Oral sex carries a very low risk of transmission of HPV. Furthermore, although it is extremely rare, it is possible for a pregnant woman infected with HPV to pass the virus to her baby's respiratory tract during birth (1.1 cases per 100,000 children).

These ‘genital’ types of HPV are classified as either “high risk” – which means they have a potential to cause certain kinds of cancer if the infection persists, or “low risk” – which means they are not associated with cancer, but can cause genital warts. There are at least 13 ‘high-risk’ types which are known to cause cervical cancer. The World Health Organisation (2010) estimated that the four most common high risk HPV types associated with cervical cancer in Southern Europe are numbered 16 (48.5%), 18 (13.6%), 31 (6.5%) and 33 (4.9%). Some types of low-risk HPVs cause genital warts, and some low-grade cervical disease, but these types have not been associated with cervical cancer.

Risk factors for HPV infection
The key determinants for HPV infection for both men and women are related to sexual behaviour. They include being young when starting sexual relations, having a high number of sexual partners in a lifetime and having partners with past or current multiple partners. High risk HPV is most common in young people, with peak prevalence in women under 25 years of age. In most countries, the prevalence decreases with age over 35 years.

A number of conditions, or cofactors, have been associated with an increased risk of HPV infection persisting and progressing to cancer. These include:

- HPV types 16 and type 18
- multiple infection with several high risk HPV types
- high amounts of virus
• people with conditions that suppress their immune system (such as organ transplantation, certain medications and treatments, HIV infection, etc.)
• parity: the risk of cervical cancer increases with the number of children a woman bears
• tobacco smoking
• use of oral contraceptives for five or more years
• co-infection with other sexually transmitted infections, such as Chlamydia and Herpes Virus.

The group at highest risk of developing deadly cervical cancer, regardless of other factors, remains those women who do not attend regular cervical screening.

Incidence and prevalence of HPV infection and cervical cancer
Data is not yet available on the HPV burden in the general population of Malta. However, HPV infections seem to be the most common viral infection of the reproductive tract diagnosed at the Genito Urinary Clinic. According to the 10-year GU Clinic report, between the year 2000 – 2010 infections with HPV and first presentation of genital warts constituted a fifth of the work load of the clinic, that is 20% of all cases.

Various studies have detected asymptomatic HPV infection in 5% – 40% of women of reproductive age and most sexually active women and men become infected with at least one type of HPV during their lifetime. Prevalence peaks soon after the start of sexual activity and remains high in the 20 - 29 year age group before sharply declining. Relatively high rates of anal HPV infection have been reported in men-who-have-sex-with-men (MSM), who also have an increased risk of HPV-related anal cancer (cancer of the anus).

Only 50-60% of women develop antibodies to HPV after natural infection. A genital HPV infection is often without symptoms, transitory and is usually self-resolving. More than 90% of detected infections clear spontaneously within two years.

In Malta, cancer of the cervix in women is less common than other cancers of the reproductive tract, namely the uterus and the ovaries. According to the National Cancer and Mortality Registries (Department of Health Information), in Malta between 1992 and 2009 there were a total of 146 women diagnosed with cervical cancer and 60 deaths. It has been estimated that every year between 7 and 14 Maltese women are diagnosed with cervical cancer and 60 deaths. In Malta, there are around 33 000 cases of cervical cancer in the European Union, and 15 000 deaths each year. Virtually all cervical cancer cases (99%) are linked to a persistent genital-tract infection by a high-risk human papillomavirus type.

Genital HPV infections are very common and acquired soon after onset of sexual activity. Most of these infections clear spontaneously. However, persistent HPV infections with a high-risk HPV type can cause cellular changes in the cervix that can result in cervical cancer. High risk HPV types are also associated with other anogenital cancers, and head and neck cancers in both men and women. Some low-risk HPV types cause genital warts in both men and women.

Prevention of HPV through responsible sexual behaviour
Antibiotics or other currently available medicines cannot treat HPV infection. Since no treatment is available for the infection itself, the most effective methods of avoiding problems is by:
• primary prevention (prevention of infection)
• early detection of abnormal cells (screening)
• early treatment cervical cancer (harm minimisation).

Some primary prevention methods associated with less transmission of HPV include:
• being faithful to one sexual partner (having a monogamous relationship)
• limiting the number of sexual partners
• consistent use of the condom during penetrative sex (if one is not in a monogamous relationship)

Condons do not protect completely against HPV, since they do not cover the entire length of the penis or all areas of the genital region. However as research has shown, consistent use of condoms does significantly reduce the risk of HPV infection. In addition, they protect against other sexually transmitted infections, including HIV. There is also some evidence that male circumcision reduces the probability of men carrying HPV and of their female partners developing cervical cancer. In addition, not smoking and taking multi-vitamins (especially
folic acid supplements - a type of B vitamin - like the ones recommended for women before and during early pregnancy) can help boost the body’s immune system (the body’s natural mechanism that fights infections) and thus prevent or suppress HPV infection if it already exists.

**Prevention of cervical cancer by screening**

The main basis of cervical cancer prevention (but not of HPV infection) in women currently involves routine screening by way of the Pap-smear test (or Papanicolaou’s smear, named after a Greek Physician in the United States, 1883-1962). This test involves a routine examination of a sample of cervical cells, known as cytological screening, in order to detect abnormal cervical cells. Unfortunately, there are no such screening tests available for men. Thus, there is no way to determine whether a male has the virus unless genital warts develop and are detected by the naked eye.

Generally a woman is indicated by a medical professional to start having a regular Pap smear test every 2 years from age 21 to 29 years, or after 3 years from the onset of sexual intercourse up to the age of 29 years; then every 3 years for women aged over 30 years with a history of 3 negative (normal) tests. It is strongly advised that women get screened for women aged over 30 years with a history of 3 negative (normal) tests. It is strongly advised that women get screened regardless of their sexual preferences or practices. A woman is generally indicated by a medical professional to stop having Pap smear tests between the age of 65 to 70 with three consecutive normal Pap smear tests, and no abnormal tests in the previous 10 years. An older woman who is sexually active with multiple partners may still be indicated to continue having routine screening. However, it is very important that a woman, before deciding to start or stop having regular Pap smear test, consults her family doctor or gynaecologist.

If cell abnormalities are detected after screening, these are investigated further with procedures such as a ‘colposcopy’, where a doctor visually examines the cervix, and a biopsy. Depending on the results of these investigations, treatment may be required, ranging from taking medications, to having a surgical procedure or chemotherapy.

**Prevention of HPV by immunisation**

Two new vaccines that prevents HPV infection have been heavily promoted in the United States by their respective manufacturers to reduce cervical cancer-related deaths. Both prophylactic HPV vaccines have been licensed in Malta: a quadrivalent vaccine and a bivalent vaccine. The first was licensed for use since 2006. Both vaccines are made from virus-like particles and are non-infectious. Both vaccines have a good safety profile. Both vaccines protect against the high-risk HPV types 16 and 18 (responsible for an estimated 73% of cervical cancer cases in Europe). The quadrivalent vaccine also protects against HPV 6 and 11, which cause most cases of genital warts. In large phase III trials both vaccines have been shown to prevent more than 90% of precancerous lesions associated with types 16 or 18 among HPV-naïve women. The vaccines are not designed to be therapeutic and are given in three doses over a six-month period.

Well organised cervical cancer screening programmes that achieve high coverage and include effective follow-up and treatment of women with abnormal cytology have been proven to reduce cervical cancer incidence by over 80%. The HPV vaccine offers a new, complementary tool to improve the control of cervical cancer. However, it does not eliminate the need for cervical cancer screening even for women vaccinated against HPV types 16 and 18 who will be at risk from other high-risk types. HPV vaccines will have an impact on the effectiveness of existing screening programmes. Also, vaccinated women might have a false sense of security, resulting in lowered attendance at screenings. Women need to be informed and motivated to attend screening programmes, even if they are vaccinated.

**Who should be vaccinated?**

It is commonly argued in scientific literature that young females are expected to be the primary target population because this group has the greatest potential to benefit from prophylactic vaccination. Evidence to date suggests that the safety and immunogenicity of HPV vaccines amongst males (10 – 15 years of age) is as good, or better than, that for females. But the burden of disease associated with HPV in males is small when compared to women.

The impact of the HPV immunisation is optimised when a girl is vaccinated at the age just before sexual activity commences, or sexual debut. Reduction of cervical cancer by preventing HPV infections is believed to be greatest if females are protected from infection just before beginning sexual activity. As yet there is no conclusive evidence that the vaccine has a long duration of protection (more than 15 – 20 years) because the study periods have been too short. The longest follow-up from phase 2 research trials for both vaccines ranged from 5 years to 8.4 years, but invasive cervical cancer can take 20 to 40 years to develop from the time of HPV infection. It has been argued in scientific literature that HPV vaccines must maintain a near 100% efficacy for a full 15 years, at a minimum, for cervical cancer to be prevented. Thus it is not yet known whether the vaccines currently prevent or postpone cervical cancer. Administering the vaccine at a much earlier age would not prevent many infections. Young women and girls between nine and 26 years of age have been the primary targets of
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The Director
Health Promotion and Disease Prevention Directorate,
5B, The Emporium,
Triq C. De Brocktorff,
L-Imsida MSD 1421

Phone: During office hours 2326 6112
email: disease.surveillance@gov.mt

trials for both the available prophylactic vaccines. Evidence to date suggests that vaccination at the age of 10 – 15 years have led to better immunogenicity when compared to age 16+ years. Consideration of the vaccination of women over 26 years of age requires further evidence on the efficacy and effectiveness of vaccination at these ages.
TOPIC 10
Teenage pregnancies
Prevalence of teenage pregnancies in Malta
Teenage pregnancies

The table shows the total live births to Maltese teenage girls (aged below 20) 1960 – 2010.

<table>
<thead>
<tr>
<th>Year</th>
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<td>2005</td>
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</tr>
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<td>2010</td>
<td>234</td>
</tr>
</tbody>
</table>


In a decade, between 2000 and 2009, 936 babies were born to Maltese mothers under 18 years, or an average of 235 live births to teenage mothers (aged below 20) per year. This amount to fewer than 2.5% of all babies delivered over this period. Within the same period, a total of 47 babies were born to adolescent girls aged less than 15 years, amounting to 5% of babies born to mothers under 18 years.

In 2010, there were 255 maternities registered among Maltese teenage mothers under 20 years of age (down from 277 in 2009), of which 234 babies were born alive (259 born in 2009). Furthermore, in 2010, 6 babies were born to mothers under 15 years of age, 30 teenage mothers gave birth to their second child, while 4 mothers gave birth to their third child in their teens.

In the year 2011, 217 babies were born to Maltese mothers in their teens (aged 15 – 19) of which 80 (37%) were born to mothers under 18. Thirty two babies were born to school-age girls (<16).

It is very difficult to accurately compare the teenage birth rate of Malta with other European countries due to the thousands of abortion conducted in other countries, thus highly influencing the results. However, according to the EURO-PERISTAT (2004), when compared with the other European Union countries, Malta ranks with the first eight countries registering the highest percentage rate of teenage births out of the total birth population in the EU, in par with Poland, at 5.8%. The highest was registered in Latvia at 9.3% teenage pregnancies out of all pregnancies, followed by Estonia and Slovakia (8.1%) and the United Kingdom (7.1%). The lowest to register teenage pregnancies were Sweden (1.7%) Netherlands (1.6%) and Denmark (1.3%). When comparing births per 1000 girls aged 15 – 19 per year, Malta ranks with the highest 14 EU countries at 12 teenage births. The highest was Bulgaria at 41 births and the lowest was Netherlands at 5 births.

Risk factors for teenage parenthood

Over the last three decades, researchers have examined the experience of Western world countries in an attempt to learn why adolescents in some of those countries have fewer teenage pregnancy rates, as well as being less likely to acquire a sexually transmitted infection. Overall, teenage parenthood is more common in areas of deprivation and poverty. However, research evidence from Canada, France, Great Britain, Sweden and the United States has shown that teenage pregnancies can afflict even the most affluent and prosperous communities. But it is far worse in the poorest areas.

A review of 57 studies conducted amongst EU countries undertaken as part of REPROSTAT (Reproductive Health Indicators in the European Union) identified six broad groups...
of risk factors associated with teenage pregnancy; these are sociodemographic, family structure and stability, educational achievement, psychosocial, sexual health knowledge, attitude and behaviour, and sexual health service accessibility and acceptability. The well-recognised factors of socioeconomic disadvantage, disrupted family structure and low educational level and aspiration appear consistently associated with teenage pregnancy. However, evidence that access to services in itself is a protective factor, remains inconsistent. Having comprehensive sexuality and relationships education programmes at school and societal openness regarding sexuality have also been identified as key elements associated with teenage pregnancies. Social and economic disadvantages have been characterized by such factors as:

**Being poorly educated** – Evidence has shown that young females who have lower levels of education, lower education aspirations and performance and early school leavers are more likely to initiate intercourse during adolescence than those who spend more years in education and are better educated. Being poorly educated has been defined as having a lack of accurate knowledge about contraception, sexually transmitted infections, what to expect in relationships and what it means to be a parent. Furthermore, many parents and most public institutions, are at best embarrassed and at worst silent, hoping that if sex isn't talked about, it won't happen. On the other hand, the media bombards teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. The net result is not less sex, but more unplanned sex and less protected sex. Teenagers who practice vaginal penetrative sex but who do not use contraception have a 90% chance of conceiving in one year, and those who do not use condoms, are also exposed to a range of sexually transmitted infections.

**Growing up in poverty** - Teenage girls who live in social housing are three times more likely than their peers living in owner occupied housing to become a mother. Living in a stressful home environment due to depression, conflict at home, and a disorganised or dangerous neighbourhood has been identified as a predictor of teenage pregnancies.

**Having poorly educated parents** - Research has shown that the risk of becoming a teenage mother is almost ten times higher for a girl whose family is in social class V (unskilled manual), than those in social class I (professional). Contraception use among sexually active girls is also likely to be low among young people coming from a lower socioeconomic status family, although this was shown in some countries but not in others.

**Being raised in a single-parent family, or daughters of teenage mothers** - The daughter of a teenage mother is one and a half times more likely to become one herself than the daughter of an older mother. Living with a single parent, having elder sexually active siblings, and having pregnant or parenting teenage sisters have also been shown to be a predictive factor for teenage pregnancies.

**Having been sexually abused in childhood** - Several studies have also shown an association between being a victim of sexual, physical or emotional abuse in childhood and teenage pregnancy. Researchers put this down to a lack of confidence to resist sexual pressure – even years after the abuse.

**Being raised in care** - Children in care or leaving care have repeatedly been shown to be at higher risk of teenage pregnancy. Studies in the UK have shown that women who had been in care or fostered were nearly two and a half times more likely than those brought up with both their natural parents to become teenage mothers. One survey also showed that a quarter of care leavers had a child by the age of 16, and nearly half were mothers within 18 to 24 months after leaving care.

**Having mental health or behavioural problems** - A number of studies have also suggested a link between mental health problems and teenage pregnancy while a third of girls with conduct disorders are also likely to be pregnant before the age of 17. An association has also been reported between involvement with the police due to troubled conducts and crime, and teenage parenthood. It has been estimated that between a quarter and a third of young offenders in corrective institutions are fathers.

Belonging to a racial or ethnic minority group, and being born foreign, have also been associated with a higher incidence of teenage pregnancies. The latter characteristics are used as proxies for ‘disadvantage’ because of social discrimination. It has also been argued that teenage pregnancy is often both the cause and a consequence, of social exclusion and social discrimination. Research evidence have associated being disadvantaged with several factors that can influence teenage sexual and reproductive behaviour and outcomes, including:

- lack of successful role models in young people’s lives
- lowered personal competence, skills and motivation
- becoming more submissive and exhibiting poorer interpersonal communication skills
- having sexual intercourse at an early age
- having less reliance on or poor contraception use
- having lower motivation to avoid, or ambivalence about, having a child.
Research in the United Kingdom revealed that among the most likely factors that lead to teenage pregnancies are low expectations in life. Research in the United States revealed that among disadvantaged adolescents, accepting or even wanting a pregnancy is normative, and that their families and communities are realistic in accepting adolescent childbearing and in providing social support for young and single mothers. The researchers argued that it is the young people’s response to their lack of alternative opportunities that has led to the high rates of teenage pregnancies. Many young people share several of the risk factors identified above and have a very high chance of becoming a teenage parent. The effect of multiple risk factors has been quantified by a longitudinal study in the UK with found that women with all the following characteristics had a 56 percent chance of becoming a teenage mother, compared with a 3 percent chance for those with none of them.

Likely repercussions of teenage pregnancies
Biologically, there is no reason why a teenage pregnancy should not have a good outcome if it is well managed. The problem is that, because of their circumstances, teenage mothers tend not to have well managed pregnancies. Teenagers usually go to their doctors much later in pregnancy as the vast majority were not planning to become pregnant in the first place. For the same reason, they often miss out on important early pre-conception health measures such as taking folic acid supplements. During pregnancy, teenage mothers are the most likely of all age groups to smoke. For many, any kind of conventional ante-natal planning is an impossibility, as they face many problems of family conflict, relationship stress or breakdown, and problems with education, housing and money. As a result, some obstetric risks are greater for young pregnant women, reducing the teenager mother’s health and her baby’s health to worse than average.

Teenage mothers tend to have poor antenatal and postnatal health, such as:
- anaemia (having low haemoglobin in the blood)
- toxaemia (having toxic substances in the blood)
- eclampsia (pregnancy induced hypertension)
- prolonged and difficult labour
- low birth weight babies (teenage mothers are 25 percent more likely than average to have a baby weighing less than 2500 grams)
- higher infant mortality rates (the infant mortality rate for babies of teenage mothers in the first year of their lives is 60 percent higher than for babies of older mothers)
- Post natal depression (three times as common amongst teenage parents, with four out of ten teenage mothers affected)
- teenage mothers are only half as likely as older mothers to breastfeed.

There are many individual success stories, where teenage parents and their children cope well and do well in the long run. But more often than not, the problems of teenage mothers’ usually disadvantaged backgrounds, persist and intensify after the birth, resulting in long term negative effects on teenage parents and their children. Teenage parents are disproportionately likely to suffer relationship breakdown. In one study, only around a half of teenage mothers were still in a relationship with the father a year after the baby’s birth, with the other half usually without a steady partner. Furthermore, teenage mothers have a greater tendency of remaining poor. Teenage mothers are less likely to finish their education and less likely to find a good job, and more likely to end up both as single parents and bringing up their children in poverty. Thus, the children of teenage mothers , themselves run a much higher risk of poor health, and have a much higher chance of becoming teenage mothers themselves.
Sources of help

Dar Ġużeppa Debono – Għajnsielem, Gozo
Dar Ġużeppa Debono is a Church Entity, Non Governmental Organisation, which caters and provide help for single mothers and fathers, and promoting the value of life as from conception and the importance of healthy relationships in our lives. Professionals and others volunteers working at Dar Ġużeppa Debono support single mothers who generally are under shock at the news of an unplanned pregnancy, and educate young and adults alike to learn respect themselves and the life of an unborn child.

Dar Ġużeppa Debono provides:

• A residential services to teenage mothers who might wish to have an alternative residence apart of their home. The main aim is to give all the privacy that is required by the teenage mother who wants to be relieved from social pressures that might be daunting her.

• A social work service for unmarried mothers, fathers and their respective families. This service is also offered to single mothers who are either separated or widowed.

• Parenting skills courses offered to couples who have or are expecting a baby out of wedlock. Individual attention to each and every couple is guaranteed which offers flexibility in choosing the most appropriate days and times for the meeting to take place.

• Support for couples who have or else are expecting a baby out of wedlock. During these meetings the couple will be taught about the various phases in the relationship and will be helped to identify in which phase they currently are. The couple is helped to adapt to the sudden big change that a baby brings with him/her.

• Support groups for teenage mothers where they meet and share their opinions and experiences with the others and above all are listened to and given the support required. The idea of a group instil in these people a sense of strength and courage to share one’s own personal experiences with others. Above all, every person is seen as a unique person having its own personal life and experiences.

Dar Ġużeppa Debono, Lourdes Street, Għajnsielem (Gozo) GSM 2200 Tel: 2155 2595
Email: info@darguzeppadebono.org
www.darguzeppadebono.org

Servizz Għożża
Servizz Għożża provides a support service and an educational programme to unmarried pregnant minors, leading them to adopt a positive attitude towards motherhood while empowering them to pursue their career path.

The main services offered are:

• a guidance and counselling to pregnant girls under eighteen, their boyfriends and their parents as required;
• psychological, moral and educational support;
• support to girls both before and after the birth of the child;
• programmes in three main areas; namely,
• to prepare these girls to become mothers, the process of pregnancy, preparation to give birth, baby care, parenting skills.
• A programme based on self-development to enhance interpersonal skills.
• Educational programmes aimed at enhancing their academic development.

Providing a service to the young unmarried mothers through:

• Support in guidance and counselling sessions both individually and within group support.
• Various inputs to enhance parenting skills and issues relating to child development.
• Facilitating contacts and the support of, other relevant organisations and services for the benefit of both schoolgirl mother and child;
• Liaising with, and advising, school administrators regarding pregnant students according to specific needs of case.
• Referrals:
• Students themselves, parents, the Heads of Schools, the Guidance Teacher, School Counsellors, Education Officer, other teachers.

Servizz Għożża, Fredrick Maempel Square
Hal Qormi QRM 1515, Tel: 2124 3869
Ms Margaret Magri - margaret.magri@educ.gov.mt
Ms Josanne Grech - josanne.a.grech@gov.mt
Ms Eleonore Marmara’ - eleonore.marmara@gov.mt
TOPIC 11
Abortion
Introduction
Termination of pregnancy from natural causes prior to the 20th week of pregnancy is referred to as spontaneous abortion or miscarriage; after twenty weeks, it is referred to as a preterm birth. However, spontaneous abortions are clearly distinguished from our everyday understanding of the meaning of abortion, which is the voluntary termination of a pregnancy; also called an induced abortion or an elective abortion. An abortion is medically referred to as a therapeutic abortion when it is performed to save the life of the pregnant woman that would otherwise be inevitable if the pregnancy is continued. However, induced abortions are often unrelated to physical health problems of the embryo or the mother. The debate over induced abortion is, and has been for decades, one of the most polarising controversies and activism all over the world.

History of abortion
The voluntary termination of pregnancy has been practised since ancient China under Shennong (c. 2700BC), Ancient Egypt with its Ebers Papyrus (c.1550BC), and in Ancient Greece and in the Roman Empire in the time of Juvenal (c.200AD). There is evidence to suggest that pregnancies were terminated through a number of methods, including the administration of abortifacient herbs, the use of sharpened implements, the application of forceful abdominal pressure and other basic techniques.

The Philosopher Aristotle wrote: “...when couples have children in excess, let abortion be procured before sense and life have begun; what may or may not be lawfully done in these cases depends on the question of life and sensation.” Aristotle, Politics 7.16

It is commonly believed that the Romans and Greeks were not much concerned with protecting the unborn. Early philosophers such as Aristotle argued that a foetus did not become formed and begin to live until at least 40 days after conception for a male, and around 80 days for a female. Aristotle thought that female embryos developed more slowly than male embryos, but made up for lost time by developing more quickly after birth. He appears to have arrived at this idea by seeing the relative development of male and female foetuses that had been miscarried.

Throughout much of western history abortion was not criminal if it was carried out before ‘quickening’; that is before the foetus moved in the womb (between 18 and 20 weeks of pregnancy). Until that time people tended to regard the foetus as part of the mother and so its destruction posed no greater ethical problem than other surgery. The question of when life begins is an eternal one, debated by philosophers, theologians, scientists, pro-abortion and pro-life activists and politicians.

The Soviet Union (1919), Iceland (1935) and Sweden (1938) were among the first countries to legalize certain or all forms of abortion. In 1935 Nazi Germany, a law was passed permitting abortions for those deemed “hereditarily ill,” while women considered of German stock were specifically prohibited from having abortions. Beginning in the second half of the twentieth century, abortion was legalized in a greater number of countries.

In England, the Common Law agreed that abortion was a crime after ‘quickening’ - but the seriousness of that crime was different at different times in history. In 1803 English Statute Law made abortion after quickening a crime that earned the
death penalty, but a less serious crime before that. In 1837 English law abolished the significance of quickening, and also abandoned the death penalty for abortion. In the 1920s English law added a get-out clause that stopped abortion being a crime if it was “done in good faith for the purpose only of preserving the life of the mother.”

In 1938, Dr. Alec Bourne performed an abortion on a 14-year-old girl who claimed to have been raped by soldiers. He gave himself up to the police, was charged with performing an illegal abortion, put on trial, and acquitted on the grounds that the probable consequence of the continuance of the pregnancy would have made the young girl a physical or mental wreck - thus the doctor was operating for the purpose of preserving the life of the mother. This established that the mother’s mental suffering could be a sufficient reason for an abortion.

As a result of the Bourne case, more and more abortions were conducted in Britain in cases where the woman’s physical or mental health was thought to be in danger. The principle the judge, Mr. Justice Macnaghten, set down in that case governed British thinking about abortion for nearly 30 years.

The Abortion Act of 1967 revolutionised the situation in England by allowing doctors to perform an abortion where two other doctors agree:

• that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; OR
• that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

In the United States, abortion was common in most of colonial America, but it was kept secret because of strict laws against unmarried sexual activity. Laws specifically against abortion became widespread in America in the second half of the 1800s, and by 1900 abortion was illegal everywhere in the USA, except in order to save the life of the mother.

Abortions were made legal in the United States in a landmark and controversial 1973 Supreme Court judgement, often referred to as the Roe vs Wade case. The ruling came after a 25-year-old single woman, Norma McCorvey under the pseudonym “Jane Roe”, challenged the criminal abortion laws in Texas that forbade abortion as unconstitutional except in cases where the mother’s life was in danger. Henry Wade was the Texas attorney general who defended the anti-abortion law.

Ms McCorvey first filed the case in 1969. She was pregnant with her third child and claimed that she had been raped. But the case was rejected and she was forced to give birth. However, in 1973 her appeal made it to the US Supreme Court where she was represented by Sarah Weddington, a Dallas attorney. Her case was heard on the same day as that of a 20-year-old woman from Georgia, Sandra Bensing. They argued that the abortion laws in Texas and Georgia ran counter to the US Constitution by infringing women’s right to privacy. Both won their case.

The court justices ruled that governments lacked the power to prohibit abortions. The court’s judgement was based on the decision that a woman’s right to terminate her pregnancy came under the freedom of personal choice in family matters as protected by the 14th Amendment of the US Constitution. The decision - on 22 January 1973 remains one of the most controversial ever made by the Supreme Court.

Norma McCorvey announced in 1987 that her rape testimony in 1969 had been false and changed sides to the pro-life lobby. Two years later Sandra Bensing followed suit. In 2003 the plaintiff in Roe vs Wade asked for the decision to be reversed and put forward evidence that abortion is harmful to women. But Ms McCorvey’s attorney, Sarah Weddington, insisted that the rape testimony was not a factor in the Roe vs Wade verdict, and that her decision to change sides has no bearing on the ruling. Abortion rights faced restriction in 2003 after the US House of Representatives and the US Senate voted to ban late-term ‘partial birth’ abortions.

**Procedures for terminating a pregnancy**

The two types of procedures for terminating a pregnancy are:

• surgical abortions and
• medical abortions.

The manner selected often depends upon the gestational age of the embryo or foetus, which increases in size as the pregnancy progresses. Until the late 1990s, virtually all abortions performed used surgical procedures, and nearly all of those used a technique called vacuum aspiration. Most early abortions today (usually defined as within the first 12 weeks of pregnancy) use a process called Manual Vacuum Aspiration (MVA), also known as ‘mini-suction’. This technique incorporates a syringe device that is operated by hand or a
small hand-held electrical vacuum device. Vacuum aspiration, as the name implies, incorporates a small tube that is inserted through the cervix of the woman to which suction is applied, creating a slight vacuum that draws out the contents of the uterus, including the endometrium lining and the embedded embryo. The procedure takes up to 15 minutes, and where abortion is legal, is typically performed in a doctor’s office or medical clinic under local anaesthetic. Side effects of the procedure include abdominal cramping and usually some bleeding. More serious complications may include perforation of the uterine wall or infection.

The second most common method of surgical abortion is by Dilatation and Curettage (D&C) which is a standard gynaecological procedure performed for a variety of reasons, including examination of the uterine lining for possible malignancy and investigation of abnormal bleeding. Curettage refers to cleaning the walls of the uterus with a curette. The World Health Organisation recommends this procedure only when manual vacuum aspiration is unavailable.

If pregnancy has progressed beyond the first trimester, the usual termination procedure is Dilation and Evacuation, or D&E. This is a more invasive and extensive procedure, largely because by the second trimester (13 to 26 weeks) the pregnancy is more firmly established and the developing foetus in the uterus is larger, thus requiring greater dilation of the cervix. A vacuum tube is inserted to remove the foetus and most of the remaining contents of the uterus. Next, a curved surgical instrument, or the curette is inserted to scrape the linings of the uterus to free any additional tissue. This procedure is typically performed as a ‘day surgery’ in a hospital setting, and usually conducted under general sedation or general anaesthetic. Side effects include cramping for several hours and bleeding for about two weeks following the procedure. Rare but serious complications may include damage to or perforation of the uterine wall, severe bleeding and infection.

More recently there has been a clear trend away from surgical abortions for early pregnancies towards medical methods of terminating a pregnancy. A medical abortion relies on specifically targeted drugs, also known as abortifacient pharmaceuticals, to terminate a pregnancy. In cases of failure of medical abortion, a surgical abortion will complete the procedure. Early medical abortions account for the majority of abortions before 9 weeks gestation in most European countries.

Complications of abortion
The mentioned procedures for terminating a pregnancy are generally considered safe and effective. Studies have shown that the long-term effects on the mother’s fertility from a single abortion performed during the first trimester of pregnancy has little effect on the woman’s future ability to become pregnant and give birth. However, the effects of later-term abortions or of multiple abortions on future fertility and pregnancy have yet to be established by scientific studies.

However, when conducted illegally and by persons without the necessary skills and proper training, and in below standard conditions that do not conform to minimal medical standards, or outside a medical environment, may lead to permanent disabilities including infertility or maternal death. Women in developing countries, have the least access to family planning services and the fewest resources to pay for safe abortion procedures; they are also the most likely to experience complications related to unsafe abortion. Complications from unsafe abortion lead to morbidity and are a major cause of maternal deaths. The World Health Organisation estimated that globally some 68,000 women die each year as a consequence of unsafe abortion. Besides death, possible complications include infection, haemorrhage, and injury to internal organs, and can lead to long-term health problems such as chronic pain, pelvic inflammatory disease, and infertility. It has also been estimated that 5.3 million suffer temporary or permanent disability.

In addition to its immediate negative impact on women’s health, unsafe abortion also carries significant financial burden on both the individual and the public health care system. For example, complications from unsafe abortion may cause maternal deaths that leave children motherless; reduce women’s productivity, both inside and outside the home, increasing the economic burden on poor families and an inability to care for children; as well as have an adverse effect on sexual relations. Costs for women and their families include fees for medical services, medicine, and supplies; and lost income from missing work. Unsafe abortion also places a substantial burden on health and social care systems, resulting in considerable costs to already struggling public health systems. In many countries, women with incomplete abortion account for a large segment of gynaecological admissions to hospitals, and treatment may require several days of hospital stay, significant staff time, blood transfusion, and general anaesthesia.

Out of the estimated 43.8 million abortions performed globally every year, 19 million are estimated to be unsafe. In Europe, but up to 30% of maternal deaths are due to unsafe
abortion in some countries of eastern Europe. Between 1995 and 2008, the rate of unsafe abortion worldwide remained essentially unchanged, at 14 abortions per 1,000 women aged 15–44. During the same period, the proportion of all abortions that were unsafe increased from 44% to 49%, meaning that almost half of all abortions worldwide are unsafe – although these estimates have also been described as modest.

The psychological and emotional experience of abortion

Many people mistakenly believe that a woman’s decision to terminate her pregnancy is a relatively easy, uncaring or detached decision. The primary emotion reported by most women after having an abortion is relief. Yet most women rarely describe the experience in such terms. Research has shown that most are conflicted about the decision and may experience complex, painful, and confusing emotional reactions about the unwanted pregnancy and their decision to terminate it.

Undergoing abortion is not something many women choose to discuss with many others in their lives. They recognise the variety of opinions people hold on the subject and that they risk being judged for becoming pregnant, for not taking proper precautions, or for choosing to abort. As a result, many women are not given the opportunity to process the experience emotionally with the help of others. As a result, a delayed negative reaction may occur. Some may experience feelings of guilt, shame, sadness, depression, anger, anxiety, concern over judgement from others, isolation, and relationship breakdown. When such emotions are denied or buried, they can resurface having been magnified over time.

The term Post-Abortion Syndrome (PAS), or Post Abortion Stress Syndrome has been coined to describe the emotional and psychological consequences of abortion, similar to Post-Partum Depression or Post Traumatic Stress Disorder. That said, few women who choose to have an abortion are believed to suffer from such severe short or long-term negative psychological outcomes afterwards. Some social scientists argue that no such syndrome exists, and that the best predictor of post abortion emotional adjustment is the level of the woman’s adjustment in life before the pregnancy occurred.

Most mental health professionals today agree that when a woman is considering her options for dealing with an unplanned pregnancy, doctors, clinicians and counsellors should either attempt to provide non-judgemental and empathic support, or refer the woman for psychological or religious counselling services if they suspect she is having difficulty with the emotional effects of her decision to abort a pregnancy. She should be given as much information about all her pregnancy options as she personally needs and wants, including keeping the baby and giving the baby up for adoption. She should be encouraged to discuss her feelings about the pregnancy, the potential of becoming a parent or bringing a new child into the family, her ability and desire to provide for a child, and her attitudes about abortion and adoption. The medical or counselling setting should also be open to discussing issues relating to the father of the baby, and when possible, to include the father in the decision-making process.

In Malta, a crisis pregnancy support group called HOPE, which is one of the branches of the pro-life movement Gift of Life, seeks to help pregnant women who are considering a termination. This group adopts a non-judgemental approach and speaks to mothers-to-be in strict confidentiality to help them make informed decisions by providing them with support and information about pregnancy and foetal development, as well as available support and options. HOPE provides free pregnancy testing and non-diagnostic ultrasound scanning, referrals (obstetric, gynaecological, social, as well as referrals for professional support to women who have experienced pregnancy loss through abortion), emotional support, practical assistance and support, and psychotherapy. The support group also offers maternity and baby items.

Perhaps the single area of agreement between the pro-choice and pro-life factions of the abortion debate is the desire to reduce the number of abortions performed each year. Many argue that making abortion illegal does not prevent abortion, but rather drives it underground or to other countries, where the procedures are often conducted illegally and in an unsafe manner, leading to maternal deaths. An alternate route argued is to reduce abortions by decreasing the number of unplanned pregnancies through holistic sexuality and relationships education; education about substance abuse related to alcohol and drugs; empowering people make healthier and safe choices about their sexual lifestyle and behaviours, including postponement of sexual activity among adolescents; adopting alternate sexual expressions that are safe from unplanned pregnancies and the transmission of sexually transmitted infections; and encourage the effective and consistent use of birth control among those who despite knowledge and awareness of the risks, opt for risky penetrative sexual practices.
Abortion in Malta

Under the Criminal Code of Malta (Chapter 9 of the Laws of Malta), abortion is prohibited in all circumstances. The person performing the abortion is subject to 18 months’ to three years’ imprisonment, as is a woman who performs an abortion on herself or consents to its performance. A physician, surgeon, obstetrician, or apothecary who performs an abortion is subject to 18 months’ to four years’ imprisonment and lifelong prohibition from exercising his or her profession.

It has been commonly reported on Maltese newspapers that it is a well known fact that Maltese women seeking to terminate their pregnancy travel to the UK and Sicily to have an abortion. Malta’s only records on the number of women who terminate their pregnancies are those conducted in the UK and documented in the National Statistics Office, Malta publication - Children 2010 (shown below). No records on the number of Maltese women who have abortions in other countries are available. An article published on the Malta Independent on Sunday of 26th January 2012 (Borg and Vella, 2012) stated that procedures terminating pregnancies have been carried out in unauthorised clinics in Malta in the past. However there seems to be no evidence supporting these claims to date.

The past 20 years saw an average of 56 abortions per year being carried out on Maltese nationals in England and Wales. The lowest number of abortions was registered in 2008, with 38 abortions; while the highest number registered was 78 in 2009.

The Catholic Church position

The Roman Catholic Church opposes abortion because it holds that life is sacred and inviolable. It bases this doctrine on natural law and on the written word of God. The Catholic Church has always condemned deliberate abortion as a grave moral wrong. For example, “thou shalt not murder a child by abortion nor kill them when born” (Didache, or Teachings of the Twelve Apostles 2:2); Mark Felix, a second century Christian lawyer, writes of women who “commit murder before even giving birth” (Octavius, 30); another Christian lawyer, the great Tertullian, writes: “To hinder a birth is merely a speedier man-killing; nor does it matter whether you take away a life that is born, or destroy one that is coming to birth. That is a man which is going to be one” (Apology 9:8). Indeed, from the earliest Christian authors up to Pope John Paul II’s encyclical Evangelium Vitae (“The Gospel of Life”) abortion has always been considered as the moral equivalent of murder. In his encyclical, Centesimus Annus, Pope John Paul II discusses the issue of human rights and lists as one of these rights, “… the right of the child to develop in the mother’s womb from the moment of conception” (par.47).

The gravity of the offense of abortion can be seen when considering the penalty prescribed by the Code of Canon Law for this crime: “A person who actually procures an abortion incurs automatic excommunication” (canon 1398). Thus, causing or having an abortion leads to automatic excommunication (latae sententiae), meaning that the person is barred from receiving the Eucharist and the other sacraments (except the Sacrament of Penance), and from taking a ministerial part of the liturgy (reading, bringing the offerings, etc.), while still being bound by obligations such as attending Mass. The aim of this penalty is not to reduce the scope of mercy, but to point out the irreparable harm to the child, the parents and society brought about by abortion. Furthermore, the Pontifical Commission for the Authentic Interpretation of the Code of Canon Law has declared that the canonical concept of abortion is “the killing of the fetus in whatever way or at whatever time from the moment of conception” (Response of 23 May 1988).

Indeed, the Catholic Church maintains that human life begins at fertilisation. From that moment a unique life begins, independent of the life of the mother and father. Each new life that begins at this point is not a potential human being but a human being with potential. The strong stance taken by the Roman Catholic Church has underpinned many of the pro-life groups which have been formed to challenge the legalisation of abortion.

In 1995, Pope John Paul II wrote Evangelium Vitae, an encyclical letter on The Gospel of Life, in which he spoke of “the sacred value of human life from its very beginning” and of the struggle between the Culture of Life and the Culture of Death. In this authoritative document, the Pope declared that: “Given such unanimity in the doctrinal and disciplinary tradition of the Church … this tradition is unchanged and unchangeable. Therefore, by the authority which Christ conferred upon Peter and his Successors … I declare that direct abortion, that is, abortion willed as an end or as a means, always constitutes a grave moral disorder, since it is the deliberate killing of an innocent human being. This doctrine is based upon the natural law and upon the written Word of God, is transmitted by the Church’s Tradition and taught by the ordinary and universal Magisterium. No circumstance, no purpose, no law whatsoever can ever make licit an act which is intrinsically illicit, since it is contrary to the Law of God which is written in every human heart, knowable by reason itself, and proclaimed by the Church.”

The *Catechism of the Catholic Church* reiterates this too. Citing from *Donum Vitae*, the *Instruction on Respect for Human Life in its Origin*, issued in 1987 by the Congregation for the Doctrine of the Faith (which deals with matters of faith and morals), the Catechism states: “The inalienable rights of the person must be recognized and respected by civil society and the political authority. These human rights depend neither on single individuals nor on parents; nor do they represent a concession made by society and the state; they belong to human nature and are inherent in the person by virtue of the creative act from which the person took its origin. Among such fundamental rights one should mention in this regard every human being’s right to life and physical integrity from the moment of conception until death.” (*Catechism of the Catholic Church*, 2273).

**Fast facts about induced abortion today**

**Worldwide**
- Between 1995 and 2003, the abortion rate (the number of abortions per 1,000 women of childbearing age—i.e., those aged 15–44) for the world overall dropped from 35 to 29.
- Between the years 2003 and 2008, there has been about 28 abortions for every 1,000 women of childbearing age (15–44) conducted every year, adding to about 43.8 million abortions performed annually.
- Nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions (98%) occur in developing countries. In the developing world, 56% of all abortions are unsafe, compared with just 6% in the developed world.
- More than 85% of all abortions occur in developing countries, a disparity that largely reflects population distribution.
- A woman’s likelihood of having an abortion is similar whether she lives in a developed or developing country. Each year, there are 24 abortions per 1,000 women aged 15–44 in developed countries, compared with 29 per 1,000 in developing countries.

**Europe**
- In Europe, 30% or close to a third of pregnancies end in abortion.
- Both the lowest and highest sub regional abortion rates in the world are in Europe, where abortion is generally legal under broad grounds. At the regional level, the lowest abortion rate in the world is in Western Europe (12 per 1,000 women aged 15 – 44 years), followed by 15 per 1,000 in Southern Africa and 17 per 1,000 in Northern Europe. The abortion rate in the United states is 20 per 1000 women. The highest is in Eastern Europe (43 per 1,000).
- The discrepancy in rates between the two regions reflects relatively low contraceptive use in Eastern Europe, as well as a high degree of reliance on methods with relatively high user failure rates, such as the condom, withdrawal and the rhythm method.
- In Malta and Andorra abortion is illegal on any grounds. In Poland and Ireland, legal abortion is severely limited in availability.
**Sources of help**

**Dar Ġużeppa Debono – Għajnsielem, Gozo**

Dar Ġużeppa Debono is a Church Entity, Non Governmental Organisation, which caters and provide help for single mothers and fathers, and promoting the value of life as from conception and the importance of healthy relationships in our lives. Professionals and others volunteers working at Dar Ġużeppa Debono support single mothers who generally are under shock at the news of an unplanned pregnancy, and educate young and adults alike to learn respect themselves and the life of an unborn child.

**Dar Ġużeppa Debono provides:**
- **A residential services** to teenage mothers who might wish to have an alternative residence apart of their home. The main aim is to give all the privacy that is required by the teenage mother who wants to be relieved from social pressures that might be daunting her.
- **A social work service** for unmarried mothers, fathers and their respective families. This service is also offered to single mothers who are either separated or widowed.
- **Parenting skills courses** offered to couples who have or are expecting a baby out of wedlock. Individual attention to each and every couple is guaranteed which offers flexibility in choosing the most appropriate days and times for the meeting to take place.
- **Support for couples** who have or else are expecting a baby out of wedlock. During these meetings the couple will be taught about the various phases in the relationship and will be helped to identify in which phase they currently are. The couple is helped to adapt to the sudden big change that a baby brings with him/her.
- **Support groups for teenage mothers** where they meet and share their opinions and experiences with the others and above all are listened to and given the support required. The idea of a group instil in these girls a sense of strength and courage to share one’s own personal experiences with others. Above all, every person is seen as a unique person having its own personal life and experiences.

**Dar Ġużeppa Debono, Lourdes Street, Għajnsielem (Gozo) GSM 2200 Tel: 2155 2595**
Email: info@darĠużeppadebono.org
www.darĠużeppadebono.org

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**HOPE – Crisis Pregnancy Support**

In Malta, a crisis pregnancy support group called HOPE, which is one of the branches of the pro-life movement Gift of Life, seeks to help pregnant women who are considering a termination. This group adopts a non-judgemental approach and speak to mothers-to-be in strict confidentiality to help them make informed decisions by providing them with support and information about pregnancy and foetal development, as well as available support and options. Hope provides free pregnancy testing and non-diagnostic ultrasound scanning, referrals (obstetric, gynaecological and social), as well as referrals for professional support to women who have experienced pregnancy loss through abortion, emotional support, practical assistance and support, and psychotherapy. The support group also offers maternity and baby items.

For further information contact us on 2141 8055 or hope@lifemalta.org

**Rachel’s Vineyard**

Rachel's Vineyard offer a healing service after abortion. The program is an opportunity for people who had undergone an abortion to examine their abortion experience, identify the ways that the loss has impacted on them in the past and present, and helps to acknowledge any unresolved feelings that many individuals struggle with after abortion. Because of the emotional numbness and secrecy that often surrounds an abortion experience, conflicting emotions both during and after the event may remain unresolved. These buried feelings can surface later and may be symptoms of post abortion trauma.

Married couples, mothers, fathers, grandparents and siblings of aborted children, as well as persons who have been involved in the abortion industry have come to Rachel's Vineyard in search of peace and inner healing. To learn more, please call:

Nina or Chris Sansone on 79 248 842
Email: chrissansone@onvol.net

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**Servizz Għoża**

Servizz Għoża provides a support service and an educational programme to unmarried pregnant minors, leading them to adopt a positive attitude towards motherhood while empowering them to pursue their career path.

The main services offered are:
- a guidance and counselling to pregnant girls under eighteen, their boyfriends and their parents as required;
- psychological, moral and educational support;
- support to girls both before and after the birth of the child;
- programmes in three main areas; namely,
- to prepare these girls to become mothers, the process of pregnancy, preparation to give birth, baby care, parenting skills.
- A programme based on self-development to enhance interpersonal skills.
- Educational programmes aimed at enhancing their academic development.

Providing a service to the young unmarried mothers through:
- Support in guidance and counselling sessions both individually and within group support.
- Various inputs to enhance parenting skills and issues relating to child development.
- Facilitating contacts and the support of, other relevant organisations and services for the benefit of both schoolgirl mother and child.
- Liaising with, and advising, school administrators regarding pregnant students according to specific needs of case.
- Referrals:
  - Students themselves, parents, the Heads of Schools, the Guidance Teacher, School Counsellors, Education Officer, other teachers.

**Servizz Għoża, Fredrick Maempel Square**
Hal Qormi QRM 1515, Tel: 2124 3869
Ms Margaret Magri - margaret.magri@educ.gov.mt
Ms Josanne Grech - josanne.a.grech@gov.mt
Ms Eleanore Marmara - eleonore.marmara@gov.mt
TOPIC 12
Sexuality and relationships education
What is sexuality and relationships education?
Sexuality and relationships education ought to be understood in a broad and holistic way, and based on an understanding of sexuality as a positive human potential. A human being is understood to be a sexual being from birth, although a child’s sexuality differs from an adult’s in many ways. Therefore, sexuality and relationships education is a lifelong learning process, starting in early childhood, with a potential to promote positive sexuality.

Psychosexual development during childhood means the development of several physical, emotional, cognitive and social skills characteristic of the child’s age level. In each age group and development stage, specific questions and ways of behaviour occur (e.g. mutual discovery and investigation among peers – playing “doctors and nurses”; enjoyment of showing own body parts and looking at others; showing shame in front of others, etc.) which need to be reacted to in a pedagogical way. In this understanding, sexuality education is much more than giving facts about reproduction and the prevention of disease. It helps to develop the child’s senses and body image, strengthens the child’s self-confidence, and contributes to the development of self-determination: the child will be enabled to behave responsibly towards himself/herself and others.

Positive sexuality and sexual well-being (as opposed to ill-health) can be promoted among children and adolescents by:
• enhancing their knowledge and understanding of matters related to sexuality, relationships and sexual health, thus addressing their cognitive domain
• developing or strengthening interpersonal and relationship skills related to sexual expression and behaviour, addressing their behavioural domain
• explaining and clarifying feelings, attitudes and values, addressing their affective domain in relation to their sexual development
• sustaining preventive, protective and risk-reducing behaviours; and
• increasing comfort with their own developing sexuality and identity.

Among many other issues and topics, sexuality education includes the teaching and understanding of sex, sexuality and sexual health; the importance of stable and loving relationships; the importance of marriage for family life; the importance of respect, love and care; respect for life from the moment of conception and respect for sexual diversity.

Why is sexuality and relationships education important?
The increased tolerance of sexual diversity and practices by the upcoming generation of Maltese young people will almost certainly lead to further secularisation of sexuality locally. Many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender. Young people not receiving adequate preparation for their sexual lives remain potentially vulnerable to coercion, abuse and exploitation, unplanned pregnancy and sexually transmitted infections including HIV. For healthy outcomes, adolescents need the information, skills, commitment to the future and, sometimes, protection which will enable them to avoid sex, unplanned pregnancies and sexually transmitted infections including HIV and AIDS. They need the skills to establish healthy and adaptive non-exploitative sexual relationships.

In the absence of scientifically accurate, non-judgemental, age-appropriate, culture sensitive and holistic information, children and young people will often receive conflicting and sometimes...
Interventions are to be effective. Different sexual subcultures of youth if their programmes and interventions can effectively meet the learning needs of children and young people, with the involvement and full participation of parents, guardians, educators and other professionals in the process. Given the complexity of the task facing any educator, parent or guardian in guiding and supporting children's and young people's learning process and growth, guidance needs to be developed to assist educators strike the right balance between young people's need to know and what is age-appropriate and relevant, especially in the development and implementation of sexuality and relationships education programmes, interventions and materials. These are sensitive and challenging issues for those with responsibility for designing and delivering sexuality education, and the needs of those most vulnerable and special groups must be taken into particular consideration.

How can young people's learning needs about sexuality and relationships be met?

Debates about sexuality education – who provides this and how, and what it encompasses – are ongoing and heated. Then there are timeless questions such as how parents and educators talk to adolescents about sex. With the changing values, attitudes and sexual behaviour, young people's learning needs related to sexuality and relationships will also change. This will surely challenge previous sexuality education practices and interventions, and create new challenges for parents and educators to meet young people's learning needs. Education enabling young people to develop sexual and relationships knowledge and skills is likely to be most effective if educators take into account the current beliefs and practices of their target audience. Educators need to know about the different sexual subcultures of youth if their programmes and interventions are to be effective.

Sexuality and relationships education and learning needs can be addressed by way of evidence-based practice policies and guidelines aiming at educational programmes and interventions that can effectively meet the learning needs of children and young people, with the involvement and full participation of parents, guardians, educators and other professionals in the process. Given the complexity of the task facing any educator, parent or guardian in guiding and supporting children's and young people's learning process and growth, guidance needs to be developed to assist educators strike the right balance between young people's need to know and what is age-appropriate and relevant, especially in the development and implementation of sexuality and relationships education programmes, interventions and materials. These are sensitive and challenging issues for those with responsibility for designing and delivering sexuality education, and the needs of those most vulnerable and special groups must be taken into particular consideration.

Emphasis needs to be placed on the need for programmes that are locally adapted for cultural relevance through engaging and building support among the custodians of culture in our community, and logically designed to address and measure factors such as beliefs, values, attitudes and skills which, in turn, may affect sexual behaviour. Anyone involved in the design, delivery and evaluation of sexuality education, in and out of school, including curriculum developers, school administrators and teachers, health educators and youth workers would find such guidance useful.

Such guidance and policies would help:
- Promote an understanding of the need for sexuality education programmes by raising awareness of salient sexual and reproductive health issues and concerns affecting children and young people
- Provide clear understanding of what sexuality education comprises, what it is intended to do, and what the possible outcomes are
- Provide guidance to school authorities on how to build support at community and school level for sexuality education
- Build teacher preparedness and enhance institutional capacity to provide good quality sexuality education; and
- Develop responsive, culturally relevant and age-appropriate sexuality education materials and programmes.

What are the goals of sexuality education?

Sexuality and relationships education aims to help and support children and young people through their physical, emotional and moral development; to respect and take care of themselves and to respect others; and move with confidence from childhood through adolescence into adulthood.

The purpose of sexuality and relationships education is also extended to include learning about psychological well-being by enhancing young people's ability to deal with their emotions. Indeed sexuality education ought to be an element within a broader objective of developing emotional resourcefulness and forming 'emotionally intelligent citizens'. 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
Since its conception at the beginning of the 20th century, a value-laden or a value-free activity?

Is sexuality education in a pluralistic society. social, cultural and socio-political context and of the Maltese consistent with values that reflect the beliefs of the Maltese community in a pluralistic society.

All of the above should be based upon concepts that are consistent with values that reflect the beliefs of the Maltese social, cultural and socio-political context and of the Maltese community in a pluralistic society.

Is sexuality education a value-laden or a value-free activity?

Since its conception at the beginning of the 20th century, sexuality education has provoked numerous debates which have drawn attention to its controversial nature. This is mainly due to its moral dimension. As has already been highlighted above, sexuality education can provide young people with age-appropriate, culturally relevant and scientifically accurate information about matters related to sexuality, sexual health and relationships. Thus sexuality education is about the private and intimate life of the learner, having to do with intense emotions related to intimacy, pleasure, affection, anxiety, guilt and embarrassment. Therefore, sexuality and relationships education is inescapably a value-laden activity. It is not possible to divorce considerations of values from discussions of sexuality. ‘Values’ within this context are understood as principles and fundamental convictions by which people judge beliefs and behaviours to be good, right, desirable or worthy of respect. Wherever moral judgements about what is of value or not and what is right or wrong are involved, people are bound to disagree.

The transmission of cultural values from one generation to the next forms a critical part of socialisation; it includes values related to gender and sexuality. Young people are exposed to several sources of information and values (e.g. from parents, teachers, media and peers). These often present them with alternative or even conflicting values about gender, gender equality and sexuality. Therefore, sexuality education consists not only of information, but also of support for the acquisition of skills and competencies and of support for the development of one’s own standpoint and attitude towards sexuality. It presents young people with a structured opportunity to explore their attitudes and values, and to practise decision-making and other life skills they will need to be able to make informed choices about their sexual lives. Whether or not young people choose to be sexually active, sexuality education prioritises the acquisition and/or reinforcement of values such as respect, acceptance, tolerance, equality, empathy, reciprocity and responsibility, which are prerequisites for healthy sexual and social relationships.

Settings for sexuality education: the role of schools and families

In the past, debates about sexuality education focused on whether to teach sexuality education in schools or entrust it exclusively into the hands of parents, because of speculation 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 – a fear which, although empirically unfounded, still prevails. The quality of innocence should not be confused with ignorance. The sexual abuse of children is more likely to thrive where they are kept in ignorance about sexual matters.

The education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities; the transition to adulthood requires becoming informed and equipped with the appropriate knowledge and skills to make responsible choices in their social and sexual lives. School settings provide an important opportunity to reach large numbers of young people with sexuality education before they become sexually active in ways that are replicable and sustainable. School systems benefit from an existing infrastructure, including teachers likely to be skilled and trusted sources of information, and long-term programming opportunities through formal curricula. Moreover, as local evidence shows, many young people are having their first sexual experiences while they are still attending school, making the setting even more important as an opportunity to provide education about sexual and reproductive health.

Sexuality education is the responsibility of the whole school via not only teaching but also school rules, in-school practices, the curriculum and teaching and learning materials. School authorities have the power to regulate many aspects of the learning environment to make it protective and supportive, and schools can also act as social support centres, trusted institutions that can link children, parents, families and communities with other services (such as health services). But schools can only be effective if they can ensure the protection and well-being of their learners and staff, if they provide relevant learning and teaching opportunities, and if they link up to psychosocial, social and health services.

School authorities and teachers in the classroom have a responsibility to act in partnership with parents and communities to ensure the protection and well-being of children and young people. Education and health authorities are responsible to support parents by responding to the
challenge of giving children and young people access to the knowledge and skills they need in their personal, social and sexual lives.

But education about sexuality does not just occur in schools. It is pervasive in our culture through modeling adult behavior, through messages in the media, through talking with each other and family, and through our laws as well as religious and other values. From the moment a child is born, his/her education starts, at first mainly through nonverbal messages, and later verbally as well. Sexuality education is part of the child’s general education and is always imparted to the child, even if this is not done consciously. The way parents relate to each other gives the children vivid examples of how relationships work. Parents also serve as role models for gender roles and expression of emotions, sexuality and tenderness. By not talking about sexuality (for example not naming sexual organs) parents teach something about sexuality (in the chosen example their silence might be interpreted as discomfort). The general environment also influences a child’s sexual socialization, for example other children in kindergarten or their curiosity about their own or others’ bodies.

The subconscious or natural way of teaching and learning about sexuality can be complemented by an active way of teaching and informing. The benefit of this approach is the normalization of the topic of sexuality. The child’s questions exist and need to be respected (you can’t touch anyone you want to). Even more importantly, the child learns to realize and express his/her own boundaries (you can say no; you can ask for help). In this sense, sexuality education is also social education and contributes to the prevention of sexual abuse.

It is equally important to provide formal sexuality education to children and young people out of school, especially for those who may be marginalised for a variety of reasons. These settings could include mental health institutions for young persons, young persons with physical or learning disabilities, hospitalised children, young people requiring long term care, and children in care.

Is there evidence that sexuality education works? While it is not realistic to expect that an education programme alone can eliminate the risk of HIV and other STIs, unplanned pregnancy, coercive or abusive sexual activity and exploitation, properly designed and implemented programmes can reduce some of these risks and underlying vulnerabilities. Various studies examined the relation between sexuality education and early initiation of sexual experimentation. 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 sexuality education encourages experimentation or increases sexual activity. Thus, it can be said with a degree of certainty that sexuality education does not 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.

A recent comprehensive review of studies which explored the impact of sexuality and relationships education on sexual behaviour suggests that effective programmes may:-

Reduce misinformation and increase correct knowledge
Clarify and strengthen positive values and attitudes
Increase skills to make informed decisions and act upon them
Improve perceptions about peer groups and social norms
Increase communication with parents or other trusted adults
Can help abstain from or delay the debut of sexual relations
Reduce frequency of unprotected sexual activity
Reduce the number of sexual partners; and
Increase the use of protection against unintended pregnancy and STIs during sexual intercourse

What makes ‘effective’ sexuality education? With the advent of HIV and AIDS in the 80s, the focus of the debate steered away from whether to provide sexuality education and started addressing the how, thus looking at the nature of sexuality education and seeking a socially, politically and culturally acceptable raison d’être for this education practice. Unfortunately, much of today’s public sexuality discourse is almost exclusively about risks and dangers such as abuse, addiction, dysfunction, infection and teen pregnancy. Public discourse about the physiological and psychosocial health benefits of sexual expression has been almost entirely absent.

It is commonly argued that the scope of sexuality education should be more ambitious than that of reducing the negative consequence of adolescent sexual behaviour and should not be a negative process that attempts to frighten teenagers away from a powerful biological drive. Sex education which stresses fear-arousing messages, punitive outcomes of
experimentation or value stances considered ‘out-of-date’ will fail to reach those most needing intervention.

Instead, sexuality education should take into account positive aspects of sexuality and intimate relationships. Discourses within sexuality education need to be reformulated into a reality that more readily matches young people’s life experiences.

An independent review of sexuality and relationships education programmes showing evidence of effectiveness in increasing knowledge, clarifying values and attitudes, increasing skills and impacting upon behaviour led to the identification of a number of recommendations emanating from key common characteristics among these successful programmes. These are:

- implement programmes that include at least twelve or more sessions
- include sequential sessions over several years
- peer-led versus adult-led sexuality education
- focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy
- focus narrowly on specific risky sexual and protective behaviours leading directly to these health goals
- address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them
- give clear messages about behaviours to reduce risk of STIs or pregnancy
- focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, social norms, attitudes and skills)
- employ participatory teaching methods that actively involve students and help them internalise and integrate information
- implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors
- provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection
- address perception of risk (especially susceptibility).
- address personal values and perceptions of family and peer norms about engaging in sexual activity and/or having multiple partners
- address individual attitudes and peer norms concerning condoms and contraception
- address both skills and self-efficacy to use those skills.
- cover topics in a logical sequence.

**Barriers to sexuality education**

Despite the clear and pressing need for effective sexuality and relationships education, which can help address young people’s learning needs to prevent ill-health and enjoy more positive sexual development and expression, evidence shows that in a number of Maltese schools this is still not available. Many people, including community leaders, heads of schools, teachers and parents, may not be convinced of the need to provide sexuality education. Other barriers to sexuality and relationships education include:

- ‘perceived’ or ‘anticipated’ resistance resulting from misunderstandings about the nature, purpose and effects of sexuality education
- fear that sexuality education may lead to early initiation of sexual practices
- fear that sexuality education deprives children of their ‘innocence’
- fear that sexuality education goes against our culture or religion
- the belief that sexuality education should be exclusively trusted to the parents and extended family
- fear that parents will object to sexuality education being taught in schools
- the belief that sexuality education may be good for young people, but not for children
- teachers that are willing to teach sexuality education but are uncomfortable, lacking in skills and confidence to do so
- teachers’ personal or professional values could also be in conflict with the issues they are being asked to address, or else there is no clear guidance about what to teach and how to teach it.

Some parents may have strong views and concerns about the effects of sexuality education. Sometimes, these concerns are based on limited information or misapprehensions about the nature and effects of sexuality education, or perceptions of norms in society. The cooperation and support for parents, families and other community actors should be sought from the outset and regularly reinforced as young people’s perceptions and behaviours are greatly influenced by family and community values, social norms and conditions. It is important to emphasise the shared primary concern of schools and parents with promoting the safety and well-being of children and young people.

Parental concerns can be addressed through the provision of parallel programmes that orient them to the content of their children’s learning and that equip them with skill to
communicate more openly and honestly about sexuality with their children, putting their fears to rest and supporting the school’s efforts in delivering good quality sexuality education. Research has shown that one of the most effective ways to increase parent-to-child communication about sexuality is to provide student homework assignments to discuss selected topics with parents and other trusted adults. If teachers and parents support each other in implementing a guided and structured teaching/learning process, the chances of personal growth for children and young people are likely to be much better.
**Glossary**

Some of these definitions are pulled from a Sexual Diversity Tool Kit of the International Planned Parenthood Federation. These terms may vary in interpretation and definition based on country and cultural context.

A

**Aanorgasmia:** The delay or absence of sexual climax (orgasm).

**Abdominal hysterectomy:** The surgical removal of the uterus through an incision in the abdomen.

**Abstinence:** A natural method of contraception whereby a man and woman refrain from sexual intercourse during the fertile phase of the menstrual cycle in order to avoid pregnancy. Abstinence offers no protection against sexually transmitted infections (STI) if practiced with an infected partner.

**Adenocarcinomas:** Cancer that begins in the cells lining of the glands of the body.

**AIDS or Acquired Immunodeficiency Syndrome:** A potentially fatal sexually transmitted infection (STI) caused by the HIV virus. The virus attacks and weakens the body’s immune system, making it susceptible to many kinds of infectious diseases it would normally fight off.

**Ally:** Someone who advocates for and supports members of a community other than their own. Reaching across differences to achieve mutual goals. For example, any person who supports and stands up for the rights of LGBTI people.

**Amenorrhea:** When a woman does not get her monthly period.

**Androgens:** Hormones found in both men and women. The main androgen is called testosterone. It helps maintain muscle, bone mass, and a healthy sex drive in both men and women, and helps regulate a woman’s menstrual cycle. Since women need a much smaller amount of testosterone than men, they tend to have very low levels of androgens. In women, high levels of androgens can cause unwanted facial and body hair and androgens have also been known to cause acne in both men and women. Some oral contraceptive pills which have anti-androgenic properties which can reduce acne.

**Androgynous:** A person whose appearance or self-expression is a mix of feminine and masculine traits and/or behaviours. A person who is not identifiable as either male or female in the context of social standards of masculinity and femininity.

**Anus:** The opening of the rectum to the outside of the body.

**Asexual:** Having no evident sex or sex organs. In usage, may refer to a person who is not sexually active, or not sexually attracted to other people.

B

**Bacterial vaginosis:** The most common vaginal infection in women of reproductive age. Bacterial vaginosis often causes a vaginal discharge that is thin and milky, and is described as having a “fishy” odour. Bacterial vaginosis is caused by a combination of several bacteria.

**Balanitis:** An inflammation of the skin covering the head of the penis.

**Balanoposthitis:** Inflammation of the head and the foreskin of the penis.

**Bartholin’s glands:** The small, mucus-producing glands on either side of the vaginal opening.

**Benign:** Not cancer, as in a benign tumour.
Bias: Prejudice; an inclination or preference, especially one that interferes with impartial judgment.

Bigendered: Refers to those who feel they have both a male and a female side to their personalities. Some “bigendered” people cross-dress, others may eventually have a sex-change operation, others may do neither.

Biological therapy: A treatment that uses the body’s own immune system to fight cancer. It uses materials made by the body or made in a laboratory to boost, direct or restore the body’s natural defences against disease. Biological treatment is sometimes called biological response modifier (BRM) therapy.

Biopsy: The removal of a small sample of tissue for testing.

Biphobia: The irrational fear and intolerance of people who are bisexual.

Birth control: A way for men and women to prevent pregnancy.

Birth Sex/Sex: The sex one is assigned at birth due to the presence of whatever external sex organs. Once this determination is made, it becomes a label used for raising the child in either one gender image or other (either as male or female).

Bisexual: Also bi. A person who is emotionally, romantically, and/or sexually attracted to two sexes or two genders, but not necessarily simultaneously or equally. (This used to be defined as a person who is attracted to both genders or both sexes, but since there are not only two sexes (see intersex and transsexual) and there are not only two genders (see transgender), this definition is inaccurate.

Bulbourethral glands (Cowper’s glands): Pea-sized structures located on the sides of the urethra just below the prostate gland. These glands produce a clear, slippery fluid that empties directly into the urethra. This fluid serves to lubricate the urethra and to neutralize any acidity that may be present due to residual drops of urine in the urethra.

Cancer: A disease that occurs when abnormal cells in a part of the body divide and grow uncontrolled.

Candida: A species of fungus that normally lives in small numbers in the vagina, as well as in the mouth and digestive tract of both men and women.

Carcinoma in situ: This is a condition that is considered a pre-cancer, because cancer cells are found on the surface of the organ or tissue. (“In situ” literally means “in its proper place.”)

Carcinomas: A type of cancer that arises from the lining cells of the body, called epithelial cells. Epithelial cells form the outer layer of the skin, and the membranes lining the digestive tract, bladder and uterus, as well as the tubes and ducts that run through the body’s organs.

Celibacy: One who abstains from sexual intercourse, especially by reason of religious vows. 2. One who is unmarried. Note: Historically, celibate means only “unmarried”; its use to mean “abstaining from sexual intercourse” is a 20th-century development. But the new sense of the word seems to have displaced the old, and the use of celibate to mean “unmarried” is now almost sure to invite misinterpretation in other than narrowly ecclesiastical contexts.

Cervical biopsy: A procedure in which the doctor removes a small amount of tissue from the cervix to be examined more closely.

Cervical cancer: Cancer that occurs when abnormal cells in a woman’s cervix—the lowest part of the uterus (womb) through which babies pass when they are born—divide and grow uncontrolled.

Cervix: The lowest part of the womb, or uterus, through which babies pass when they are born.

Chlamydia: A germ that is primarily sexually transmitted and that can infect genital organs.

Circumcision: An operation in which the doctor removes the foreskin from the penis. The foreskin is the skin that covers the tip of the penis.

Cis-gender or cis-sexual: is a class of gender identities where there is a match between an individual’s gender identity and the behaviour or role considered appropriate for one’s sex. There are a number of derivatives of the term in use, including cis-male for a male with a masculine gender identity, and cis-female for a female with a feminine gender identity. A similar adjective is gender-normative. The prefix cis is antonymous with the prefix trans. Therefore cisgender complements transgender.

Clitorectomy
The removal of the entire clitoris and the adjacent labia (the external and internal folds of skin, or lips, that protect the vaginal opening).
Clitoris
The small structure at the front of the vulva. The clitoris is very sensitive to stimulation and helps a woman reach sexual climax.

Colposcopy: An examination of the cervix (lower part of the uterus) and the wall of the vagina. It is performed using a special microscope (colposcope) that gives a magnified view of the tissue lining the cervix and vagina. A special solution may be applied to the cervix that causes abnormal cells to turn white or yellow so they may be more easily viewed.

Coming Out: The on-going process of becoming aware of one's sexual orientation. This may include accepting it, acting on it, and telling others about it. To be “in the closet” means to hide one’s identity. Coming out can be difficult for some because reactions vary from complete acceptance and support to disapproval, rejection and violence.

Conception: The fertilization of an egg by a sperm.

Condom: A device usually made of latex (a type of rubber), plastic or animal membrane that is used for birth control and to prevent the spread of sexually transmitted diseases. Male condoms are fitted over the erect penis. Female condoms are inserted into the vagina. The closed end of the condom covers the cervix, and the open end covers the area around the opening of the vagina.

Condyloma (genital warts): Growths or bumps on the penis, vagina, vulva (vaginal lips), cervix (the opening between the vagina and womb), rectum or groin. Genital warts are caused by a virus that is sexually transmitted, meaning it is spread by having sex with an infected person.

Corpus luteum: The structure formed during the luteal phase of a woman's menstrual cycle. The corpus luteum secretes oestrogen and progesterone. Progesterone prepares the uterus with the rich lining needed for the fertilized egg to implant.

Cowper's glands (Bulbourethral glands): Pea-sized structures located on the sides of the urethra just below the prostate gland. These glands produce a clear, slippery fluid that empties directly into the urethra. This fluid serves to lubricate the urethra and to neutralize any acidity that may be present due to residual drops of urine in the urethra.

Cross Living: Living full-time in the preferred gender image, opposite to one’s assigned sex at birth, generally in preparation for a sex change operation.

Cross-dresser: Used to describe an individual who dresses as someone from a different gender category; cross-dressing is a form of gender expression and is not necessarily tied to erotic activity. Cross-dressing is not indicative of sexual orientation.

Cryosurgery: The use of extremely cold temperatures to freeze and destroy abnormal tissues. This procedure is used to treat pre-cancerous tumours. It is often used to remove abnormal tissue of the cervix, the lower part of the uterus (womb) that opens into the vagina (birth canal).

Cryptorchidism: A condition in which the testicles do not descend from the abdomen, where they are located during development, to the scrotum shortly before birth. Also called undescended testicle.

D
“Date” rape: When one person forces another person to have sex. It differs from rape because the victim agreed to spend time with the attacker. Perhaps he or she even went out with his or her attacker more than once.

Diaphragm: A round piece of flexible rubber with a rigid rim. The woman places the diaphragm in her vagina and against her cervix. The diaphragm prevents semen from entering the womb. Spermicide must be used with a diaphragm.

Dilation and curettage (D & C): A procedure in which the opening of the cervix is stretched with a special instrument, and the walls of the uterus are scraped gently.

Direction: Refers to the way in which one is crossing the gender line. Masculine/Male to Feminine/Female (MTF) is one way; Feminine/ Female to Masculine/Male (FTM) is another.

Domestic Partner: One who lives with their beloved and/or is at least emotionally and financially connected in a supportive manner with another. Another word for spouse, lover, significant other, etc.

Dominant culture: The cultural values, beliefs, and practices that are assumed to be the most common and influential within a given society.

Douche: A liquid used to clean a woman's genitals and vagina.

Drab: Means dressing as a boy, referring to men's clothes or wearing men's clothes; is used mainly by gender benders and cross-dressers of both directions.
Drag King: A female who, on specific occasions, cross-dresses and often employs stereotypical masculine dialogue, voice and mannerisms, for the entertainment of herself or others.

Drag Queen: A male who, on specific occasions, cross-dresses and often employs stereotypical feminine dialogue, voice and mannerisms, for the entertainment of himself or others.

Drag: The act of dressing in gendered clothing as part of a performance. Drag Queens perform in highly feminine attire. Drag Kings perform in highly masculine attire. Drag may be performed as a political comment on gender, as parody, or simply as entertainment. Drag performance does not indicate sexuality, gender identity, or sex identity.

Dysmenorrhea: The medical term for the painful cramps that may occur during a woman's menstrual period.

Dyspareunia: Pain during intercourse.

Dysplasia: A pre-cancerous condition involving changes in the surface cells of the vulva and/or cervix. It also is called vulvar intraepithelial neoplasia (VIN) or cervical intraepithelial neoplasia (CIN).

Ectopic (tubal) pregnancy: A pregnancy that occurs outside the uterus, often in the fallopian tubes.

Ejaculate: The fluid that is expelled from a man's penis during sexual climax (orgasm).

Ejaculation: When sperm and other fluids come from the penis during sexual climax (orgasm).

Ejaculatory ducts: The structures formed by the fusion of the vas deferens and the seminal vesicles. The ejaculatory ducts empty into the urethra.

Embryo: A fertilized egg.

Emergency contraception: Also called emergency post-coital oral contraception (EPOC) or the “morning after pill.” It is a form of birth control that may be used by women within 72 hours of having unprotected sex. The most commonly used emergency contraception consists of two doses of hormone pills taken in one day 12 hours apart.

Endometrial biopsy: A procedure in which a small sample of tissue from the lining of the uterus (endometrium) is removed for evaluation and testing.

Endometrial cancer: Cancer that occurs when abnormal cells in the endometrium—the lining of the uterus (womb)—divide and grow uncontrolled.

Endometriosis: A condition in which tissue that looks and acts like endometrial tissue is found outside the uterus, usually inside the abdominal cavity.

Endometrium: The tissue that lines the inside of the uterus.

Epididymis: The long, coiled tube that rests on the back side of each testicle. It transports and stores the sperm cells produced in the testes. The epididymis also brings the sperm to maturity, since the sperm that emerge from the testes are immature and incapable of fertilization. During sexual arousal, contractions force the sperm into the vas deferens.

Epididymitis: Inflammation of the epididymis.

Erectile dysfunction (impotence): The inability to attain and/or maintain an erection suitable for intercourse.

Erection: An erection, or penile erection, is a physiological phenomenon where the human penis becomes firmer, engorged and enlarged. Penile erection is the result of a complex interaction of psychological, neural, vascular and endocrine factors, and is usually, though not exclusively, associated with sexual arousal or sexual attraction. Erections during sleep or when waking up are known as nocturnal penile tumescence (NPT). A penis which is partly, but not fully, erect is sometimes known as a semi-erection; a penis which is not erect is typically referred to as being flaccid, or soft.

Exhibitionism: A disorder characterized by intense, sexually arousing fantasies, urges or behaviours involving exposure of the individual’s genitals to an unsuspecting stranger.

Fallopian tubes: The narrow, muscular tubes attached to the upper part of the uterus that serve as tunnels for the ova to travel from the ovaries to the uterus. Conception, the fertilization of an egg by a sperm, normally occurs in the fallopian tubes.

Female circumcision: The removal of part of a female’s external genitalia (reproductive organs), usually the clitoris. Also called female genital mutilation.

Fetishism: A disorder in which a person has sexual urges and engages in behaviour associated with non-living objects.

Fibroids: Nodules of smooth muscle cells and fibrous connective tissue that develop within the wall of the uterus.
(womb). Medically, they are called uterine leiomyomata (singular: leiomyoma).

Fimbriae: The finger-like projections on the end of the fallopian tubes. The fimbriae sweep the egg into the tube.

Foetus: the developing child in the uterus, specifically the unborn offspring in the postembryonic period, in humans from nine weeks after fertilization until birth.

Follicle-stimulating hormone (FSH): A hormone produced by the pituitary gland (at the base of the brain). In men, FSH is necessary for sperm production (spermatogenesis). In women, FSH stimulates the growth of follicles, the small, fluid-filled cysts that hold the eggs and the supporting cells responsible for the growth and nurturing of the egg.

Foreskin: The loose skin that covers the head of the penis.

Frotteurism: A disorder in which the focus of a person’s sexual urges is related to touching or rubbing his genitals against the body of a non-consenting, unfamiliar person.

FTM: female-to-male (transvestite or transsexual).

Gamete: Gametes are reproductive cells that unite during sexual reproduction to form a new cell called a zygote. In humans, male gametes are sperm and female gametes are ova (eggs).

Gay: A person who identifies as a man and who is emotionally, romantically and/or sexually attracted to men. Colloquially used as an umbrella term to include all LGBTIQ people.

Gender: 1) A socially constructed system of classification that ascribes qualities of masculinity and femininity to people. Gender characteristics can change over time and are different between cultures. Words that refer to gender include: man, woman, transgender, masculine, feminine, and gender queer. 2) One’s sense of self as masculine or feminine regardless of external genitalia. 3) Refers to the way we perceive certain things to be masculine or feminine. These things need not be human; for example, in the language of many cultures, cups are feminine, and pencils masculine. [Traditionally, we tend to associate gender – that is, masculine and feminine meanings – with features that include: · physical sex or genitals; · other physical features (for example height, weight, and body hair); · sexual orientation (gay men are often considered more feminine than their heterosexual counterparts, and lesbian women more masculine); and · behaviour or dress (a man who cries may be considered unmanly, a woman who is aggressive or wears a suit-coat and slacks may be considered unfeminine).]

Gender Binary System: The idea that human gender exists in ONLY two forms: masculine and feminine. The term also describes the system in which a society divides people into male and female gender roles, gender identities and attributes. A system of oppression that requires everyone to be raised either male or female, and masculine or feminine. Eliminates the possibility for other gender expressions, and gives power to people whose genders do not break gender norms at the expense of transgender and intersex people. Manifests itself as transphobia.

Gender Characteristics: Refers to the primary and secondary sexual physical characteristics like height, weight, and body hair, over which the individual has no control and which do not constitute part of their expression or identification. Examples might include a man with a high voice, a woman with prominent facial hair, or a person with anomalous genitalia (more correctly referred to as “intersex”).

Gender Conformity: When your gender identity and sex “match” (i.e. fit social norms). For example, a male who is masculine and identifies as a man.

Gender Expression/Gender Image: The way a person expresses his or her gender through gestures, movement, dress, and grooming. The way one presents oneself to the world, as either masculine or feminine, or both or neither. This can include dress, posture, vocal inflection, and other behaviour.

Gender Identity: 1) “Gender identity” refers to an individual’s self-awareness or fundamental sense of themselves as being masculine or feminine, and male or female. The phrase “gender identity” originated as a psychiatric term, and is commonly used to protect transsexual or transgender employees, particularly those who transition from one sex to another on the job. 2) The gender that a person sees oneself as. This can include refusing to label oneself with a gender. Gender identity is also often conflated with sexual orientation, but this is inaccurate. Gender identity does not cause sexual orientation. For example, a masculine woman is not necessarily a lesbian.

Gender non-conforming refers to a person who is or is perceived to have gender characteristics and/or behaviours that do not conform to traditional or societal expectations. Gender non-conforming people may or may not identify as straight, lesbian, gay, bisexual, transgender, or queer.
Gender Queer (or Genderqueer): A person who redefines or plays with gender, or who refuses gender altogether. A label for people who bend/break the rules of gender and blur the boundaries.

Gender Role: This is the set of roles and behaviours assigned to females and males by society. Our culture recognizes two basic gender roles: masculine (having the qualities attributed to males) and feminine (having the qualities attributed to females). How “masculine” or “feminine” an individual acts. Societies commonly have norms regarding how males and females should behave, expecting people to have personality characteristics and/or act a certain way based on their biological sex.

Gender Stereotypes: “Gender stereotypes” are the patterns or mental templates for what we expect members of each sex to be. For instance, the stereotype for males frequently includes being tall, muscular, hirsute, solitary, and impassive. For females it might include being small, weak, social, sensitive, and emotional.

Genderism: Holding people to traditional expectations based on gender, or punishing or excluding those who don’t conform to traditional gender expectations.

Gender-neutral: Nondiscriminatory language to describe relationships—e.g. “spouse” and “partner” are gender-neutral alternatives to the gender-specific words “husband;” “wife,” “boyfriend” and “girlfriend.”

Gender-variant / Gender non-conforming: Displaying gender traits that are not normatively associated with their biological sex. “Feminine” behaviour or appearance in a male is gender-variant as is “masculine” behaviour or appearance a female. Gender-variant behaviour is culturally specific.

Genetic: refers to the chromosomal endowment of the individual, with emphasis on the sex chromosomes (XX in women and XY in men).

Genital warts (condyloma): Growths or bumps on the penis, vagina, vulva (vaginal lips), cervix (the opening between the vagina and womb), rectum or groin. Genital warts are a sexually transmitted disease, or “STD,” which means that they are spread by having sex with an infected person.

Glans: The head of the penis.

Gonads: Glands that make sex hormones and reproductive cells, in humans – the testes in the male, and the ovaries in the female.

Gonorrhoea: A serious bacterial infection that is caught by having sex with an infected person. A person can become infected when the bacteria enter any opening in the body, including the penis, anus, vagina or mouth. Gonorrhoea also is called “clap” or “drip.”

H

Hate crime: Hate crime legislation often defines a hate crime as a crime motivated by the actual or perceived race, colour, religion, national origin, ethnicity, gender, disability, or sexual orientation of any person.

Hepatitis B: A disease involving inflammation of the liver. A type of hepatitis that can be spread from another person who has the virus. Most commonly, it is spread by having sex with an infected person or by sharing a needle.

Herpes: A virus spread by close personal contact, such as kissing or sexual intercourse. There are two types of herpes. The first type is herpes simplex type 1 (or HSV-1). HSV-1 occurs most often on or near the mouth and appears as a chancre or cold sore. The second type, herpes simplex type 2 (or HSV-2), occurs most often on or near the sex organs and is sometimes called “genital herpes.” Genital herpes is a sexually transmitted disease, or “STD.”

Heterosexism: Assuming every person to be heterosexual therefore marginalizing persons who do not identify as heterosexual. It is also believing heterosexuality to be superior to homosexuality and all other sexual orientations. Enforcement of that ideology translates into discrimination and oppression of those who fail to adhere to it.

Heterosexual Privilege: Benefits derived automatically by being (or being perceived as) heterosexual that are denied to homosexuals, bisexuals, and queers.

Heterosexual: A person who is emotionally, romantically, and/or sexually attracted to people of another gender.

Heterosexuality: Sexual, emotional, and/or romantic attraction to a sex other than your own. Commonly thought of as “attraction to the opposite sex” but since there are not only two sexes (see intersex and transsexual), this definition is inaccurate.

HIV test: A test to look for signs of HIV in the blood.

Homophobia: A irrational fear or intolerance of homosexuality, or people thought to be lesbian, gay, or bisexual. This attitude is at the root of prejudice and discrimination based on an individual’s sexual orientation. At its most extreme, homophobia can manifest in harassment or violence against LGBTI individuals. This assumes that heterosexuality is superior.
**Homosexual:** A person who is emotionally, romantically, and/or sexually attracted primarily to people of the same gender. Anybody who is attracted to someone of their same gender could technically be called “homosexual,” i.e. a trans man attracted to other trans men. Because of the clinical history of the word “homosexual” and its pejorative connotations, the terms “gay man” or “lesbian” may be preferred.

**Homosexuality:** Sexual, emotional, and/or romantic attraction to the same sex.

**Hormones:** Chemicals that stimulate or regulate the activity of cells or organs.

**Hormone replacement therapy (HRT):** The use of hormones, usually oestrogen and progesterone, as a therapy, often used to treat the discomforts of menopause or to replace hormones (especially oestrogen) lost after menopause.

**Hormone therapy:** The use of hormones, usually taken by pill, to kill cancer cells.

**Human Immunodeficiency Virus (HIV):** The virus that causes AIDS (acquired immune deficiency syndrome). HIV weakens a person’s ability to fight infections and cancer. People with HIV are said to have AIDS when the virus makes them very sick and they develop certain infections or cancers. A person gets HIV when an infected person’s body fluids (blood, semen, fluids from the vagina or breast milk) enter his or her bloodstream. The virus can enter the blood through linings in the mouth, anus or sex organs (the penis and vagina), or through broken skin.

**Human papillomavirus (HPV):** A group of more than 100 types of viruses that can cause warts (papillomas).

**Hypogonadism:** A disorder in men that occurs when the testicles (gonads) do not produce enough testosterone.

**Hysterectomy:** A surgical procedure to remove the cervix, uterus, fallopian tubes and part of the vagina. It can be radical (complete) or partial.

**Immune system:** The body’s natural defence system against infection or disease; a system of cells that protects the body from bacteria, viruses, toxins and other foreign substances.

**Impotence (erectile dysfunction):** The inability to attain and/or maintain an erection suitable for intercourse.

**In the closet:** Keeping one’s sexual orientation and/or gender or sex identity a secret.

**Incontinence:** Loss of bladder and/or bowel control.

**Inhibited or retarded ejaculation:** When ejaculation does not occur.

**Inhibited sexual desire (reduced libido):** A decrease in desire for or interest in sexual activity.

**Institutional Oppression:** Arrangement of a society used to benefit one group at the expense of another through the use of language, media education, religion, economics, etc.

**Intercourse:** Heterosexual sexual intercourse involves the penetration of the vagina by the penis, also known as coitus. Intercourse as in anal or oral intercourse does not involve penetration of the vagina.

**Internalized Oppression:** The process by which an oppressed person comes to believe, accept, or live out the inaccurate stereotypes and misinformation about their group.

**Intersex:** A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that is different from the standard definitions of female or male in terms of his/her internal or external body features. For example, a person might be born appearing to be female on the outside, but have mostly male-typical anatomy on the inside; or a person may be born with genitals that seem to be a combination of the usual male and female types.

**Intrauterine device (IUD):** A small, plastic, flexible, T-shaped device that is placed into the uterus (womb). The IUD is a form of birth control.

**Invisible minority:** A group whose minority status is not always immediately visible, such as some disabled people and LGBTIQ people. This lack of visibility may make organizing for rights difficult.

**Labia majora:** Part of the female external reproductive system, the labia majora are the two outer lips that are covered by pubic hair in adult women.

**Labia minora:** Part of the female external reproductive system, the labia minora are the two inner lips that surround the opening of the vagina (the birth canal) and the urethra (the exit tube for urine.)

**Lambda:** The Gay Activist Alliance originally chose the lambda, the Greek letter “L,” as a symbol in 1970. Organizers chose the letter “L” to signify liberation. The word has become
Laparoscopy: A procedure in which the doctor inserts a small device through an incision in the abdomen. He or she then views the reproductive organs and pelvic cavity using the device. A sample of tissue may also be collected for testing.

Laparotomy: A procedure in which the doctor opens the abdomen to inspect the internal organs.

Lesbian: A person who identifies as a woman and who is emotionally, romantically, and/or sexually attracted to women.

LGBT: An acronym for Lesbian, Gay, Bisexual, Transgender, Transsexual, and Transsexual and Intersex.

LGBTIQ: Lesbian, Gay, Bisexual, Transgender, Intersex, Queer.

Luteinizing hormone (LH): A hormone produced by the pituitary gland (at the base of the brain). In men, LH stimulates the production of testosterone, which is necessary for sperm production. In women, LH causes the dominant follicle to release its egg from the ovary (ovulation).

Luteinizing hormone (LH): A hormone produced by the pituitary gland (at the base of the brain). In men, LH stimulates the production of testosterone, which is necessary for sperm production. In women, LH causes the dominant follicle to release its egg from the ovary (ovulation).

Male supremacy: A system of oppression that gives power to men and values masculinity, at the expense of women and femininity.

Malignant: Cancerous, as in a malignant tumour.

Marginalized: Excluded, ignored, or relegated to the outer edge of a group/society/community.

Masturbation: Self-stimulation of the genitals to achieve sexual arousal and pleasure, usually to the point of orgasm (sexual climax).

Men who have sex with men (MSM): Men who engage in same-sex behaviour, but who may not necessarily self-identify as gay.

Menarche: the first menstrual period, usually occurring during puberty.

Menopause: When a woman’s ovaries stop producing hormones because the number of eggs (follicles) is limited. At this time, regular menstrual periods stop.

Menstrual cycle: The recurring monthly series of physiological changes in healthy women in which an egg (ovum) is produced in the process known as ovulation, and the uterine lining thickens to allow for implantation if fertilization occurs. If the egg is not fertilized, the lining of the uterus breaks down and is discharged during menstruation (menses).

Menstruation: The periodic shedding of the uterine lining.

Mittelschmerz: The pelvic pain that some women experience during ovulation. (Ovulation generally occurs about mid-way between menstrual cycles; hence the term mittelschmerz, which comes from the German words for “middle” and “pain.”)

Monogamy: The practice of having sex with only one partner.

Mons pubis or mons veneris: A rounded fleshy prominence situated over the pubic bones (symphysis pubis) that becomes covered with hair during puberty. Also called pubis.

MTF: Male to Female (transvestite or transsexual).

N

Non-coital behaviour: Physically stimulating activity that does not include intercourse (such as sensual massage).

Non-infectious vaginitis: A form of vaginitis (infection or inflammation of the vagina) that may result as a reaction to certain substances or chemicals, such as soap, laundry detergent or fabric softener.

Non-Op: Refers to transsexuals who seek sex reassignment through hormones and who cross-live, but stop just short of surgery. Some have concerns about major surgery, which is not always successful, others are unable to pay for the expensive procedures surgery would entail, and still others feel that they are complete without the surgery.

O

Oocytes (ova or egg cells): The female cells of reproduction.

Oogenesis: The production or development of an ovum in women.

Oophorectomy: A surgical procedure in which one or both of the ovaries is removed.

Oppression: Results from the use of institutional power and privilege where one person or group benefits at the expense of another. Oppression is the use of power and the effects of domination.

Orchietomy: A surgical procedure to treat testicular cancer in which the doctor removes one or both testicles through an incision (cut) in the groin.

Orgasm: Sexual climax.
Out or Out of the closet: Refers to varying degrees of being open about one’s sexual orientation and/or sex identity or gender identity.

Ova (singular: ovum): The female reproductive cell or gamete; egg, which, after fertilization, becomes a zygote that develops into a foetus.

Ovarian cancer: An abnormal growth of tissue (tumour) that develops in a woman’s ovaries.

Ovarian cyst: A sac filled with fluid or a semisolid material that forms on or within one of the ovaries, the small organs in the pelvis that make female hormones and hold egg cells.

Ovary: A small organ in the pelvis that makes female hormones and holds egg cells which, when fertilized, can develop into a baby. There are two ovaries: one located on the left side of the uterus (the hollow, pear-shaped organ where a baby grows) and one on the right.

Ovulation: The discharge of an ovum from the ovary. The phase of the female monthly cycle when a developed egg is released from the ovary into the fallopian tube for possible fertilization.

Pansexual: A person who is fluid in sexual orientation and/or gender or sex identity.

PAP test: A screening test in which a sample of cells is taken from a woman’s cervix. The test is used to detect changes in the cells of the cervix.

Paraphilias: Impulse disorders (mental illnesses) that are characterized by recurrent and intense sexual fantasies, urges and behaviours. Paraphilias are considered deviant—outside of acceptable patterns of behaviour—because they involve unusual objects, activities or situations not considered sexually arousing to others.

Paraphimosis: A condition in which the foreskin of the penis, once retracted, cannot return to its original location.

Pass: Means to be in your preferred gender image and to be able to do so convincingly in the eyes of those around you, for example an FTM or cross dresser or drag king who looks like a man and not like a woman.

Paedophilia: A disorder in which a person has fantasies, urges or behaviours that involve sexual activity with a pre-pubescent child or children (generally age 13 years or younger).

Pelvic examination: An examination during which a doctor inserts a speculum (an instrument that lets the clinician see inside the vagina) and examines the vagina, cervix and uterus. The doctor will feel for any lumps or changes. A Pap test is usually done during a pelvic exam.

Pelvic inflammatory disease (PID): An infection of the female reproductive organs usually contracted through sexual contact.

Penectomy: The surgical removal of the penis. In a partial penectomy, part of the penis is removed. In a total penectomy, the whole penis is removed.

Penetration: The insertion of an erect penis into a woman’s vagina.

Penile cancer: Cancer of the penis.

Penis: One of the external structures of the male reproductive system, along with the scrotum and testicles.

Perineum: The space between the vagina and the opening of the rectum.

Peyronie’s disease: A condition in which a plaque, or hard lump, forms on the penis. The hardened plaque reduces flexibility, causing pain and forcing the penis to bend or arc during erection.

Phimosis: A condition in which the foreskin of the penis becomes constricted and difficult to retract.

Polyamory: The practice of having multiple open, honest love relationships.

Polycystic ovary syndrome (PCOS): A common disorder in women caused by a hormonal imbalance. Symptoms of PCOS include irregular or no periods, acne, obesity and excess hair growth. This disorder often prevents ovulation (the release of an oocyte by the ovary), leading to infertility.

Post-Op: A transsexual who has had their sex change operation and now has the physical anatomy which mimics that of the sex they have transitioned to.

Preconception care: A set of interventions that aim to identify and modify biomedical, behavioural, and social risks to a woman’s health or pregnancy outcome through prevention and management before pregnancy.

Premature ejaculation: Ejaculation that occurs before or soon after penetration.
Premenstrual dysphoric disorder (PMDD): A severe form of PMS. The symptoms of PMDD are similar to those of PMS, but are severe enough to interfere with work, social activities and relationships.

Premenstrual syndrome (PMS): A combination of physical and mood disturbances that occur after ovulation and normally end with the onset of the menstrual flow.

Pre-Op: A transsexual who has not yet had their sex change operation(s) but who ‘plans on having it/them.

Prepuce: The fold of skin that covers the head of the penis (also called the foreskin). Also the hood or covering of the clitoris.

Priapism: A persistent, often painful erection that can last from several hours to a few days.

Primary amenorrhea: A condition in which a young woman never gets her first period.

Progestosterone: A female hormone that acts to prepare the uterus (the womb) to receive and sustain a fertilized egg.

Prognosis: Chance of recovery from an injury or disease.

Prostate cancer: Cancer of the prostate gland.

Prostate gland: A male sex gland located below the bladder and in front of the rectum. About the size of walnut, the prostate makes a milky fluid that joins with sperm during ejaculation (when sperm and other fluids are expelled from the penis during orgasm).

Prostate-specific antigen (PSA) test: A test to screen for prostate cancer and to help monitor treatment.

Puberty: The stage of adolescence (pre-adolescent to early adolescence) in which a young person becomes physiologically capable of sexual reproduction.

Pubic lice: Tiny insects that live in the pubic hair and other hairy areas, except the scalp. Pubic lice are spread through close physical contact with someone who has them. They also are called “crabs.”

Queer: 1) An umbrella term used to refer to all LGBTIQ people. 2) A political statement, as well as a sexual orientation, which advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid. 3) A simple label to explain a complex set of sexual behaviours and desires. For example, a person who is attracted to multiple genders may identify as queer. Many older LGBT people feel the word has been hatefully used against them for too long and are reluctant to embrace it. 4) Originally a synonym for “odd”, this word became a derogatory expression for gays in the 20th Century. Even though many people still use “queer” as an anti-gay epithet, a movement emerged in the 1980s that calls itself queer. Used in this way, queer means sexually dissident, but not necessarily gay. Many gays, transsexuals, bisexuals and even heterosexuals whose sexuality doesn’t fit into the cultural standard of monogamous heterosexual marriage have adopted the “queer” label. In academic circles, the term “queer” often refers to the approaches and sensibilities of queer theory.

Questioning: Refers to people who are uncertain as to their sexual orientation or gender identity. They are often seeking information and support during this stage of their identity development.

R

Racism: Discrimination against people of colour that results from the white supremacy system of domination. Racism is prejudice plus institutional power.

Rainbow Flag: The Rainbow Freedom Flag was designed in 1978 by Gilbert Baker to designate the great diversity of the LGBTIQ community. It has been recognized by the International Flag Makers Association as the official flag of the LGBTIQ civil rights movement.

Rape: A situation when a person has sex with another person against his or her will.

Recurrent disease: A term used to describe a disease that has come back (recurred) after it has been treated.

Reduced libido (inhibited sexual desire): A decrease in desire for or interest in sexual activity.

Retrograde ejaculation: A condition that occurs when, at orgasm, the ejaculate is forced back into the bladder rather than through the urethra and out the end of the penis.

Rhythm: Also called natural family planning, rhythm is a method of birth control that focuses on learning to recognize the days a woman is fertile, and abstaining from sex before and during those days.

Risk factor: A factor that increases a person’s chance of developing a disease or predisposes a person to a certain condition.

S

Salpingo-oophorectomy (BSO): The removal of the fallopian tubes and ovaries.
**Sarcoma of the uterus:** Cancer of the muscle of the uterus.

**Scabies:** A skin condition caused by tiny mites that burrow under the skin, producing small red bumps and severe itching. The mites easily spread from person to person, especially among people who share close living spaces.

**Scrotum:** The sac of skin that surrounds the testicles.

**Secondary amenorrhea:** A condition in which a woman who has had normal menstrual cycles stops getting her monthly period.

**Self-Identify:** Refers to the process of people choosing with which identifying terms/groups they identify. (E.g. Someone could self-identify as male, female or bigendered, multi-racial, etc.)

**Semen:** The fluid containing sperm (the male reproductive cells) that is expelled (ejaculated) through the end of the penis when the man reaches sexual climax (orgasm).

**Seminal vesicles:** The sac-like pouches that attach to the vas deferens near the base of the urinary bladder. The seminal vesicles produce a sugar-rich fluid (fructose) that provides sperm with a source of energy and helps with the sperm’s motility (ability to move). The fluid of the seminal vesicles makes up most of the volume of a man’s ejaculatory fluid, or ejaculate.

**Seminiferous tubules:** Coiled masses of tubes within the testes that are responsible for producing the sperm cells through a process called spermatogenesis.

**Seminoma:** A type of testicular cancer that is made up of a single type of cell. Seminomas tend to be slow growing and occur most often when men are in their 40s.

**Sex (gender) reassignment surgery:** Surgery to change the appearance of a person’s anatomy to match as closely as possible the anatomy of the opposite sex.

**Sex Identity:** The sex that a person sees themselves as. This can include refusing to label oneself with a sex.

**Sex/Biological Sex:** The biological classification of bodies as male or female, based on factors including external sex organs, internal sexual and reproductive organs, hormones, and chromosomes. Such classification is not objective but heavily influenced by social stereotypes about the “right” shapes and functioning of body parts and their correspondence with the only socially accepted gender identities (female or male).

**Sex:** Refers to a person based on their anatomy (external genitalia, chromosomes, and internal reproductive system). Sex terms are male, female, transsexual, and intersex. Sex is biological, although social views and experiences of sex are cultural.

**Sexism:** Discrimination against women that results from the male supremacy system of oppression.

**Sex-Reassignment Surgery (SRS):** Sex change operation.

**Sexual abstinence:** A natural method of contraception whereby a man and woman refrain from sexual intercourse during the fertile phase of the menstrual cycle in order to avoid pregnancy. Abstinence offers no protection against sexually transmitted infections (STI) if practiced with an infected partner.

**Sexual addiction:** The behaviour of a person who has an unusually intense sex drive or obsession with sex.

**Sexual culture:** The intersection of values, beliefs, and social standards that regulate sexual behaviour within a specific society or community.

**Sexual diversity:** This term refers to the full range of sexuality which includes all aspects of sexual attraction, behaviour, identity, expression, orientation, relationships and response. It refers to all aspects of humans as sexual beings.

**Sexual dysfunction:** This refers to a problem during any phase of the sexual response cycle that prevents the individual or couple from experiencing satisfaction from the sexual activity.

**Sexual health:** Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Sexual health refers to the many factors that impact sexual function and reproduction. These factors include a variety of physical, mental and emotional issues. Disorders that affect any of these factors can impact a person's physical and emotional health, as well as his or her relationships and self-image.

**Sexual masochism:** A disorder in which a person uses sexual fantasies, urges or behaviours involving the act (real, not simulated) of being humiliated, beaten or otherwise made to suffer in order to achieve sexual excitement and climax.
Sexual minority: 1) Refers to members of sexual orientations or who engage in sexual activities that are not part of the mainstream. 2) Refers to members of sex groups that do not fall into the majority categories of male or female, such as intersexuals and transsexuals.

Sexual Orientation: A term used to refer to a person’s emotional, romantic and sexual attraction to individuals of a particular gender (male or female). The deep-seated direction of one’s sexual (erotic) attraction. It is on a continuum and not a set of absolute categories, sometimes referred to as affection orientation or sexuality. The direction of one’s sexual attraction toward the same sex (homosexual), other sex (heterosexual) or both sexes (bisexual). A person’s sexual orientation can change often or infrequently over the course of a person’s lifetime.

Sexual response cycle: The sequence of physical and emotional changes that occur as a person becomes sexually aroused and participates in sexually stimulating activities, including intercourse and masturbation. The sexual response cycle has four phases: excitement, plateau, orgasm and resolution.

Sexual sadism: A disorder in which a person has persistent fantasies in which sexual excitement results from inflicting psychological or physical suffering (including humiliation and terror) on a sexual partner.

Sexually transmitted disease (STD): A disease passed from one person to another by unprotected sexual contact. You can get a sexually transmitted disease from sexual activity that involves the mouth, anus or vagina.

Shaft of the penis: The long, slender cylinders of tissue inside the penis that contain spongy tissue and expand to produce erections.

Smegma: A thick, bad-smelling substance that results when oily secretions from the skin accumulate under the foreskin of the penis.

Socialized: Refers to the “training” process that takes place once birth sex is determined/decided upon. People whose birth sex is female are “socialized” as women although they may or may not self-identify as women.

Speculum: An instrument inserted into the vagina to allow the health care provider to view the inside of the vagina.

Sperm: The male reproductive cells.

Spermatogenesis: The process of producing sperm, the male reproductive cells.

Spermicide: Foams, jellies, tablets or suppositories that a woman places in her vagina and up next to the cervix (the opening leading from the vagina to the womb) before sex to prevent pregnancy. Spermicides block the cervix and paralyze the sperm, making them unable to travel into the womb.

SRS: Acronym for Sexual Reassignment Surgery, the surgery done by transsexuals to make their bodies and their sex identity match.

Stereotype: An exaggerated oversimplified belief about an entire group of people without regard for individual differences.

Sterilization: A form of contraception that involves surgically blocking the release of reproductive cells. In women, the fallopian tubes are block so that oocytes (eggs) cannot reach the uterus. In men, the tube that carries sperm from the testicle to the penis (vas deferens) is sealed, tied or cut (vasectomy).

Straight: A colloquial term for heterosexuals. Person who is attracted to a gender other than their own. [Commonly thought of as “attraction to the opposite gender,” but since there are not only two genders (see transgender), this definition is inaccurate.

Sunna circumcision: The removal of the tip of the clitoris and/or its hood or covering (prepuce).

Syphilis: A serious sexually transmitted disease (STD) that, without treatment, can lead to heart disease, nerve disorders, brain damage, mental disorders, blindness and death.

Testicles (testes; singular testis): Part of the male reproductive system, the testicles manufacture the male hormones, including testosterone, and produce sperm, the male reproductive cells. The testicles are located inside the scrotum, the loose sac of skin that hangs below the penis.

Testicular self-examinations (TSE): A procedure to detect changes in the testicles by rolling them between the fingers and thumbs of both hands to check for any lumps.

Testicular torsion: A condition in which the spermatic cord gets twisted around a testicle, cutting off the testicle’s blood supply. Symptoms of testicular torsion include sudden and severe pain, enlargement of the affected testicle, tenderness, and swelling. This condition requires emergency treatment.

Testosterone: The male hormone that is essential for sperm production and the development of male characteristics, including muscle mass and strength, fat distribution, bone mass and sex drive.
**The Pill:** A medication containing hormones that women take to prevent pregnancy.

**Trans Female/Woman:** A male-to-female transition (MTF). [The medical literature tends to use the extremely demeaning term "male transsexual" to mean the same thing. Note that you can tell the preferred form is in use when the gender word comes after the "T" word.]

**Trans Man/Male:** A female-to-male transition (FTM). [The medical literature tends to use the extremely demeaning term "female transsexual" to mean the same thing. Note that you can tell the preferred form is in use when the gender word comes after the "T" word.]

**Transgender:** 1) Transgender (sometimes shortened to trans or TG) people are those whose psychological self ("gender identity") differs from the social expectations for the physical sex they were born with. To understand this, one must understand the difference between biological sex, which is one's body (genitals, chromosomes, etc.), and social gender, which refers to levels of masculinity and femininity. Often, society conflates sex and gender, viewing them as the same thing. But, gender and sex are not the same thing. Transgender people are those whose psychological self ("gender identity") differs from the social expectations for the physical sex they were born with. For example, a female with a masculine gender identity or who identifies as a man. 2) An umbrella term for transsexuals, cross-dressers (transvestites), transgenderists, gender queers, and people who identify as neither female nor male and/or as neither a man or as a woman. Transgender is not a sexual orientation; transgender people may have any sexual orientation. It is important to acknowledge that while some people may fit under this definition of transgender, they may not identify as such.

**Transgenderist:** A person who lives either full time, or most of the time, in a gender role different than the role associated with their biological or chromosomal sex (a gender nonconformist).

**Transition:** A complicated, multi-step process that can take years as transsexuals align their anatomy with their sex identity; this process may ultimately include sex reassignment surgery (SRS).

**Transphobia:** 1) Discrimination, fear or hatred of people who blur traditional gender lines that results from the gender binary system. Often comes from one's own insecurity about being a "real man," or a "real woman." 2) Fear or hatred of transgender people; transphobia is manifested in a number of ways, including violence, harassment and discrimination.

**Transsexual:** Refers to a person who experiences a mismatch of the biological sex they were born as and the biological sex they identify as. A transsexual sometimes undergoes medical treatment to change his/her physical sex to match his/her sex identity through hormone treatments and/or surgically. [Transsexuals are included in the umbrella term transgender, but not all transgendered people are transsexual. See also gender, sex, transgender.]

**Transvestite/Cross Dresser:** Individuals who regularly or occasionally wear the clothing socially assigned to a gender not their own, but are usually comfortable with their anatomy and do not wish to change it (i.e. they are not transsexuals); the preferred term is **crossdresser.** Cross-dresser is the preferred term for men who enjoy or prefer women's clothing and social roles. Contrary to popular belief, the overwhelming majority of male cross-dressers identify as straight and often are married. Very few women call themselves cross dressers.

Note that the term "travesti" as used in Latin America is not a translation of "transvestite", as travestis usually live full-time in their self-defined gender identity and do not identify with the gender to which they were assigned at birth.

**Trichomoniasis:** An infection that most often occurs in a woman's vagina. A man also can get the infection in the urethra (the tube that carries urine out of the body), as well as in the prostate. It is caused by a tiny single-celled organism known as a "protozoa."

**Tubal ligation:** Surgery to "tie the tubes" (fallopian tubes) of a woman, which causes permanent sterility by preventing transport of the egg (ovum) to the uterus.

**Undescended testicle:** A condition in which the testicles do not descend from the abdomen, where they are located during development, to the scrotum shortly before birth. Also called cryptorchidism.

**Urethra:** The tube that carries urine from the bladder to outside of the body.

**Urinary tract infection (UTI):** A condition that occurs when bacteria from outside the body get into the urinary tract and cause infection and inflammation.

**Uterine fibroids:** Nodules of smooth muscle cells and fibrous connective tissue that develop within the wall of the uterus (womb). Medically, they are called uterine leiomyomata (singular: leiomyoma).

**Uterus:** The hollow, pear-shaped organ where a baby grows.
Vagina: The tube that joins the cervix (the lower part of uterus, or womb) to the outside of the body. It also is known as the birth canal.

Vaginal discharge: A clear or whitish fluid that comes out of the vagina. The uterus, cervix or vagina can produce the fluid. A foul-smelling, yellow or green discharge is abnormal and should be evaluated by a health care provider.

Vaginal intraepithelial neoplasia (VAIN): A condition that often begins as pre-cancerous changes in the surface cells of the vagina.

Vaginectomy: The surgical removal of the vagina. It is sometimes used to remove cancerous growths. If all or part of the vagina is removed, the vagina must be reconstructed using tissue from another part of the body.

Vaginismus: A painful, involuntary spasm of the muscles that surround the vaginal entrance.

Vaginitis: A medical term used to described various disorders that cause infection or inflammation of the vagina.

Vaginoplasty: A procedure in which the bulk of the penis tissue is removed, but the outer skin is reshaped, turned “inside out” and inserted into the body to form a vagina. This procedure is done during male to female gender reassignment surgery.

Vas deferens: The long, muscular tube that travels from the epididymis into the pelvic cavity, to just behind the urinary bladder. The vas deferens transports mature sperm to the urethra in preparation for ejaculation.

Vasculitis: An inflammation of blood or lymphatic vessels. This inflammation can lead to the formation of scar tissue.

Vasectomy: A permanent sterilization procedure for men. The operation, usually done in a physician’s office, requires cutting and sealing the vas deferens, the tubes in the male reproductive system that carry sperm. A vasectomy prevents the transport of sperm out of the testes.

Viral vaginitis: A form of vaginitis (infection or inflammation of the vagina) caused by viral infection. One form caused by the herpes simplex virus (HSV) is often just called “herpes” infection. These infections also are spread by sexual contact.

Virus: A microorganism (germ) that causes various infections.

Voyeurism: A disorder that involves achieving sexual arousal by observing an unsuspecting and non-consenting person who is undressing or unclothed, and/or engaged in sexual activity.

Vulva or pudendum: The area of skin between a woman’s legs that includes all of the visible (external) organs of reproduction.

Vulvar intraepithelial neoplasia (VIN): Pre-cancerous changes in the surface cells of the vulva. Also called dysplasia.

Vulvectomy: Removal of the vulva. Skinning vulvectomy is a procedure in which the skin of the vulva that contains the cancer is removed. Simple vulvectomy is a procedure in which the entire vulva is removed, but no lymph nodes. Partial vulvectomy is a procedure that removes less than the entire vulva. Radical vulvectomy is a procedure in which the entire vulva is removed, and lymph nodes in the groin usually are removed.

Vulvovaginitis: Inflammation of both the vagina and vulva (the external female genitals).

Yeast infections: Infections of the vagina caused by one of the many species of fungus called Candida. A change in the chemical balance in the vagina allows the fungus to grow too rapidly and cause symptoms.
Cana Movement
Cana Movement is an organisation of people who have the family at heart. It is a voluntary organisation within the Catholic Church of Malta. Cana Movement provide a counselling service in a Christian perspective that accompanies people on their journey towards their fulfilment as individuals and members of healthy families and communities. The objectives of this service are:
• to help couples prepare for marriage;
• to help couples or individuals who are facing difficulties in their relationships;
• to help couples strengthen their marriage and their family.

More often than not, people seek help when they feel that they have outdone all their resources in managing a situation by themselves. However, this might be too late in the day as therapy works best when the problems are not so entrenched that it would be difficult to work through them.

The counsellors are trained to deal with relationship issues. At various point throughout the lifespan of a relationship, difficulties may arise. Couple who are deciding to get married might wish to iron out certain difficulties that they might have before they go along with the marriage plans. Once the couple get married, they might need help to adjust to married life and perhaps learn how to be husband and wife. Eventually should the couple have children, they might need help to go through that transition in order to maintain their marital relationship alive despite the transition to parenthood. Of course, couples may face other problems such as infidelity, the death of a spouse or child, infertility, financial problems etc. that would necessitate counselling. Should the unfortunate circumstance happen that the marriage breakdowns, persons who are undergoing separation may also access Cana services to get help to come to terms with the loss and pain and to adjust to their new reality.

One may access the service by phone on 21238942 or 21238068. A receptionist will answer the phone and gives an appointment with one of the counsellors. Alternatively one can drop in at Cana at the Catholic Institute, Floriana and make a booking with reception in person.

The opening hours for Cana are Monday to Friday 9.00am – 1.00pm and 4.00pm – 7.00pm.

However some counsellors also offer their services on a Saturday. In addition, a counselling service is also provided at Cana house in Paola for people who would find it more convenient to access the service there.

The Cana counselling service is free of charge. However clients are invited to make a voluntary contribution that goes towards Cana Movement funds.

Cana Movement
Catholic Institute, St. Publius Street, Floriana FRN 1441
Tel: 2123 8942
2123 8068
22039300
Email: info@canamovement.org
Web: www.canamovement.org

Coordinating Centre for Sexuality and Sexual Health Research
Sexual Health Research Programme
Faculty of Health Sciences
University of Malta

Mater Dei Hospital
Block A, Floor 1, Rm 70
L-Imsida – MSD 2080
Coordinator: Dr Roderick Bugeja
Telephone: 23401165
Mobile: 99896308
Email address: roderick.bugeja@um.edu.mt

Curriculum Management and eLearning Department
The Curriculum Centre
Humanities Section, PSD Education Officers
Triq Sarria, Floriana
Tel: 2598 2606 / 2598 2607
Email: eau@gov.mt
www.curriculum.gov.mt/information.htm

Sources of help & information

Dar Ġużeppa Debono
Situated in Gozo, Dar Ġużeppa Debono is a Church run, Non Governmental Organisation, which caters and provide help for single mothers and fathers, and promoting the value of life as from conception and the importance of healthy relationships in our lives. Professionals and others volunteers working at Dar Ġużeppa Debono support single mothers who generally are under shock at the news of an unplanned pregnancy, and educate young and adults alike to learn respect themselves and the life of an unborn child.

Dar Ġużeppa Debono provides:
• A residential services to teenage mothers who might wish to have an alternative residence apart their home. The main aim is to give all the privacy that is required by the teenage mother who wants to be relieved from social pressures that might be daunting her.
• A social work service for unmarried mothers, fathers and their respective families. This service is also offered to single mothers who are either separated or widowed.
• Parenting skills courses offered to couples who have or are expecting a baby out of wedlock. Individual attention to each and every couple is guaranteed which offers flexibility in choosing the most appropriate days and times for the meeting to take place.
• Support for couples who have or else are expecting a baby out of wedlock. During these meetings the couple will be taught about the various phases in the relationship and will be helped to identify in which phase they currently are. The couple is helped to adapt to the sudden big change that a baby brings with him/her.
• Support groups for teenage mothers where they meet and share their opinions and experiences with the others and above all are listened to and given the support required. The idea of a group instil in these people a sense of strength and courage to share one’s own personal experiences with others. Above all, every person is seen as a unique person having its own personal life and experiences.
• A Fostering Course for those who wish to be foster carers is provided by the foster care team at ‘Appogg’ which offer exceptional courses at ‘Dar Ġużeppa Debono’ home.
• Home – Start is a service run by trained volunteers who are monitored closely. The volunteers visit families and offer practical and emotional support to help couples strengthen their marriage and their family alike to learn respect themselves and the life of an unborn child.

Sources of help & information 125
support. The service is targeted for families having at least one child under five years of age. Having a young child can cause a certain amount of stress for parents who may not be equipped to deal with the constant needs of the child. This situation could arise because of various factors – isolation of the parents, post-natal depression, serious financial constraints, health reasons, and many others.

For further information contact or visit:
Dar Ġużeppa Debono, Lourdes Street, Ghajnsielem (Gozo) GSM 2200 Phone: +356 21515295 email: info@darguzeppadebono.org
www.darguzeppadebono.org

Drachma – A Catholic Space for LGBT
Drachma is a group of gay, lesbian, bi-sexual and transgender (LGBT) people who meet to pray. It is a safe place where LGBT people can focus on the love of God for us – no matter who or what we are. Drachma is a place where people search for what brings us together rather than what divides us. Drachma is an inclusive group so any one desiring an experience of prayer can join. Persons who are not LGBT are also welcome to join.

Email: drachmalgbt@gmail.com
Blog: www.drachmalgbt.blogspot.com

Drachma Parents Group
The Drachma Parents’ Group is a Christian organisation established in April 2008 and meets once a month at Mt St Joseph Retreat House, Mosta. The group is committed to encourage and uphold LGBT people and their families in an effort to create more awareness of the difficulties faced because of the stigma society unfortunately attaches to persons with a different sexual orientation.

For more information contact Drachma on:
Mob: 7944 2317
Email: drachmalgbt@gmail.com

Genito Urinary Clinic (GU Clinic)
In Malta and Gozo there is one Genito Urinary Clinic, also known as the GU clinic, which delivers a specialist medical service in the treatment of sexually transmitted infections as part of the National Health Service programme. Thus, screening, treatment and counselling is given FREE to ALL (Maltese and tourists) at the Out-patients Department, Mater Dei Hospital.

Services delivered at the clinic include:
• Diagnosis and treatment of Sexually Transmitted Infections
• Counselling and testing for HIV
• Other genital conditions not necessarily sexually acquired

Unlike other clinics patients do not need a doctor’s referral ticket. Patients can refer themselves to the GU clinic by phoning the clinic for an appointment (Tel. 21227981), without having to be referred by a family doctor. About 80% of patients who attend the GU clinic are self-referrals. The clinic operates on the essential factor of ABSOLUTE CONFIDENTIALITY: No information is given to ANYBODY without the patient’s EXPRESS (and written) permission. All patients are given a unique code number, and only this number appears on all request forms. Patients can therefore confidently leave their contact details.

Genito Urinary (GU) Clinic
Mater Dei Hospital, Out-patients Department (Level 1)
To book an appointment call telephone no. 21227981.

HOPE – Crisis Pregnancy Support
In Malta, a crisis pregnancy support group called HOPE, which is one of the branches of the pro-life movement Gift of Life, seeks to help pregnant women who are considering a termination. This group adopts a non-judgemental approach and speak to mothers-to-be in strict confidentiality to help them make informed decisions by providing them with support and information about pregnancy and foetal development, as well as available support and options. Hope provides free pregnancy testing and non-diagnostic ultrasound scanning, referrals (obstetric, gynaecological and social), as well as referrals for professional support to women who have experienced pregnancy loss through abortion, emotional support, practical assistance and support, and psychotherapy. The support group also offers maternity and baby items.

For further information contact or visit: +356 21418055 hope@ifemalta.org

Infectious Disease Prevention and Control Unit
The Infectious Disease Prevention and Control Unit (IDCU) is the only centre in Malta dealing with surveillance of infectious diseases. Data is collected from various sources, including medical doctors, laboratories and through our surveillance systems in order to provide more information on prevailing issues in infectious diseases. The unit is also responsible for managing outbreaks of infectious diseases as well as to provide data on infectious diseases to the local and international scientific community.

The objectives of the IDCU are:
• To undertake surveillance of communicable diseases in Malta.
• To improve reporting of notifiable diseases by creating methods that would encourage early notification.
• To disseminate relevant, accurate and timely information.
• To undertake responsibility for the control of infection through timely investigation and management of incidents of communicable diseases.

• To undertake epidemiological research.
• To provide advice on communicable diseases to health professionals and the general public.
• To contribute to training in communicable disease control.

The Director, Health Promotion and Disease Prevention Directorate, 5B, The Emporium, Triq C. De Brocktorff, L-Imsida MSD 1421
Phone: During office hours: 232666112
Out of office hours: 21332235
email: disease.surveillance@gov.mt

Kellimni.com
Kellimni is a joint effort between SOS Malta, Salesian’s of Don Bosco, Agenzija Zghazagh and Agenzija Appogg, who are seeing the realisation of setting up a local child and adolescent online support service, under the guidance of Child Helpline International.

Kellimni.com offer one-to-one, real-time telephony and online help, support services and counselling to children and adolescents who are suffering from any form of social exclusion, abuse, neglect, and/or psychological difficulties and are in need of immediate emotional, moral and social support.

This project aims that all young people have the opportunity to voice their concerns, express and realize their rights through which medium of communication they would feel most comfortable or available to them.

The service being offered is encompassing mainly on a child and adolescents online support targeting more youths and adolescents through www.kellimni.com. The Kellimni staff can be reached through e-mail, chat and forums for support. Kellimni.com is aimed at children and youths who want someone to listen to them and who can provide assistance. It will allow service users to express their concerns and talk about the issues directly affecting them. Young people need to know that they are not alone, that someone outside of their immediate surroundings cares about them, that their life can be free from pain and fear. The service is providing an opportunity to all young people to reach out for help and support through frequently and easily accessible channels of communication.

Malta Gay Rights Movement
The Malta Gay Rights Movement was set up in June 2001 with the mission to achieve full equality for LGBT people in Maltese society; a society that enables people to live openly and fully without fear of discrimination based on one’s sexual orientation, gender identity and gender expression.

If at any time a person requires support or wishes to express his/her thoughts freely to an understanding person he/she can, send an email on: support@maltagayrights.org
One may also call the National Gay Helpline, run by MGRM
Tel: 21430006
Mob: 99255559
Malta Gay Rights Movement (MGRM)
32, Parish Street, Mosta – MST 2021

Rachel's Vineyard
Rachel's Vineyard offer a healing service after abortion. The program is an opportunity for people who had undergone an abortion to examine their abortion experience, identify the ways that the loss has impacted on them in the past and present, and helps to acknowledge any unresolved feelings that many individuals struggle with after abortion. Because of the emotional numbness and secrecy that often surrounds an abortion experience, conflicting emotions both during and after the event may remain unresolved. These buried feelings can surface later and may be symptoms of post abortion trauma.

Married couples, mothers, fathers, grandparents and siblings of aborted children, as well as persons who have been involved in the abortion industry have come to Rachel's Vineyard in search of peace and inner healing.

Nina or Chris Sansone on 7924 8842
Email: chrissansone@onvol.net

Servizz Għożża
Servizz Ghozza provides a support service and an educational programme to unmarried pregnant minors, leading them to adopt a positive attitude towards motherhood while empowering them to pursue their career path. The main services offered are:
- guidance and counselling to pregnant girls under eighteen, their boyfriends and their parents as required;
- psychological, moral and educational support;
- support to girls both before and after the birth of the child;
- programmes in three main areas; namely,
  - to prepare these girls to become mothers, the process of pregnancy, preparation to give birth, baby care, parenting skills;
  - A programme based on self-development with the aim of enhancing interpersonal skills.
  - Educational programmes aimed at enhancing their academic development.
- Providing a service to the young unmarried mothers through:
  - Support in guidance and counselling sessions both individually and within group support.
  - Various inputs to enhance parenting skills and issues relating to child development.
  - Facilitating contacts and the support of, other relevant organisations and services for the benefit of both schoolgirl mother and child;
  - Liaising with, and advising, school administrators regarding pregnant students according to specific needs of case.

Ms Margaret Magri - margaret.magri@educ.gov.mt
Ms Josanne Grech - josanne.a.grech@gov.mt
Ms Elenaore Marrama - eleonore.marmara@gov.mt
Address: Servizz Ghozza
Fredrick Maempel Square, Hal Qormi, QRM 1515
Telephone: 21 243869

Referrals: Students themselves, parents, the Heads of Schools, the Guidance Teacher, School Counsellors, Education Officer, other teachers.


Useful Websites

World Health Organization. /EIP Burden of Disease Projections

European Centre for Disease Prevention and Control
www.ecdc.europa.eu

Eurosurveillance Journal
hww.eurosurveillance.org