National SEXUALHEALTH Strategy

2025-2030

GOVERNMENT OF MALTA
MINISTRY FOR HEALTH
AND ACTIVE AGEING

FOREWORD

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This is the second National Sexual Health Strategy to be published with an aim to set the policy and strategic direction with regards the sexual and reproductive health and reproductive rights in the Maltese population for the next six years. The first policy and strategy has set the stage for sexual health in terms of prevention, education, health promotion, and sexual health services including treatment appropriate to the context at the time; however, much has changed since then in terms of the population's demography, behaviour, health needs and demands, opportunities, advances in diagnostics, prevention and treatment and possible future challenges.

The latest census showed that more than a quarter of Maltese residents were foreign born with possibly different socio-cultural norms and attitudes in terms of sexual and reproductive health matters. There has been a notable five time increase in migrants over that of the previous decade with these tending to reside in the Northern and Northern Harbour areas of the Island (1) also reflected in the progressive increase in non-Maltese workers in the labour market. Malta is also a hub for over 2 million tourists annually who may form part of our community for weeks or months at a stretch. (2) Prevalent gender and sexual norms, access to contraception, and family-friendly policies are all important factors to enable women's participation in the work force. In the legal realm, a number of changes took place such as lowering of the age of sexual consent from 18 years to 16 years, and reforms to protect persons from gender-based discrimination and violence.

Throughout this last decade, Malta has championed legislative changes for legal gender recognition, marriage equality, non-discrimination legislation on the basis of gender, gender identity and expression, sexual orientation or sex characteristics. Evidence-based and research-based gender affirming health care services have been made available for transgender persons wishing to access gender affirming medical care. The entitlement of state-funded IVF services to include a broader definition of parent/s made these more inclusive of the realities Maltese society is composed of today. This is just a mention of the notable social, economic, cultural and legislative changes which have shaped and continue to influence the health-related behaviours of our population in this decade. As a result, the sexual health needs and rights (SRHR) of the population have been prioritised including measures in relation to sexual health for specific groups which are prominently referred to in other government strategies- in the LGBTIQ+ Equality Strategy and Action Plan 2023-2027 (3) and also the Gender Equality

and Mainstreaming Strategy and Action Plan 2022-2027. (4) One must not forget the plight of persons who still suffer any form of gender-based violence including sexual violence and intimate partner violence.

As a basis for the development of this strategy, quantitative research on the Social Determinants of Sexual and Reproductive Health was carried out between 2022/2023 within the context of ESF 02.065 Project 'Establishing a National Platform to address the Social Determinants of Health' through which updated information as regards the Sexual Health knowledge, attitudes, behaviour and needs of a representative sample of the Maltese population was collected and analysed. This recent national research, other local research, international literature and evidence-based guidance, together with stakeholder feedback was used to compile this document for consultation.

Sexual health and wellbeing are tackled through a positive perspective. Sexual health and also reproductive rights are characterised in terms of the current burden, current needs, current social norms and also the challenges encountered by key population groups in accessing sexual health services whilst ensuring having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The general public and civil society organisations are invited to use this opportunity to provide feedback on the measures proposed in this initial consultation document. Only in this way would we be able to develop patient-centered services, including preventative, screening and clinical services which meet the requirements of the population today. A focus is made on the needs of key populations such as migrants and LGBTIQ+ persons, amongst others, and also persons with disabilities in line with international obligations and standards (5–7) to ensure that the sexual health needs of all are truly met.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CSE	Comprehensive Sexuality Education
ECDC	European Centre for Disease Prevention and Control
EHIS	European Health Interview Survey
EMIS	The European MSM Internet Survey
ESF	European Social Fund
GU	Genito-Urinary
HBSC	Health Behaviour in School-aged Children
HIV	Human Immunodeficiency Virus
HPDP	Health Promotion and Disease Prevention Directorate
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development Programme of Action
IDCU	Infectious Disease and Control Unit
IUSTI	International Union Against Sexually Transmitted Infections
IVDU	Intravenous drug use/r
LGBTIQ+	Lesbian, Gay, Bisexual, Trans and Gender diverse, Intersex and Queer
MHA	Ministry for Health and Active Ageing
MSM	Men Who have Sex with Men
NGO	Non-Governmental Organization
NGU	Non-Gonococcal Urethritis
NMC	National Minimum Curriculum
NSHS	National Sexual Health Survey
NSU	Non-Specific Urethritis
PEP	HIV Post Exposure Prophylaxis
PLHIV	Persons living with HIV
PSCD	Personal, Social and Career Development
PrEP	HIV Pre-Exposure Prophylaxis
PWID	People Who Injects Drugs
SRE	Sexuality and Relationships Education
SRHR	Sexual and Reproductive Health and Reproductive Rights
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
U=U	Undetectable = Untransmittable
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organisation

Chapter 1
Definition of Sexual Health

Cognisant of the landmark definition of sexual health as developed during the International Conference on Population and Development (1994), (8) the working definition of sexual health for this Strategy is the current one adopted by WHO.

> "*…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive 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.*" (WHO, 2006a) (9)

Rights critical to the realisation of sexual health include:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

The responsible exercise of human rights requires that all persons respect the rights of others." (9)

Whereas this document limits itself to the male and female sex, this strategy shall seek to implement measures applicable to persons of all genders which is consistent with research and policy. It is also recognised that while women are the predominant gender to undergo pregnancy and childbirth, people of different genders may also share this experience.

Policy Context

Nearly three decades ago, the International Conference on Population and Development shifted the focus from populations and numbers to an emphasis on human rights, particularly those of gender equality and non-discrimination. Female empowerment and equity were recognised as important targets to strive towards and were highlighted as an integral part of universal human rights in themselves. This Programme for Action included the right of every person to achieve one's highest attainable standard of physical and mental health with the signatory states encouraged to adopt policies to ensure that all have universal access to health services including those related to reproductive health services including family planning services and sexual health. (8)

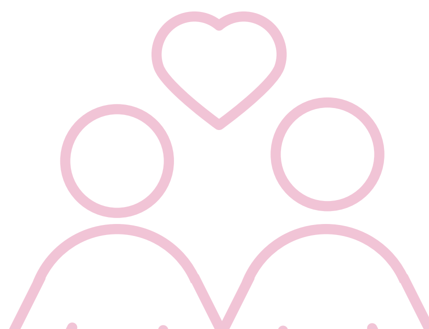
This conceptual framework for Sexual and Reproductive Health and Reproductive Rights (SRHR) was reaffirmed in the Beijing declaration of September 1995 (10) and subsequently adopted by the World Health Organisation as "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes. (11)"

SRHR is considered to encompass a wide range of health issues including family planning; maternal and newborn health care; prevention, diagnosis, and treatment of sexually transmitted infections (STIs), including HIV; adolescent SRH; cervical cancer screening; infertility prevention and management. These services aim at preventing poor SRH, such as complications of pregnancy and childbirth, unintended pregnancies, unsafe abortions, complications caused by STIs, sexual violence and women dying from avoidable cancer.

This context formed the backdrop for the first regional strategy of the WHO European Region which provided the framework for many countries in the Region to formulate their own national policy documents. Also cognisant of the International Labour Organisation Convention's recommendation on HIV and AIDS, which puts value on the role of work and the workplace in the fight against HIV and AIDS. This reaffirms the commitment to integrate policies on HIV and AIDS in workplace policies ensuring access to preventative, treatment, support services and also occupational health and safety procedures in place in the workplace. (12)

The 2016 WHO European Region Action Plan for Sexual and Reproductive Health (11) document draws from the Health 2020 (13) to combat inequalities through cross-sectoral action and a health in all policies approach together with strong commitment for 'leaving no one behind' by adopting the 2030 Agenda for the related Sustainable Development Goals (14) with member states having committed towards the following SDG targets:

> ***SDG Target 3.7*** *"ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030".*
>
> ***SDG Target 5.6*** *"ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the ICPD Programme of Action and the Beijing Platform for Action and the outcome documents of their review conferences".*



Vision

The vision for the Sexual Health Strategy 2025-2030 is in line with that for the WHO European Region, whereby all the Maltese population regardless of sex, age, gender, sexual orientation, gender identity, socio-economic condition, culture and ethnicity, and legal status is enabled and supported to achieve sexual and reproductive health and wellbeing with a focus on respect of one's sexual and reproductive rights and a commitment to create an enabling environment through intersectoral action and by tackling inequities.

Strategic Direction

In line with the WHO European Region Action Plan (11) on the development of SRHR policy throughout the life course, the steps in this policy process are as follows:

1. Perform a situation analysis to allow current local epidemiology and trends in sexual and reproductive health to guide policy priorities. To include non-exhaustive qualitative interviews with key stakeholders working in this field.
2. Strengthen and integrate health services including prevention, in order to provide high-impact and evidence-based interventions and universal health coverage targeted to the population's needs.
3. Ensure broad cross-governmental and cross-sectoral participation and ownership.
4. Improve leadership and participatory governance for health in the policy framework and in the implementation of the policy measures.
5. Enhance and improve information, evidence and accountability. Promote innovation.

Methodology

The process of compiling this policy started with the evaluation of the surveillance data with respect to STIs, HIV and health service use trends through various sources of routine data collection. The direct impact of the COVID-19 pandemic and response on laboratory capacity for testing during the acute phase of the pandemic in Malta must also be noted when interpreting the data within this document. Stakeholder meetings were held with several clinicians specialised in infectious diseases, urology, genito-urinary medicine, public health, NGOs, and representatives from the education sector to gather feedback as regards the gaps which required to be addressed.

Current government policy documents relating to this area were reviewed in order to identify measures related to sexual and reproductive health which were highlighted for action in their respective plans.

The Ministry for Health through ESF project 02.065 on 'Establishing a National Platform to address the Social Determinants of Health' commissioned research with an aim to carry out comprehensive quantitative research based on the Social Determinants of Sexual and Reproductive Health. This provided the latest data on sexual health knowledge, attitudes and practices across the general population. The main findings from this research were used in the compilation of this document.

Overview of the Quantitative Research on the Social Determinants of Sexual and Reproductive Health

The overarching aim of this research project was to update the national epidemiological data available as regards to sexual and reproductive health indicators and where possible compare these to the National Sexual Health Survey carried out in 2012. This feedback was also used to inform the strategy and action plan.

The objectives of the study were as follows:

- To explore the knowledge and perceptions in terms of sexual and reproductive health education of the Maltese population in both formal and non-formal means including the role of the internet and social media (sexual media).
- To characterise the patterns of sexual and reproductive risk behaviour and also analyse these according to the Social Determinants of Health.
- To obtain self-reported estimates of sexual and reproductive health outcomes for example pregnancy, contraceptive use, STIs, sexual dysfunctions amongst others.
- To explore perceptions and attitudes in relation to available sexual health services and what constitutes quality service provision.
- To identify & characterise the sexual and reproductive health needs and demands of the Maltese population.
- To investigate the enabling factors and barriers related to access and utilisation of sexual health services.

A survey tool was designed and piloted as a computer assisted personal interview or one which could be completed online and the fieldwork for this research took place between October 2022 and January 2023. For this survey there were 2123 participants of the Maltese population aged between 16-70 years of age. The participants required to be residents in Malta for at least 6 months and they were recruited in accordance with a sampling grid to ensure that the results would be representative of the Maltese population.

The survey tool comprised four domains including knowledge, attitudes, behaviours and needs of the population. The variables included in the survey included:

- Personal Sexual Experiences
- Contraception and STI Protection
- Sexual and Reproductive Health
- Reproductive Rights and Justice
- Sexual Violence
- Alcohol, Drugs, Chemsex and Paid Sexual Experiences

The participants were recruited via online and social media advertisements, directly through recruiters, workplaces and also through telephone calls. A total of 11,383 attempts at recruitment were made which works out to a response rate of 18.6%.

The majority of the study population were female (63%) with 35% of males participating and the remaining 2% of the respondents comprising persons who did not wish to indicate a gender, or were gender queer, gender non-conforming or gender fluid. Throughout this document, in view of the low representation of gender minorities in this survey, results were only presented for male and female respondents in order to permit generalisability of the findings.

The age and gender distribution of the respondents can be noted in Figure 1 below:

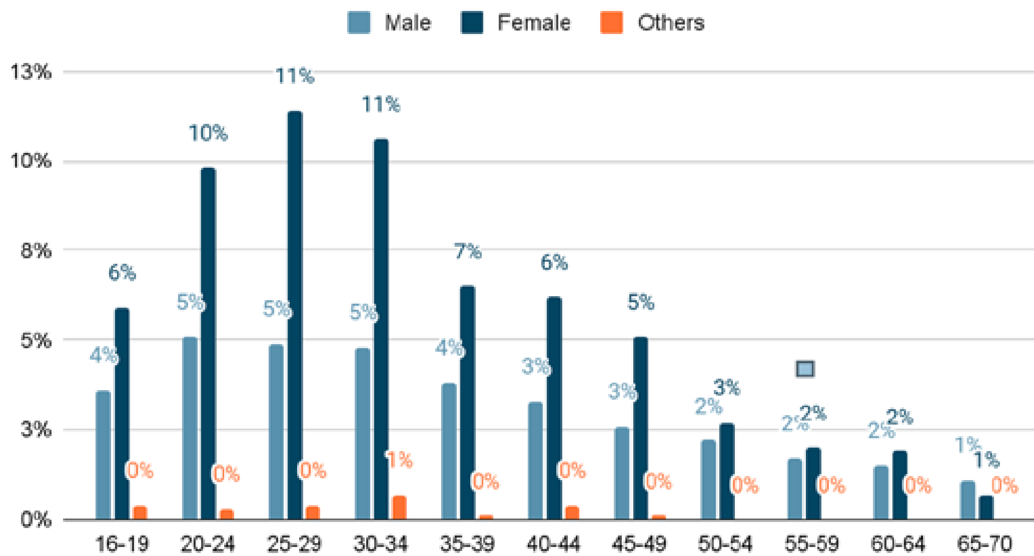


Figure 1 Study population according to age and gender distribution.

Around 44.8% of the respondents had a bachelor's or masters level degree with 2.8% holding a doctorate level degree. Over three quarters of the sample population were actively employed, with 10.8% being students or student workers. Around 8% of the respondents were non-European residents.

Findings from this survey are used throughout this document to inform the context and the strategic measures proposed.

Priorities for Policy Action

The initial policy exercise has highlighted five main priority areas for action with each priority area comprising several measures for action. Finally, the key populations have been identified either by virtue of their increased burden of illness, specific needs or as a group who may face additional barriers to achieve their full health potential.

- **Health Promotion, Prevention and Education**
- **Medical Services-Screening, Management, Treatment, Organisation of Health Services**
- **Reproductive Health Needs- Family planning & Contraception**
- **Key populations**
- **Governance, Innovation and Research**

Chapter 2
Health Promotion, Prevention and Education

The right to good quality sexuality education is established as one of the internationally accepted human rights, particularly the right to access appropriate health-related information, and has been confirmed by various international treaties and conventions. (10,15–18) It is therefore essential that the provision of good quality, easily accessible sexuality and relationship education is facilitated and accessible for the whole population. This will ensure that individuals will be enabled to make responsible and informed decisions about their sexual health.

In Malta, the 'National Minimum Curriculum' (NMC) is the legal framework that establishes the parameters within which every school is empowered to design and propose an educational provision that meets its particular curricular needs and the needs of the students. 'A National Curriculum Framework for All' (19) continues to emphasise the need that students and young persons are equipped 'with the necessary knowledge, attitudes and skills which they will need to maintain, promote and enhance physical, emotional, psychological and social well-being throughout their school life and as lifelong learners'.

In Maltese schools, Sexuality and Relationships Education (SRE) is delivered mainly as part of the Personal, Social and Career Development (PSCD) Curriculum, starting in Grade 4 and continuing up till Grade 11 (ages 8-16 years). SRE topics are also, however, addressed during other subjects including Science, Biology and Religion lessons thus is important that all educators of related subjects are able to effectively respond to the students' queries in terms of SRE.

Children and young people who do not receive high-quality, age and developmentally appropriate sexuality and relationship education may be left vulnerable to harmful sexual behaviours (20) and sexual exploitation especially when taking into consideration the greater exposure that exists nowadays to sexually explicit material through the Internet and other media. (21) The best approach where children and young people are concerned is through the provision of comprehensive sexuality education (CSE) starting in the younger age groups.

The aim of CSE is to develop and strengthen the ability of children and young people to make conscious, safe, healthy, and respectful choices regarding relationships, sexuality, and emotional and physical health through a curriculum-based process of teaching. (22) This applies a learner-centered approach and provides age-appropriate and phased education on topics ranging from emotional relations and responsibilities to human sexual anatomy, sexual activity, sexual reproduction, age of consent, safe sex and birth control. (21) This also promotes safer sexual behaviours such as encouraging good, open communication with partner/s, seeking testing for STIs where appropriate. It also provides an opportunity to present sexuality with a positive lens, emphasising values such as respect, inclusion, non-discrimination, equality, empathy, consent, responsibility and reciprocity. (20)

Sexuality education does not encourage children and young people to have sex. On the contrary, it has been shown to help students and young persons to delay the onset of sexual activity and reduce the risk of infections and teen pregnancy, as well as to give them the necessary skills to make informed choices about abstinence and contraception. (22)

Parental involvement in the delivery of a successful CSE programme is important. Where possible parental concerns should be considered from the outset of the delivery of a programme and addressed where feasible. Tools for educators to empower parents to be able to support their child include: concurrent CSE sessions for parents, equipping parents with correct information sources, and discussing specific difficult scenarios in relation to sexuality which they may encounter and how best to respond. (23)

Sex education in schools was cited as the most prominent source from where the respondents of the National Sexual Health Survey (NSHS) received information as regards sexual practices[1] through formal SRE in schools. Partners were also a prominent source from where the survey respondents received information, with this influence starting in the mid-twenties and continuing along the life course. An interesting gender difference to note is that female respondents were more likely to acquire their related knowledge from SRE and partners whilst males respondants mentioned pornography and friends as their primary sources of information.

Whilst sex education provided from schools was a primary element in provision of information on sexual activity, it was the least relevant entity as to how respondents got their information on sexually transmitted infections (16%). The most relevant information source cited was printed material (42%) followed by family (40%), online information/ websites (39%), friends (37%) and health professionals (35%). Parents were not selected as being a prominent information source for respondents for either knowledge as regards to sexual practices and also knowledge related to STIs.

Sexual media content and its effect on wellbeing and health

Children and youth are inundated by information (or misinformation) through internet, social media, and websites. Not all have the ability and maturity to discern and verify the reliability of the information being provided. Many factors contribute to developing sexual attitudes, beliefs, and behaviour, including early sexual debut. New technologies have expanded, and social media has displayed problematic content of beliefs and behaviours among viewers. According to the latest statistics, over 95% of the Maltese population used social media, a proportion which has increased by 5% since January 2020. (24) Sexual socialisation, sexual interest and activity are part of adolescent development, however, given the vast exposure

[1] The sexual practices referred to in the survey included masturbation, oral sex, anal sex, vaginal sex and use of sex toys.

and increased amount of time youth spend online, this further increases the potential to influence behaviours. The NSHS questions in relation to online sexual behaviour showed that nearly a quarter (24%) of the respondents participated in sexting (sexual-related chats) and around one in five (19%) of the respondents had sent sexually explicit photos of their body to others. Around 16% of the respondents had met a sexual partner in person following an initial encounter online, with around 14% of the participants reporting use of dating apps for romantic or sexual encounters.

Sexting is an example of how technology and sex are incorporated. Sexting involves the exchange of sexual content (text or images) via a mobile phone or the internet. Although it can start as part of a romantic relationship, it can develop into a risk of dispersed naked images all over social media. (25) Furthermore, online pornography[2] is always available at hand and can be accessible all the time at any place. It is very easy for viewers, especially youths, to be influenced on sexual expectations. People who closely work with youths should be able to identify potential opportunities to improve adolescent sexual health through digital media. There has been an increased demand for reliable information which empowers them to make informed decisions in a world that poses many challenges and educational opportunities where sexuality and relationships are concerned.

The BeSmartOnline! Project (launched in 2010 and still ongoing) is a project which aims to educate the public as regards inappropriate content on the internet and social media. This is coordinated by a consortium led by the Foundation for Social Welfare Services within the Ministry for Social Policy and Children's Rights and includes the Directorate for the Learning and Assessment Programmes (Ministry for Education, Sport, Youth, Research and Innovation), Office of the Commissioner for Children and the Cyber Crime Unit (Malta Police Force). The objectives of this project include the provision of training to children and youth and also to

[2] Any involvement (viewing, distribution) in pornography involving minors is illegal in Malta.

professionals who work with them and delivering information campaigns through various channels to the general public. In addition, there is the possibility for reporting of inappropriate content through a freephone, email and web reporting system which can be accessed from their website https://www.besmartonline.org.mt/ .(26)

To eliminate menstrual stigma and tackle gender inequalities the Human Rights Integration Directorate hosted a conference on menstrual stigma during 2023. It was announced that further education on destigmatising menstruation would take place through PSCD lessons. Funding has been allocated to the *End the Stigma. Period.* campaign. As part of this campaign and to end the stigma surrounding periods in those who menstruate, a pilot initiative was launched this scholastic year, whereby three secondary schools were fitted with dispensers providing free menstrual products for their students. This will be rolled out at a national level following completion of the pilot project.

The needs for sexual health education and promotion, however, never stop. It is therefore necessary to ensure that all individuals, no matter their age and across the life course, can have access to reliable, evidence-based and research-based information and support at any moment that they require it by individuals who are properly trained to provide it and using channels and technologies which are most accessible to them. The Sexual Health Promotion Unit within the Health Promotion and Disease Prevention Directorate are responsible for various campaigns throughout the year promoting wellbeing in terms of sexual health for all. These are pitched at the population across the life course. Through collaborations with civil society organisations, other governmental bodies outreach activities within the community are also frequently organised. Advice and support to the public is provided via the updated Sexual Health Malta webpage https://sexualhealth.gov.mt/ and also through the associated social media sites including the Messenger service where the public can be guided on specific issues of concern.

To ensure the most efficient use of resources, it is important that all interventions are properly evaluated. Some gaps identified during this policy process include the need to focus on youth aged 16 years and above in post-secondary settings and workplaces since these were the years where a lack of adequate knowledge was highlighted. It is also important to focus efforts on engaging parents to encourage dialogue on matters related to sexuality education. Population-based sexual health education must be accessible to all, including persons with disabilities, and persons from different cultural and linguistic backgrounds.

Finally, SRE must pay particular attention to the element of consent and in particular not only elements linked to the age of consent, but also to the nature of and requirements for such consent. These factors are key for all benficiaries, but of utmost importance to persons in situations of increase vulnerability, such as persons with disabilities, notably those with intellectual of psychosocial disabilities, non-speaking people or people who might face situational mutism in situations where they might be overwhelmed. Additionally, this education should address elements such as social cues and context which are crucial to these people. Recognising healthy relationships as opposed to abusive ones should be addressed in a manner that is additionally disability-sensitive and culturally sensitive. Information about and procedures for reporting abuse should be guaranteed in different formats/in different manners that allow for accessibility benefitting the widest possible access. (27)

Policy Measures

To invest in the promotion of Relationships and Sexual Health education across the life-course with emphasis on the education of children & youth adopting a positive approach and inclusive of all

1. Measures for children and youth-

- Through an interministerial and intersectoral committee comprising representation from the Health and Education Ministries and also stakeholders from across the education sector (state, church and independent schools), together with other stakeholders as necessary, a permanent working group should be set up with an aim to ensure consistent, evidence-based and research-based comprehensive sexuality education is delivered to all students in primary and secondary schools in Malta and Gozo including those with disabilities and those with diverse cultural, ethnic backgrounds, in an age appropriate and gender appropriate manner. The outcomes of the Sexual and Relationships Education component of PSCD lessons from the perspective of the educators, students and parents require to be regularly evaluated to ensure that this remains consistent, evidence-based, research-based, and age appropriate.
- To continue with the implementation of the provision of free menstrual products in school settings following successful completion of the pilot project. To continue working with children and youth to educate on matters related to menstrual health and positive body image.

2. Measures for youth and adolescents

- To work with post-secondary institutions, Aġenzija Żagħżagħ and workplaces to design and implement a structured, age-appropriate, gender and disability-sensitive module on comprehensive sex education for youth beyond the years of compulsory schooling and accessible to vulnerable youth and those living in custodial settings.
- To further invest and engage this demographic in appropriate sexual health promotion through the use of appropriate media including digital tools.

3. Measures for parents and guardians: to engage parents as primary educators for their children in CSE by providing tools and resources to be able to support their children in acquiring knowledge in terms of sexual health and rights including knowledge on current cultural trends and behaviours prevalent on social media, equipping them with knowledge and resources to support their children and counter any misinformation while specifically addressing concerns of parents and guardians whose children might be in situations of increased vulnerability, such as migrant parents, or parents/guardians of children with disabilities.

4. To invest in the continued professional development of health care professionals, youth workers and educators, including through the use of digital technologies as a means to make learning more accessible and interactive.

5. Continue developing and investing in the Sexual Health Promotion Unit within the Directorate for Health Promotion and Disease Prevention in terms of human resources and other required resources to enable this Unit to effectively design and implement sexual health promotion campaigns targeted at the general population and also targeted campaigns for key populations.

- Aspects to highlight are prevention of HIV and STIs by increasing awareness and promoting responsible sexual behaviour including the use of condoms, PrEP and PEP, U=U, promotion of HIV and STI testing and importance of linkage to care. Campaigns targeted at addressing stigma, fear and discrimination of HIV are also to be included.
- Material presented should target the whole population factoring in elements of sexual orientation and gender identity, be adapted where necessary for elderly persons, disabled persons by including multiple formats e.g. Easy Read, and also translated and accessible to the different ethnicities and languages within the population.
- Awareness and outreach campaigns would be necessary to target hard to reach groups by collaborating with other governmental entities and Commissions, NGOs, civil society groups and academic institutions amongst others.
- Employers and workplaces should be engaged and encouraged to champion sexual health promotion campaigns and educational initiatives.

Chapter 3

Medical Services - Screening, Management, Treatment and Organisation of Health Services

In 2016, the global incidence of the four most common and treatable sexually transmitted infections was 376.4 million infections (Chlamydia-127.2 million cases; Gonorrhoea 86.9 million cases; Syphilis 6.3 million; Trichomoniasis 156 million cases). These STIs affect the health and wellbeing of those infected, with possibilities of fetal and neonatal deaths, increased potential for co-acquiring HIV, pelvic inflammatory disease, chronic pelvic pain, together with psychological and social consequences. (28) There are and have been outbreaks of sexually transmissible infections such as Zika, Ebola and more recently Mpox. Besides these, there have been new outbreaks of acquired and congenital syphilis, *Lymphogranuloma venereum*, together with a concerning increase in antibiotic resistant *Neisseria gonorrhoeae* and potential resistance in *Treponema pallidum* and *Mycoplasma genitalium*. (29) Figure 2 below provides a glimpse of the local STI notification rate as compared to EU/EEA comparators according to 2022 surveillance data.

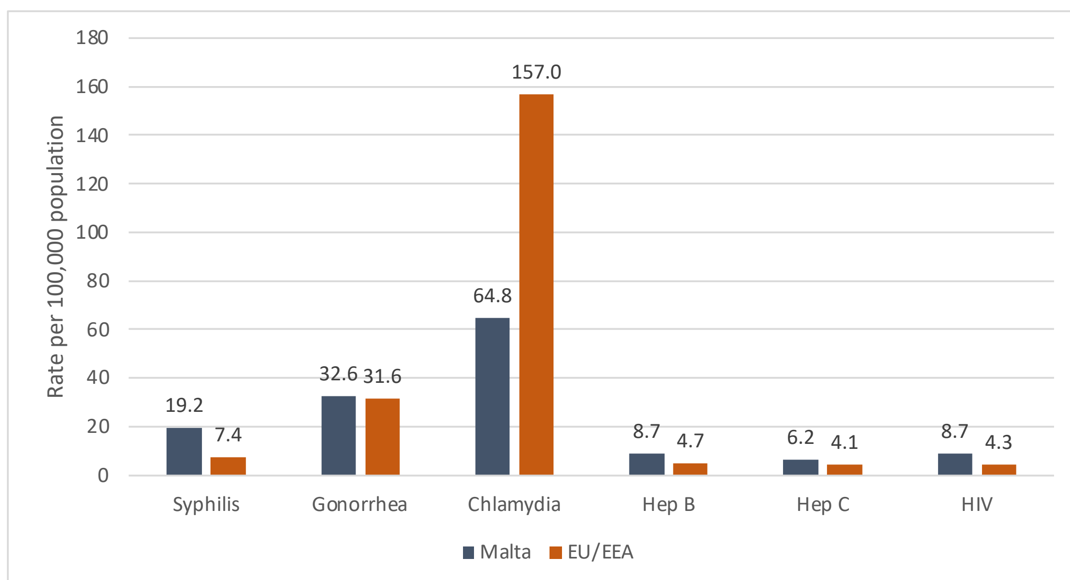


Figure 2 Comparing notification rates of STIs to EU/EEA average (30–35) Data from 2019 for Syphilis, Gonorrhoea, Chlamydia; Data from 2021 for Hep B & C and from 2022 for HIV.

The trends in notification rate of the commoner STIs in Malta have been generally increasing as can be noted in Figure 3 below.

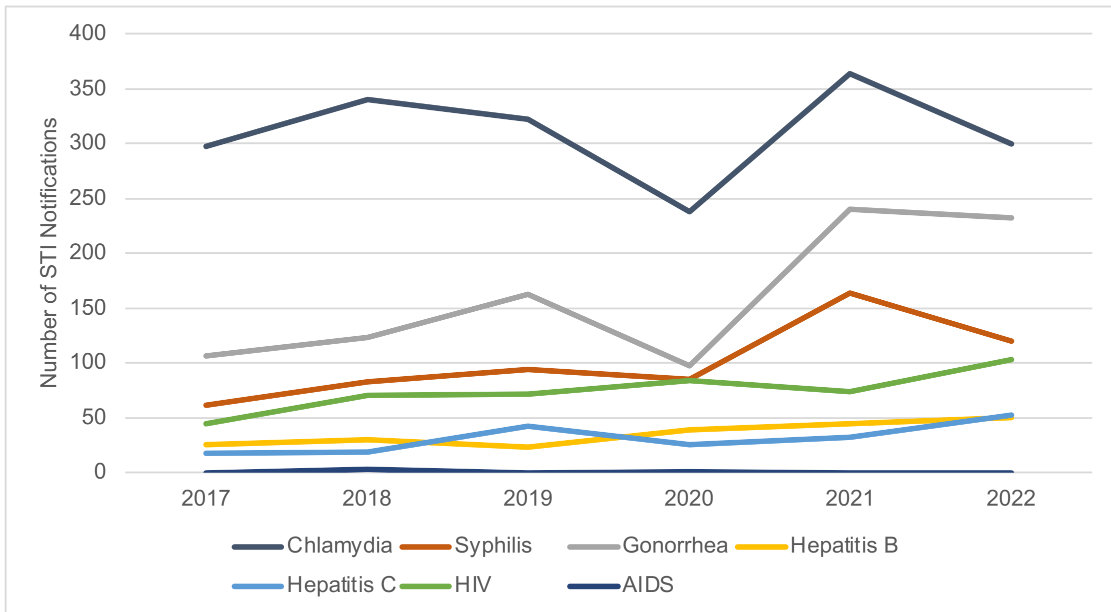


Figure 3 Trends in notified STI cases in Malta

The NSHS also provided valuable insights on the knowledge, attitudes and behaviour of the population on STIs and HIV. A summary of the major findings are as follows:

- When assessed on the awareness of 13 listed STIs, at least 70% of respondents were aware of 8 of the STIs listed. The less known STIs included pubic lice, HPV, Trichomonas, non-gonococcal urethritis (NGU), and non-specific urethritis (NSU).
- When asked about possible symptoms of an STI, the two symptoms that most respondents correctly picked were an unusual discharge and pain when passing urine, followed by genital blisters/lesions and itchy genitals. It is interesting to note that only 1/5 of the respondents correctly identified that a STI can be asymptomatic.
- There was a notable lack of awareness regarding PEP[1] and PrEP[2] and their role in decreasing the risk of infection with HIV.

[1] PEP: Post-exposure prophylaxis
[2] PrEP: Pre-exposure prophylaxis

A focus on HIV infection

HIV infection, as a major global public health epidemic, has claimed more than 40.4 million lives since the start of the epidemic until 2022. (36) It is estimated that the number of persons living with HIV/AIDS were 39 million. Global estimates show that as many as 1.3 million people (Figure 4) encountered the infection during 2022 and another 630,000 died as an effect of HIV.

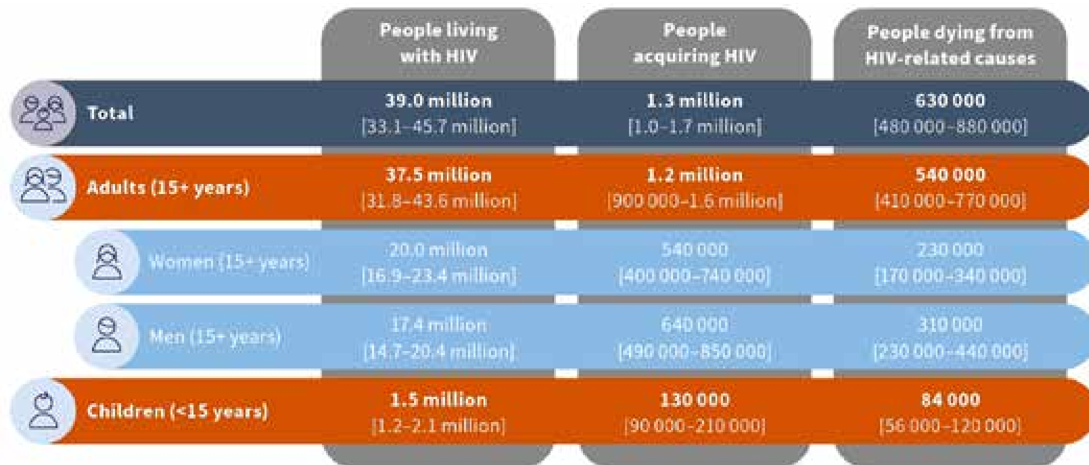


Figure 4 Summary of the global HIV epidemic, 2022

The international community has committed itself to ending AIDS by 2030 at a meeting of the United Nations General Assembly held in 2015 (United Nations General Assembly Resolution 70/1). (37) This political declaration adopted by the 193 United Nations member states outlines a course to end AIDS as a global public health threat by 2030. The progressive, new, and actionable political declaration includes a set of specific time-bound targets and actions that had to be achieved by 2020. These objectives were identified to get the world on the fast-track to control the AIDS epidemic by 2030 within the framework of the Sustainable Development Goals. The target annual rate of new HIV infections has been identified to 370,000 by 2025 and 200,000 by 2030.

The majority of the newly diagnosed with HIV in Europe in 2021 (HIV/AIDS surveillance in Europe 2022–2021 data) hailed from the Eastern part of the region recording 83,438 new HIV infections while 17,130 people were diagnosed in Western Europe and another 5,940 people diagnosed in the central European region. (38) This data identified a prevalence of 15.7 per 100,000 population for males and 8.5 per 100,000 population for females within European Region. (39)

In 2019, sex between men remained the predominant mode (50.6%) of HIV transmission reported within the EU/EEA. (38) The Central and Eastern EU/EEA areas have identified a major increase in the diagnosis of HIV infections within this group reflecting in greater incidence of disease transmission especially with the increased ease of travelling around the world. Another important subgroup within the HIV infected population incorporates those who inject drugs. The Eastern region identified 24% prevalence within the newly infected population occurring through this mode of transmission. Hence, broader detection modalities can increase the

likelihood for this population to gain access to medical care, introduction to therapy, and to reduce the viral load hence reducing the level of infectivity.

In December 2020, the UNAIDS Programme Coordinating Board called on UNAIDS to support country- and region-led efforts to establish new targets (beyond the 90:90:90 targets for 2020) for HIV treatment scale-up beyond 2025. The updated objectives to be attained by 2025 include:

- 95% of all people living with HIV to know their HIV status.
- 95% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy.
- 95% of all people receiving antiretroviral therapy to have viral suppression.

Maltese statistics are routinely provided, and an epidemiological model is used by ECDC to estimate the progress with respect to these indicators. It is estimated that there are around 740 persons living with HIV in Malta. Despite exceeding the second target of having 90% of persons diagnosed with access to antiretroviral therapy, progress is required to achieve the 1st and 3rd targets of having 90% of people with HIV aware of their status and 90% of all PLHIV achieving viral suppression. (38)

Local HIV Epidemiology

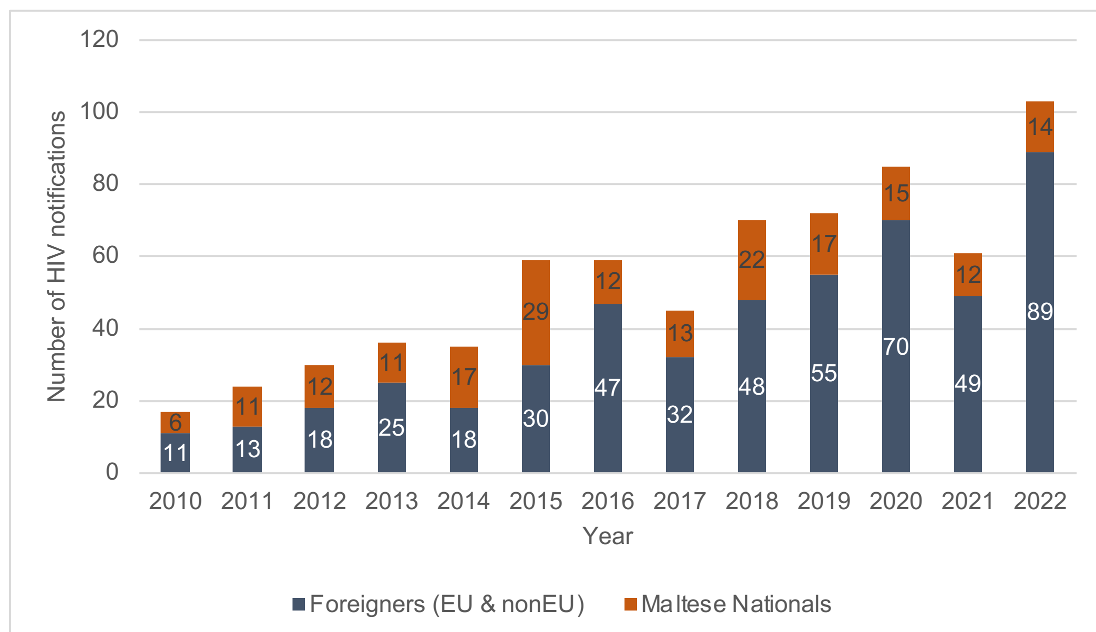


Figure 5 Trends in HIV notifications in Malta (40)

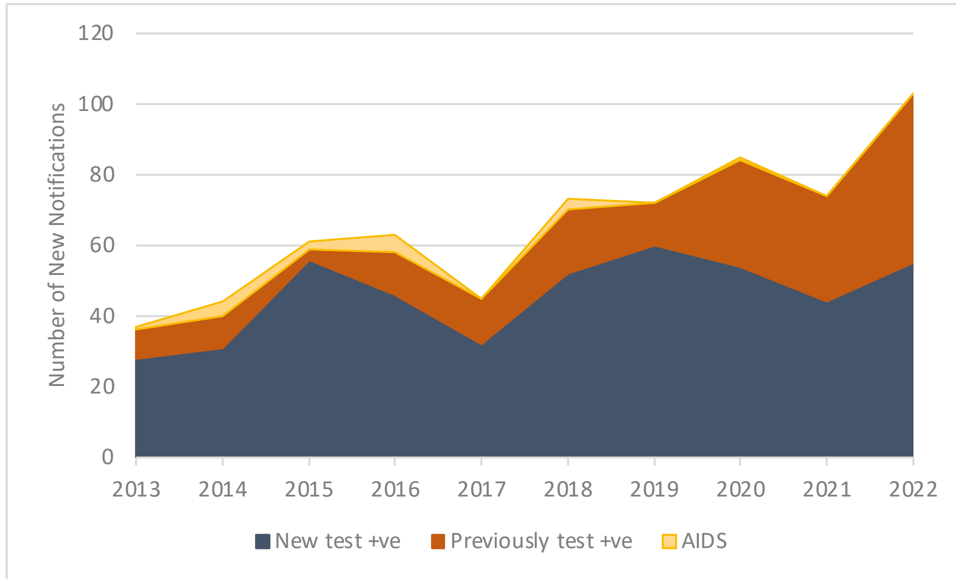


Figure 6 The proportion of new HIV notifications which had previously tested positive.

The numbers of reported incident HIV cases have been increasing over this decade with one of the steepest rates for new cases notified. It is important to further contextualise these numbers in terms of the demographic changes taking place including the notable increase in the foreign resident population. There were also changes in the reporting definition of the newly diagnosed HIV cases in Malta (reflected since 2021 to ECDC) since some persons who were being reported as new cases may have been previously diagnosed abroad and would have undergone repeat testing in Malta. Accurate surveillance and reporting of cases continue to be an important tool to support and monitor policy action. The total number of new cases (new test positive and previous test positive has important implications on the service demand however it is the new test positive notifications whose numbers are more indicative of the rates of infection locally and consequently the effectiveness of public health interventions and campaigns.

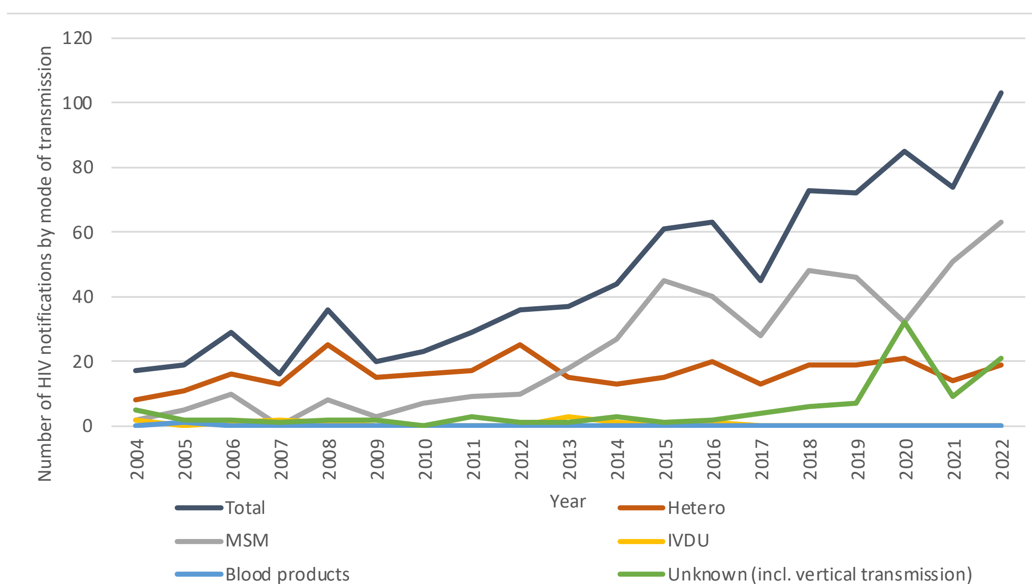


Figure 7 HIV notification trend by MOT

- Men Who Have Sex with Men (MSM)

New disease transmission of HIV in the Western part of in the European Region between 2011 and 2020 has been identified to be highest in MSM. (41) In 2021, 60% of HIV reported cases in Malta were attributed to sex between men, with a male-to-female ratio of 10.3, second only to Croatia in the EU/EEA region. (34)

- Persons Who Inject Drugs (PWID)

PWIDs have declined over the years possibly due to use of alternative substances and routes of drug abuse including sniffing. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the male population is still the primary group of PWID over the female population at a rate of 5:1. (42, 43) In Malta, there were no persons from within the PWID group who have become newly diagnosed with HIV since 2017. Also, since 2006, no person has been diagnosed to have contracted the virus from the administration of blood and blood products within the Maltese islands.

- Mother to Child Transmission

Globally, transmission of the HIV virus from the mother to their child has decreased drastically due to increasing access to treatment, support and prevention. Since the year 2000, an estimated 2.9 million HIV infections have been prevented. (44) The global numbers still indicate many new HIV infections under the age of five years relating to around 130,000 infections in 2021. This reflects in a reduction of 54% over HIV infections in the same age group since 2010, falling short of the UNAIDS target for 2020. (45) Mother to child transmission, nosocomial or blood transfusion transmission has decreased steadily between 2012 and 2021, comprising less than 1% of the transmission in Malta. (35)

- Adolescents and HIV/AIDS

Adolescents are one of the major groups contributing to the spread of HIV infection within the global population due to lifestyle changes, sexual maturity, and their introduction into sexual experiences. This group, which according to the WHO incorporates people from 10 years to 19 years of age, has been identified as one of the contributors to the disease. In Malta, ⅓ of new reported cases are amongst persons aged less than 30 years in 2021. (35)

- Mortality

Between 2011 and 2020, there were 24 deaths locally where HIV was listed as one of the causes of death. (46) This works out to a standardised mortality rate (per 100, 000 population) ranging between 0 - 1.45 per 100, 000 in 2016 when there was the largest number of yearly deaths. The latest available figures for 2020 report a mortality rate from HIV of 0.43 per 100, 000 population. (47)

Health Services currently available for management of HIV & STIs

HIV clinic

The HIV clinic caters for PLHIV (People living with HIV) and is a specialist-led outpatient clinic within Mater Dei Hospital (MDH). The clinical management of HIV is based on the continuum of HIV care conceptual framework which aims to achieve viral suppression amongst PLHIV. This enables a normal life expectancy, better quality of life and prevention of onward transmission of HIV. (38) The medical and nursing professionals fulfil health educational roles, counselling their patients as required, and they are also responsible for partner notification and contact tracing of sexual partners. Access to appropriate psychosocial support is essential to provide for the holistic needs of the patients. This can provide assessment and short-term therapeutic support to persons trying to understand and change their sexual behaviour.

Elimination of Hepatitis C Virus

Malta is well underway in its Hepatitis C Elimination Strategy (42) following the introduction of the new curative treatment for Hepatitis C introduced on the government formulary in 2018. Free treatment has been provided to all those persons known to be infected with Hepatitis C within the clinical records. In addition, surveillance in high-risk groups for new cases, for example Detox and CCF, has been strengthened in order to provide rapid linkage to the necessary care. Efforts were also made to ensure recall of any patients who might have tested positive to Hepatitis C and were lost to follow up and offer them the curative treatment.

GU clinic (MDH & Gozo)

Genito-urinary (GU) services are currently provided through the GU clinic at the Outpatient Department of Mater Dei Hospital, generally by appointment, although there is a walk-in option for symptomatic patients. The attendances to the GU clinic have increased year on year as can be shown in Figure 8, with a slight dip in 2020 in view of the COVID-19 disruptions in clinical activity and testing capacity. A specialist GU clinic takes place twice a month in Gozo providing the testing and services necessary.

During 2022, there were 6,483 persons (71% males; 29% females) who attended the GU clinic with 58% of these being Maltese nationals and the remainder (>40%) being foreign-born. This highlights the need for linguistic and cultural interpretation for a large proportion of attenders. There were 43% who were asymptomatic but who attended for an STI check after being made aware of a partner who was infected with an STI.

Roughly 1/3 of the attenders were heterosexual males and 1/3 were men who have sex with men (MSM) with a little less than a third comprising heterosexual females. There were 8% of attenders who were bisexual. One may note that the demand for GU services is increasing with a need to increase the capacity of the GU clinical services offered to cater for this demand.

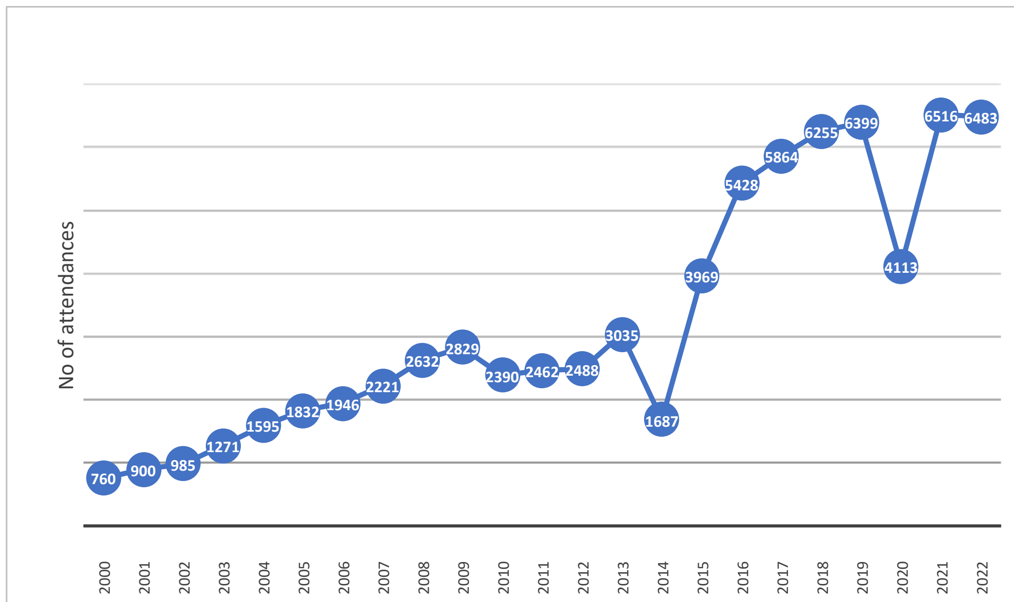


Figure 8 Attendances at GU clinic, MDH

The prevalence of four notifiable STIs, namely Chlamydia, Gonorrhoea, Syphilis, and *Mycoplasma genitalium* has been noted to have a notable increase in 2021. There are also concerns about an increasing antimicrobial resistant *Mycoplasma genitalium* being identified. The multi-country outbreak of Mpox (Monkeypox) became a concern in early 2022. Although Mpox is spread via close contact with an infected person and is not limited to those who are sexually active, most cases in these outbreaks were detected amongst MSM, bisexual men particularly through specific social networks and contacts where one may engage in multiple sexual encounters. (48) Similarly, in Malta as of May 2022, to date there have been 38 notified cases of Mpox comprising 36 males and 2 females with the majority of infections amongst MSM or bisexual men. Only sporadic cases of Mpox were notified throughout 2023. Public Health messaging throughout the summer, in collaboration with LGBTIQ+ community groups, ensuring targeted but non-stigmatising messages were disseminated. The Mpox vaccine became available to the high-risk contacts of cases as post-exposure prophylaxis. (49)

Free anti-retroviral treatment is available to PLHIV and has been upgraded on the government formulary list to include the most updated international guideline-based HIV drug treatment regimen which is available from named community pharmacies around the country. This reinforces the concept of Treatment as Prevention[3] and Undetectable=Untransmittable[4] aiming to curb the epidemic. The GU clinic also provides a free service for the clinical monitoring of PrEP users amongst persons at high risk who currently fund their own PrEP. In addition, persons who are at risk for contracting HIV following a risky exposure (sexual or occupational) are assessed at MDH and antiretroviral treatment known as post-exposure prophylaxis (PEP) is provided for free in cases of sexual assault or an occupational injury. Several interventions are highly effective in reducing the risk of acquiring HIV including the use of male and female condoms, the use of antiretroviral medication such as PEP, pre-exposure prophylaxis (PrEP),

[3] Providing antiretroviral treatment and viral suppression is a means in itself of prevention against spread of HIV
[4] This notion is based on robust evidence that HIV treatment is highly effective in reducing the transmission of HIV. Studies on thousands of couples where one was a PLHIV but whose viral load is undetectable is unable to transmit HIV sexually.

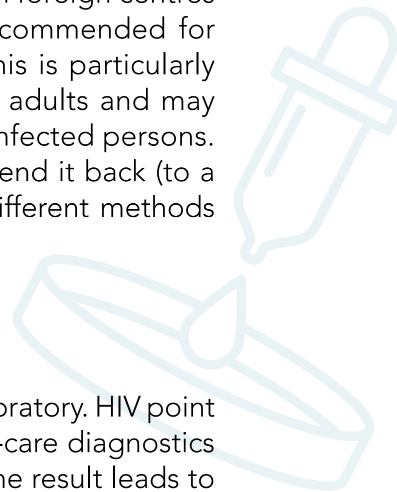
voluntary male medical circumcision, behaviour change interventions to decrease the number of sexual partners, the use of clean needles and syringes in PWID, opiate substitution therapy and the treatment and viral suppression of PLHIV.

Decentralisation of GU specialist services to other clinics within primary and secondary care settings in the community in Malta and Gozo is already being implemented. Three Health and Wellbeing Clinics within PHC run by GPs with a special interest in sexual health take place weekly in community clinics to provide services for routine testing for STIs. This decentralisation aims to improve access to testing, decrease waiting time whilst still enabling rapid linkage to care where this is required. The above ties in with Malta's obligations to ensure provision of care and support within the community, as a means of facilitating independent living, in line with Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), (18) General Comment No. 5 thereto, (50) and the Conclusions on the transition of care systems throughout life towards holistic, person-centred and community-based support models with a gender perspective adopted by the Council of the EU. (51)

HIV Testing & STI Testing

Both ECDC and WHO recommend scaling up HIV testing (52,53) as one of the key interventions to help reach the SDG targets for 2030. Different approaches to HIV testing are required to improve the coverage and accessibility to HIV testing such as including self-testing and rapid diagnostic tests particularly among key populations. Testing by lay providers at a community level is also a possible means to ramp up testing for HIV. Criteria for extending HIV testing opportunities within health care settings are outlined in the ECDC and WHO testing guidance. (53) Testing opportunities should be accompanied by appropriate pathways providing fast-tracked linkage to care, pre- and post-test counselling services. NGOs can be involved in organising events and performing HIV testing in the community. Training to healthcare providers and lay persons together with clear linkage to confirmatory testing and care is essential.

Another opportunity to test for HIV would be by means of HIV self-test kits which are currently available for sale in certain pharmacies or through an NGO website. For various reasons, patients may be reluctant to access testing for HIV in a health facility and may find a self-testing kit more acceptable. There are a number of best practices from foreign centres where home sampling, home-testing for STIs is implemented.[5] This is recommended for asymptomatic persons and who would like to screen regularly for STIs. This is particularly relevant for chlamydia which has a significant burden in youth and young adults and may have devastating consequences on the reproductive health and fertility of infected persons. Once the test kit is obtained, the client can proceed with the sample and send it back (to a laboratory) through an already paid postage. Results can be received by different methods such as email, telephone call or SMS.



STIs and HIV testing in Malta

Most of the testing for STIs relies on blood tests which require analysis in a laboratory. HIV point of care testing (POCT) in Malta is available for free at the GU clinic. Point-of-care diagnostics refers to testing that is done at or near the site of the patient's care, where the result leads to immediate diagnosis and treatment, and consequent improvement in patient care. In the last

[5] Such examples include https://www.icash.nhs.uk/contraception-sexual-health/express-test/advice-and-guidance; https://sh24.org.uk/

decade, there has been a great improvement in developing new diagnostic tools that can be administered at the point of care and that are affordable, sensitive, and specific, through which universal health coverage can be reached. (54)

Valued tenets of the GU service provided are patient confidentiality, a non-judgemental approach, good access to testing, and treatment for STIs. Besides the increase in demand for GU services which can be noted over the years, 2020 heralded significant challenges for this service as a result of clinic closure and diminished laboratory capacity for testing following the COVID-19 pandemic. In order to make up for the short fall in testing capacity for some STIs, some point of care tests (POCT) were used where indicated. Through POCT, screening and enhanced testing can be dispersed among the key populations as a one-stop shop service which is more accessible within the community.

Integrated services across the health settings and testing simultaneously for several infectious diseases in primary health care settings is feasible and can help bring down the burden of HIV and STIs. The advantages of POCT compared to laboratory testing are that it is cheaper, it reduces waiting time for the result, and prescription for treatment can take place on the same day. They may also mitigate against the overuse of antimicrobials which may lead to drug resistant STIs. (54) Another important consideration in expanding the testing modalities for HIV and STIs within community settings would be to ensure the concurrent development of an appropriate regulatory framework for the use of HIV and STI point-of care tests which can be privately purchased.

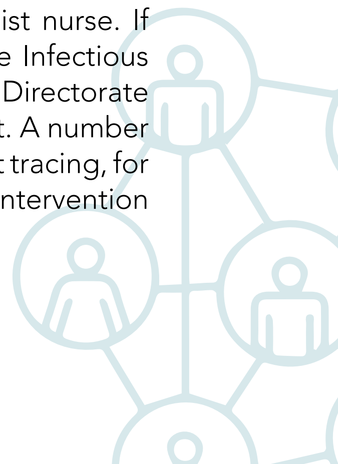
Partner notification and contact tracing

Partner notification is the practice of informing sexual partners that they have been exposed to a disease and bringing them for testing and treatment. It also controls the spread of STI, reducing STI-related morbidity and mortality, reaching people with asymptomatic STI and people exposed to infection who do not present for diagnosis, counselling and treatment. (55)

There are different approaches to partner notification:

- **Patient referral –** when the patients themselves contact partners.
- **Assisted partner notification –** healthcare or community health worker assists the patient in contacting partners WITH permission of patient.
- **Contract referral –** The provider agrees with the index patient i.e. 'makes a contract' that the index patient will contact their sexual partners within a certain time period. The health care provider would contact the sexual partner if the index patient fails to inform them within the stipulated time.

WHO (56) recommends partner notification as part of a comprehensive package of testing and treatment and ECDC (55) recommends that this is voluntary and anonymous. Furthermore, IUSTI (International Union Against Sexually Transmitted Infections) (57) recommends that this process should be an integrated aspect in patient management. Locally, partner notification takes place as part of the GU clinic encounter by the specialist and/ or specialist nurse. If an outbreak is detected outside the immediate patient and sexual partner/s, the Infectious Disease and Control Unit (IDCU) at Health Promotion and Disease Prevention Directorate (HPDP) is usually involved to support in contact tracing and outbreak management. A number of countries have specially trained health professionals whose primary role is contact tracing, for example, medical social workers in Sweden, health advisors in the UK, and disease intervention specialists in the USA. (55)



In Malta, according to the Public Health Act, 2003, directions by the Superintendent for Public Health Article 27, 73 specified communicable diseases are currently statutorily notifiable. (58) This list includes the sexually transmitted infections syphilis, chlamydia, HIV, AIDS and gonorrhoea. Notification is mandatory at law for all doctors in both public and private sectors whereby doctors should report suspected cases on the basis of symptoms only, not awaiting laboratory diagnostic confirmation. All public and private medical diagnostic laboratories are also obliged to report laboratory-confirmed cases thereby having a dual mechanism for reporting in place. The Infectious Diseases Prevention and Control Unit within the Directorate for Health Promotion and Disease Prevention, Superintendence of Public Health is responsible for the surveillance of notifiable STIs including HIV. This is critical to enable appropriate population prevention activities, guide sexual health promotion messaging, update policy action and guide strategic planning and funding. International reporting obligations are also fulfilled by providing aggregate data to enable characterisation and action on STIs and HIV at a regional and international level.

The benefits of psychosocial support

Psychosocial professionals can provide a variety of services to patients attending the sexual health services. They can provide assessment and short-term therapeutic support to patients who are trying to understand and change their sexual behaviour. They can support those struggling in adjusting to sexually transmitted infections, such as genital herpes and HIV. Psychological support joined within the medical team caring for persons with sexual health difficulties is very much needed. Some people may feel embarrassed, anxious, or ashamed of their sexual problems, especially persons who are experiencing erectile problems, sexual difficulties associated with trauma and experiencing painful sex. This service aims to provide a respectful and sensitive approach to the individual, taking in consideration the social, religious, and cultural issues that can impact sexual health and wellbeing.

Psychological assistance in sexual health helps in

- New diagnosis and difficulties with coping / adjustment
- Disclosure (to partners past / present, family, children, and others)
- Practising safer sex / risk reduction
- Relationship problems / therapy for partners and/or family members
- Pregnancy/ testing of children
- Adherence to treatment (beginning treatment/ difficulties and / or terminating treatment)
- Coping with chronic illness
- Managing co-infections e.g. Hepatitis C
- Bereavement
- Neuro-cognitive screening for mild cognitive impairment
- Substance misuse problems and onward referral
- Chemsex

In addition to improved mental health gain and quality of life of the patients, these aims can lead to other benefits including decreased transmission rates, decreased rates of unplanned pregnancy, decreased attendances, and investigations amongst others. (59)

Policy Measures

To integrate and improve the medical pathways comprising improved prevention, screening and treatment for STIs including HIV and Hepatitis

1. To continue with the re-organisation and integration of the GU services across primary, secondary, and tertiary care settings.

- To continue building on the decentralisation of GU services into the secondary care hub and various community clinics together with the recruitment and training of additional trained staff (medical, psychosocial expertise), laboratory capacity, the IT networks to ensure integrated patient care and referral, clinical protocols required. To provide psychosocial support to GU and HIV clinics to mitigate against the social and psychological impacts of HIV/STIs. To explore options for virtual consultations/ telemedicine to improve access to care. To provide professional guidance, increase access to testing and other clinical services for those who wish to seek medical care in the private sector.
- To develop care pathways and ensure appropriate linkage to specialist care and treatment when services are sought from the community public or private settings. To enhance public population campaigns on referral pathways and how to access services for the screening and management of sexually transmitted infections.
- To engage with patient representatives and NGOs to ensure that the services developed are patient-centred and acceptable to the users. To explore collaboration with NGOs with respect to aspects of peer-support for patients with a new diagnosis of an STI/HIV and also for PLHIV.

2. To strengthen the tools for prevention of HIV and STIs by introducing free barrier contraceptives (male condoms) accessible within community clinics in a multi-component free condom distribution scheme which includes sexual health education.

3. To increase access to the HIV testing

- To increase opportunities for HIV testing by extending testing opportunities in health settings, defined screening protocols for key populations according to international guidance and national epidemiology.
- To explore opportunities for providing rapid HIV testing within community settings by trained lay persons and/or health care professionals ensuring that there is fast referral to confirmatory testing and linkage to care as a means to improve the screening rate amongst marginalised groups.

4. To increase the entitlement to free anti-retroviral treatment as PEP (post exposure prophylaxis) for all those persons who may have been at risk of contracting HIV following a risky exposure according to the local evidence-based guidance.

5. To provide free PrEP (pre-exposure prophylaxis) to the key populations who are at risk of contracting HIV as part of a combination prevention approach, concomitantly increasing awareness and combatting stigma.

6. Regulation of quality and sales of medical devices such as POCT and self-tests and contraceptives including condoms, ensuring reliability and supporting advice.

7. To enhance the surveillance of STIs through updating the IT infrastructure necessary, consideration of additional STIs *(Mycoplasma genitalium, Trichomonas vaginalis)* to the notifiable list of infections, and to invest in the resources (human/ technical) necessary to improve the process of partner notification across the service.

8. To sustain efforts of rapid linkage to care for all patients with a new HIV diagnosis with updated HIV treatments available including treatment options for drug resistant cases.

9. To continue developing and resourcing the care for PLHIV through a multi-disciplinary team of professionals ensuring monitoring of care and adherence to treatment. To identify and tackle any barriers to care. To facilitate access to care for PLHIV who have related conditions, co-infections or comorbidities.

10. To increase public awareness on transmission of HIV, management and support available including combatting stigma and discrimination. To engage directly with workplaces and employers to uphold the recommendations of the International Labour Organisation on HIV and AIDS and also to combat stigma and discrimination on the basis of HIV.

Chapter 4
Reproductive Health Needs – Family Planning and Contraception

Findings from NSHS

- The most substantial portion of participants reported that their age at the first sexual experience was 18 years or over (40%) whilst for 27% of participants, this occurred at between 16-17 years and for 19% of respondents between 13-15 years of age. Sexual experience in the survey was defined as kissing, touching, intercourse or any form of sexual behaviour. There was no difference in this finding between men and women.
- During the first sexual experience, respondents were more likely to use protection (condom/ oral dam) during the first vaginal sexual intercourse in 36% of respondents whilst protection was used in only 8% of those who engaged in first oral sex and 18% of those who engaged in first anal sex.
- Slightly more than 6 out of 10 participants reported that they were currently sexually active. Of these, the majority (56%) had one sexual partner and nearly 7% had two or more partners.
- Sexual Dysfunction: Eleven percent of participants claimed to be affected with a sexual impairment or dysfunction.
- Contraception: The most frequent methods of contraception regularly used were the male condom (23%) followed by withdrawal method (19%) and the OCP (14%), rhythm method (13%), vaginal contraceptive ring (12%) and IUS (11%). Other methods (IUD, Implants, Female condom, hormone injection, PrEP, Oral dam, diaphragm, spermicide, PEP, Surgical methods) were all ranging between 9%-11% of responses.
- Abortion: Eighteen percent (18%) of the respondents were aware of someone (or had done so themselves) who had undergone a surgical abortion whilst 16% of respondents were aware of someone who had taken abortion pills with the intention to terminate a pregnancy.
- In terms of criminalisation- 46% and 48% of respondents respectively did not believe the doctor who assisted, or the pregnant person should be criminally prosecuted for undergoing an abortion. However, 15% and 13% respectively believed that the health care worker and the individual should be criminally prosecuted for undergoing or assisting in an abortion. Over 1/3 of respondents did not commit an answer on this question.

- One's attitudes and the specific indications for abortion were also surveyed. In instances of risk to life for the pregnant person 52% agreed this should be permitted, 17% disagreed and 31% did not commit a response; in cases of rape/incest- 48% agreed, 18% disagreed and 34% did not know; in instances where the carrier is a minor 36% agreed, 30% disagreed whilst 34% did not know. In instances of a fatal foetal anomaly 47% agreed abortion should be permitted, 15% disagreed whilst 38% did not commit an answer. On the other hand, in instances of a non-fatal foetal anomaly 36% agreed, 22% disagreed and 42% did not know. Where the pregnant person could have health implications as a result of the pregnancy 41% of the respondents agreed, 22% disagreed in instances of physical health implications whilst 38% agreed and 26% disagreed in instances of possible mental health implications. In both these instances 37% did not commit a response. Where an abortion is requested for economic/social reasons or for any other circumstance- 28% believed this should be permitted but there was disagreement of 36% (economic/social reasons) and 32% (any other circumstance). Over 1/3 of the respondents did not commit a response in this case also.
- Unwilling to disclose: The results from this survey show that there is a discomfort amongst respondents in answering some of the questions- including which is their preferred method of contraception. There were 43% of the survey participants who did not wish to disclose any information in this regard.

The average age at first intercourse in the Maltese population was reported to be 18 years of age during the 2012 national survey and this trend was confirmed during the more recent National Sexual Health Survey (NSHS). Between the ages of 16-19 years, around 30-41% of persons reported that they were sexually active. (60) The more recent Health Behaviour in School-aged Children survey (HBSC) in 15-year-old youth (2017/2018) reported that 15% of females and around 25% of males had engaged in sexual intercourse by this age. Of these, 33% of adolescent females and 46% of males (as compared to European averages of 58% of females and 64% of males during the same time period) had used a condom during first intercourse. Similar low trends for oral contraceptive use were reported for 15-year-old Maltese adolescents as compared to European counterparts. (56)

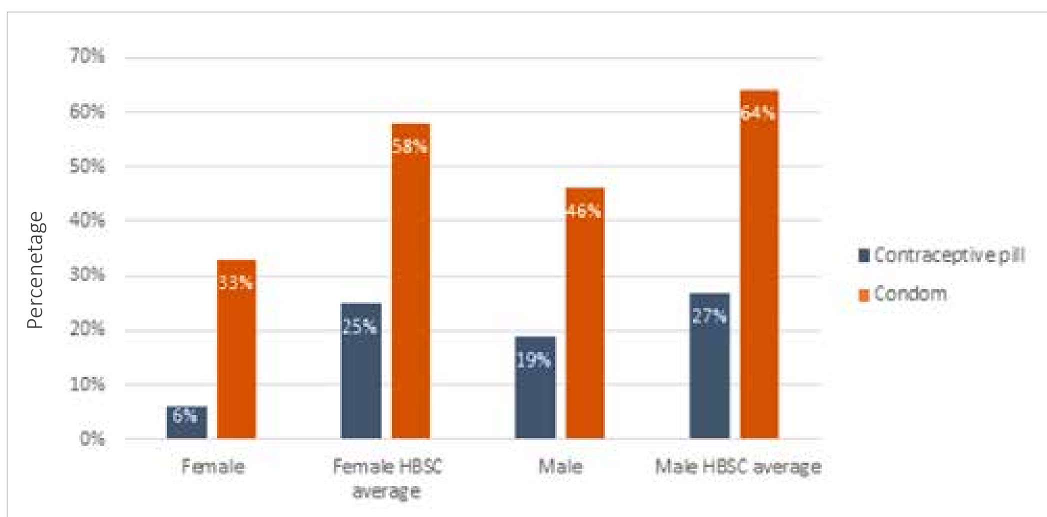


Figure 9 Use of contraception at last sexual intercourse among Maltese adolescents compared with the HBSC average (56)

Condoms are reported as the most popular method of contraception used in the Maltese adult population followed by the withdrawal method and the oral contraceptive pill according to the respondents of the NSHS. Other methods mentioned include natural family planning methods, coil, intrauterine systems, and diaphragms. An estimate of the surgical contraceptive methods reported through official surgical records include an approximation of around 60 tubal ligation procedures (female sterilisation) performed yearly and around 10 vasectomy (male sterilisation) procedures recorded yearly over the last 5 years including both public and private provision of care[1]. The data for male sterilisation procedures is likely to be incomplete since there is no obligation to report similar minor procedures.

When comparing this data to European contraceptive prevalence rates, one may note that the prevalence of contraceptive use for all methods across Europe is 60%, with the most popular contraceptive being the contraceptive pill followed by the male condom. (61) The most popular methods of contraception are female sterilisation and the male condom at a global level. Malta was given a 51.6% ranking in the Contraceptive Policy Atlas for 2023 which compares access to modern contraceptives in Europe in terms of access to supplies, access to counselling and also access to reliable information which is published by the European Parliamentary Forum for Sexual and Reproductive Rights. (62)

One of the biggest obstacles to access is the relatively high cost of contraception, especially when these are not covered by the health system, making them out of reach for some people. Another cited problem when it comes to access to contraception is a lack of available information due to a complete lack of or inadequate sexual education, and family planning services. These obstacles to contraception use ultimately expose women and people who can get pregnant to unintended pregnancies and may put their health at risk. In the EU, the majority of Member States aim to make affordable contraceptives and information available to women, however access remains a problem in instances where there is no comprehensive legal and policy framework on reproductive health and rights in place. Most importantly, when contraceptives are not subsidised by schemes financed by the healthcare system, this makes them unaffordable for a number of women and other persons who can get pregnant. (63)

There is a gap in knowledge regarding local data which caputures the rate of unintended pregnancies[2]. Around 7.2% of the NSHS respondents indicated that prior to their (or their partner's) last pregnancy there was no intention of conceiving a child. One may also look at the rate of pregnancies to persons under 20 years of age, a rate which has remained relatively consistent with a somewhat decreasing trend over the last 5 years.

[1] Data obtained from National Hospitals Information System (2021)
[2] Unintended pregnancy is taken to include a pregnancy which was not planned for that point in time in the woman's life and this also includes a pregnancy in a woman who does not desire to have children at all

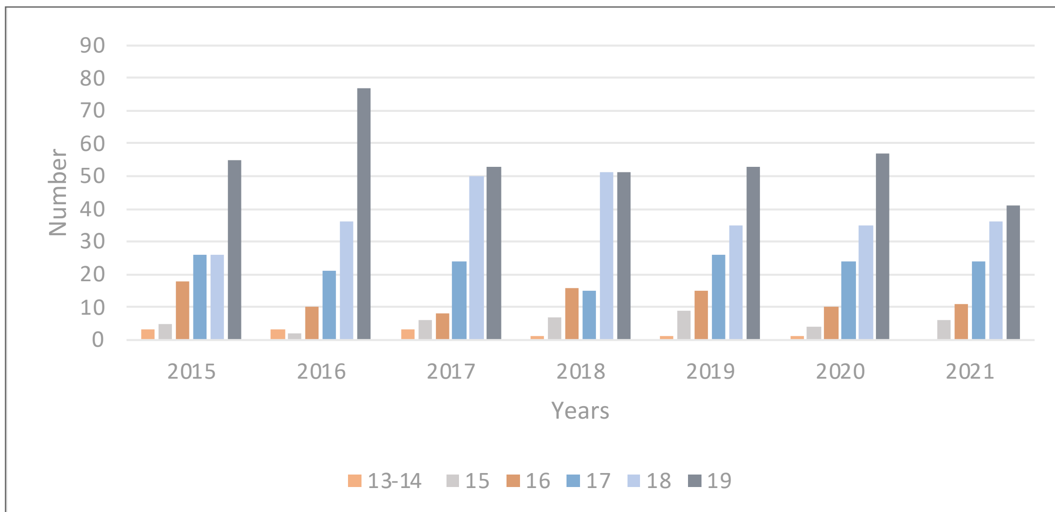


Figure 10 Deliveries by mothers aged 13-19 years in Malta 2015-2021 (64)

There is limited and incomplete data on the terminations of pregnancy of Maltese nationals carried out overseas or procured through telemedical services overseas. Data from the UK shows that on average over the last decade around 55 terminations of pregnancy were performed in the UK (England and Wales) yearly. (65) An insight into the medical abortifacients requested through telemedical consultation services shows an increase in the demand for such services since 2017 where there were 78 requests, a doubling of the requests in 2020 (178 requests), and a further increase in 2021 (261 requests). (66) There have been no maternal deaths in Malta in over ten years.[3] (60) One must also note the recent amendments to the Criminal Code, which provide the legal protection for doctors and mothers who require medical intervention to terminate the pregnancy in those instances where the mother's life is at imminent risk or cases where a woman is suffering from a medical complication that may put her life at risk or her health in grave jeopardy which may lead to death. (68)

Family Planning Services

It is estimated that unmet family planning needs using modern contraceptives amount to around 22% of the European population. (61) The ICPC Programme of Action and also the SDG target 3.7 emphasise the commitment to ensure that all persons of reproductive age have access to the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice, while recognising that appropriate methods for couples and individuals vary according to their age, parity, family-size preference and other factors. (61) Persons have different requirements for contraception at different points along the life course. In Malta, to date, access to family planning services and contraceptives occurs at the primary care setting through GP clinics, or gynaecology specialist clinics. The provision of surgical methods of contraception for women and people who can get pregnant (tubal ligation) is currently only state funded in situations where there is a medical/ social need. Similarly, modern contraceptives are privately funded by users.

The emergency contraceptive pill has been available for purchase in local pharmacies since 2016 as an over-the-counter medication. The feedback from the NSHS showed that 15% of the respondents had used the emergency contraceptive pill at least once in their lifetime, with the most frequent reasons cited being unprotected intercourse followed by a known or suspected failure of contraception.

[3] This statement was correct at time of publishing; however, unfortunately there has been a maternal death/s reported in 2024 which will be reflected in the relevant annual statistics once these are available

Sexual dysfunctions

Sexual function is complex and is coordinated by the nervous, vascular and endocrine systems of the body. Sexual dysfunction in men includes erectile dysfunction, ejaculation disorders, orgasmic dysfunctions, and disorders of sexual interest/desire. (69) On the other hand, sexual dysfunction in women includes conditions like female orgasmic disorders, female sexual interest/arousal disorder, genito-pelvic pain/penetration disorder, and substance/medication-induced sexual dysfunction. (70)

International data suggest that 40-45% of men and an estimate of 25-63% of adult women complain of at least one sexual dysfunction with the prevalence of those meeting diagnostic criteria being less well-established in population studies. The prevalence of such complaints increases in proportion to age and comorbid illness, with those reporting excellent health being less likely to suffer from a sexual dysfunction. In Malta, 9%-11% of respondents in nationally representative surveys (EHIS and NSHS) had reported a sexual dysfunction, with 3% (EHIS) of persons claiming to have sought help to address this complaint. (71) Currently services are provided from the general gynaecology and urology outpatient clinics, and these generally comprise self-referred patients who tend to initially access care in the private sector. Persons with such complaints may be reluctant to access services related to sexual wellbeing in view of stigma, cultural or religious beliefs.

Educational campaigns are important to encourage affected individuals to seek healthcare which is available. Once an organic cause for the dysfunction is ruled out, a psychogenic cause would likely be the cause, and this requires to be managed holistically including through the provision of the necessary psychosocial support and therapy. Sexual dysfunction clinics are ideally sited within the community; however, this is currently challenging in view of the limited specialised professional resources.

Avoidable Cancers caused by HPV (Human Papilloma Virus)

HPV is one of the most common sexually transmitted infections (STIs) globally and infection generally occurs soon after sexual activity is started. This virus is associated with various types of cancers including cervical, vaginal and vulvar in women and persons with such genitalia, and penile cancer in men and in persons born with penile genitalia. It is thought to cause oropharyngeal and anal cancers in both sexes. (72) Thus, HPV can affect all sexually active persons irrispective of gender.

Statistics related to avoidable cancers attributed to HPV

There are 33,987 cases of cervical cancer in the European Union (EU) and European Economic Area (EEA) annually, causing a death rate of 2.8 per 100,000 women yearly. There are also 14,700 new recorded cases of anogenital cancers due to HPV in Europe, 5,400 of them being in men and 9,300 being in women. (73)

Cancers of the head and neck are also responsible for a heavy burden, especially so in men. There are 13,800 new cases being diagnosed annually, 11,800 of which are in men. An increase in the incidence of head and neck cancers in HPV positive individuals has been noted over the last decade, when tobacco use has diminished. (73)

Cervical cancer

This is the fourth most common cancer in women and persons with a cervix and seventh most common cancer in general. (74) It is estimated that 58,373 women are diagnosed with cervical cancer in Europe every year, with 24,404 of these dying from this disease. It should be noted that the incidence and mortality of this cancer has been declining since the introduction of the smear test in the 1940s. (75) The most common risk factors for cervical cancer are smoking, sexual activity from a young age, having several sexual partners or having a sexual partner who had many other partners, and someone who is on immunosuppressant medication.

Preventing cervical cancer

- By adopting a primary prevention strategy vaccinating young adolescent girls and adolescents with a cervix to lower the risk of cervical neoplasia.
- Screening for cervical cancer through regular cervical smears is the secondary prevention strategy aimed at detecting lesions early in order to be able to take rapid remedial action.

HPV testing also has a role in preventing cervical cancer, and it does not rely on morphological interpretation. It is based on the detection of HPV DNA, HPV mRNA or other viral markers. It has become an invaluable part of clinical guidelines for cervical carcinoma screening in many countries over the last two decades. (75) It should be remembered that current HPV vaccines do not provide cover against all HPV types that cause cervical cancer. Thus, screening still has an important role among women and persons with a cervix who are vaccinated in the near future, so as to be able to detect lesions caused by HPV types not covered by the vaccine. (76)

Cervical screening and HPV vaccination in Malta

Cervical Screening is a part of the National Screening Programme of Malta, and eligible persons between 25 and 41 years of age are automatically sent an invitation to participate. They are invited at three yearly intervals up to age 50 and five yearly intervals after that. The rationale for not inviting this cohort under 25 years is that younger persons are more likely to get rid of any cervical abnormalities with no intervention. In line with a recent recommendation on cervical screening by the European Commission (EC), the EC recommends to "prioritise screening by testing for human papilloma virus (HPV)". Since in Malta, the primary screening method for cervical cancer is by cytology testing (liquid-based) and HPV testing is only done secondarily if abnormal cytology is detected, a technical working group has been set up to plan and implement this change in screening modality to primary HPV testing over the next years. Similarly, the HPV vaccine has been part of the National Schedule of vaccinations since 2013 for girls aged 12 years, with a vaccination coverage of over 90%. Since this year, the HPV vaccine is also being offered to boys besides girls aged 12 years in order to further decrease the opportunities for HPV to spread.

Policy Measures

To address the reproductive health needs of the population including the need for comprehensive family planning services which are accessible and acceptable, meeting the needs of the population

1. To train and empower health care professionals and other skilled staff within health settings, workplaces, and post-secondary educational settings to be able to inform the population on matters related to SRHR, including family planning, pre-conception advice, access to services and resources, including where to access contraception (which includes emergency contraception). To ensure equitable services, promotion, outreach activities and physical premises which are accessible to all.
2. To provide free barrier contraceptives to all the population aged 16 years and over.
3. To fund the provision of free modern contraceptives (long-acting reversible contraceptives, contraceptive implants, the oral contraceptive pill) and provide options for surgical contraceptive options to all persons of reproductive age in a staged approach starting from the most vulnerable groups and gradually increasing the entitlement to free contraception.
4. To introduce the emergency contraceptive pill into the national formulary list to improve access in accordance with a clear pathway which also links to contraceptive advice and access where this is necessary.
5. To identify, explore and mitigate against the barriers (cultural, linguistic, age-related, legal) in access to modern contraceptives including the access to emergency contraception in community pharmacies.
6. To explore means to balance the sexual health and safeguarding needs with the parental rights and responsibilities in careers of minors accessing sexual and reproductive health services unaccompanied. This can be achieved by engaging in high-level interministerial policy/legal debate on access to services in this age group to identify and mitigate legal and policy barriers to ensure that services are accessible and available to those who require them.
7. To increase public and professional awareness as regards sexual dysfunction in all persons. To explore the tools and resources necessary for the diagnosis and management of the commoner sexual dysfunctions.
8. To implement the change from a liquid-based cytology screening methodology for cervical cancer to a primary HPV testing for all women and persons with a cervix as part of the National Cervical Screening Service.
9. To explore and implement HPV screening for MSM attending GU clinical services in line with emerging clinical guidelines.
10. To continue public campaigns encouraging the improved uptake of HPV vaccination among all genders including adolescent boys and to also offer the vaccination to key populations who may benefit.

Chapter 5
Key Populations

There are groups of persons in the population who may have a higher vulnerability to acquire an STI (including HIV) in view of their sexual behaviour. Other groups may be disadvantaged by virtue of the conditions within which they are born, grow, live, work and age- the social determinants of health. Yet others must be considered through a lens of intersectionality and prevalent societal assumptions regarding their sexuality, sexual orientation and gender identity such as in the case of elderly and also persons with disabilities where societal assumptions on heterosexuality, non-sexuality or hypersexuality, as well as stigma, may create additional barriers for such persons to live positive sexual experiences free from discrimination. (27,77,78)

Other groups may be at an increased risk of illness or may have less opportunities for sexual health education than the general population since they live in custodial or institutional settings, form part of an ethnic minority group or are possibly not targeted during sexual health promotion campaigns.

The migrant groups (both migrant workers and Sub-Saharan African migrants) are also a key population who carry a disproportionate burden of STIs including HIV possibly since they may come from endemic areas where certain STIs/ HIV are more prevalent and /or may have sexual health related behaviours which may put them more at risk. Furthermore, in view of cultural or linguistic barriers, they may find it more challenging to access the appropriate healthcare. Despite the availability of free healthcare to all those entitled, some groups may fail to have access to the necessary healthcare services or reproductive health services they require.

In an effort to 'leave no one behind,' (14) we must consider the various key populations and minorities in terms of their lived experiences including barriers in access to care, financial protection mechanisms in place to ensure no group 'falls through cracks'. To do this, we must redouble efforts to engage with community organisations, cultural mediators, embassies, NGOs, community champions to customise and outreach services within the community which are acceptable, trained in disability perspective and culturally sensitive to all.

A crucial element, in all of these approaches, is to ensure that no 'one size fits all' approach is used, when considering and addressing the needs of different key populations.

Key populations which deserve specific consideration in terms of SRHR and the related services include the following:

- MSM (Men who have sex with men)
- PWID (Persons who inject drugs)
- Persons living in custodial settings or in residential group settings
- Sex workers/people involved in prostitution
- Persons who are more likely to be targeted by violence- women, LGBTIQ+ persons
- Migrants inclusive of foreign workers and Sub-Saharan African migrants

Identify the key populations and persons with specific vulnerabilities ensuring targeted action to address their needs.

Key Populations

MSM

At a European level, HIV infection through sexual transmission related to MSM is the second most common mode of transmission of HIV; however, this is the group where incident cases are growing the fastest and this is cause for concern. This mode of transmission is the predominant one which shaped the epidemic curve locally in recent years and continues to be the most prevalent. This reinforces the need for targeted action among this population group. The EMIS[1] Survey outcomes show that there is a higher prevalence to risky sexual behaviours amongst this key population. This indicates a need for targeted sexual health related intervention in terms of prevention and clinical services.

Some outcomes from the survey carried out in 2017 which included a representative sample from Malta provide information on the risk-behaviours of the MSM. The findings showed that 4.4% of the sample population claimed to have used stimulant drugs during sexual encounters (as compared to 5.5% of other EU Member states), besides higher concerns in Malta as regards a lack of control over unwanted sex (10.1% Malta vs. 8.5% EU Member States). Besides engaging in chemsex during sexual activity, the proportion of respondents who were concerned about their own illicit substance abuse was higher than the European average (15.7% Malta vs. 12.2% EU Member States). In terms of sexual activity with multiple partners and unprotected sex, around 1/3 of the respondents had sexual intercourse with a non-steady partner in the previous year, with less than 1/5 of those having used a condom as a means of STI protection. The respondents were also more likely to engage in group sex involving more than three persons concurrently (29.5% Malta vs. 22% EU Member States). Reassuringly, one in four of the MSM population had been counselled as regards the possibility of using PrEP as a means to prevent HIV infection as opposed to 9.6% of MSM of the EU member states in the survey. (79) Around one fourth of the survey respondents had either bought sex or had engaged in sex work themselves.

[1] European MSM Internet Survey

Malta, in parallel with reported trends overseas, also noted to have increased reports of 'chemsex parties'. Chemsex is reported as an activity which increases the rates of STIs. (80) Chemsex means sex while using drugs also referred to as 'chems'. It involves the intake of psychoactive drugs to enhance sexual intercourse, increase desire and reduce inhibitions during parties. Besides the risks related to promiscuity and condomless sex, there are also implications on one's ability to consent. These activities may have mental health implications related to addiction, depression and anxiety. (80, 81) Chemsex may put a person in a lot of financial, emotional, mental and stress pressures. (82) Evers et al. (2020) showed that almost one in four MSM practising chemsex expressed a need for professional counselling on chemsex-related issues.

Information about U=U, PEP and PrEP is critical to decrease the population transmission of HIV. Rigorous trials such as the PROUD trial, ANRS-IPERGAY, and Partners PrEP trial have underpinned the ECDC evidence brief of October 2016 regarding PrEP. PrEP is effective in reducing the risk of HIV infection in seronegative persons who are at substantial risk of acquiring HIV, if this is taken as prescribed. The PROUD trial, by its design, was also able to refute the potential threat of risk compensation by PrEP users which is often cited as a concern to PrEP implementation. The study group assigned PrEP had no significantly increased risk of other STIs as compared to the control group assigned placebo. (83, 84)

Anti-retroviral treatment as post-exposure prophylaxis is prescribed for those who were at a high risk of HIV through unprotected sexual exposure, based upon a risk assessment carried out by specialist doctors at MDH, in accordance with a recent, evidence-based HIV post-exposure prophylaxis guideline. Currently, persons who are sexually exposed are advised to obtain a prescription as soon after the exposure as possible in order to start this 28-day course of anti-retroviral treatment (ART). Based on principles of health equity, the updated WHO consolidated guidelines emphasise the importance of financial protection for the use of ART as PEP for both occupational and non-occupational exposures including sexual exposures. This recommendation is based on the principle that, following an exposure to HIV, it provides a reduction in the risk of acquiring HIV infection when administered as post-exposure prophylaxis, and is likely to be cost-effective in high-risk groups. This effectiveness depends on appropriate compliance and adherence to treatment as prescribed. To date, this is available for free at MDH for those who are assessed to be at high risk following an occupational exposure or following a sexual assault. (85)

Persons who are involved in sex work or prostitution

Sex workers and their partners may be at an increased risk of HIV and STIs according to ECDC, although this varies widely by sex industry sector, place and over time. The risk increases if sex work takes place in conjunction with intravenous drug use (IVDU), if the sex worker is male or transgender. However overall, there is very limited data available on this group and even less on the users of commercialised sex services.

The availability of data regarding the population who are involved in sex work or their partners depends on the country and the policy context within which the sex work takes place. Characterising sex workers and their health risks in terms of STIs and HIV is difficult since there are many intersecting structural level risk factors such as poverty, unemployment, lack of social support, being foreign-born and other individual-level risk factors such as drug abuse or being a victim of human trafficking. There is a lack of local data on sex work in Malta and the limited research available sheds light on the complexity and heterogeneity of the sex workers in Malta. Heteronormative and cis-normative assumptions often describe female sex workers; however, males and gender non-conforming persons are also known to feature.

A systematic review which aimed to characterise the HIV and STI risk of female sex workers in Europe found that HIV risk remains low amongst female sex workers who do not inject drugs but there was an increased risk of STIs. In all countries included in this review, the estimates of violence in non-injecting sex workers were higher than the risk of HIV. (86) There is a lack of adequate behavioural surveillance of this key population and of those who pay for sex, with outcomes that are difficult to generalise in view of the heterogeneity of this population and the convenience sampling of the research. (87)

There are services targeted towards sex workers in Malta provided by NGOs. This comprises those persons who concomitantly inject drugs and are involved in sex work.

Persons who reside in custodial and residential group settings

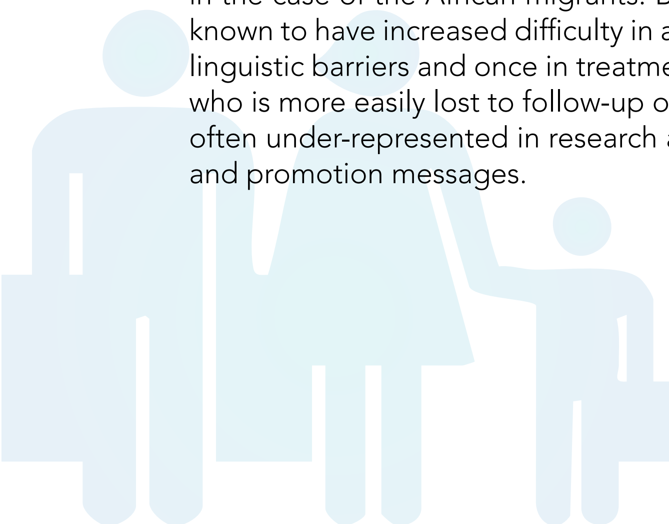
There may be an increased risk of blood borne infections such as HIV, Hepatitis B and Hepatitis C primarily in view of the association with intravenous drug abuse. Special considerations are required to ensure that those residing in correctional facilities and residential group settings have access to the same level of care available in the community as regards blood borne viruses and STIs.

Migrants

Migration patterns in European countries are driven by history, including former colonial links, and also European migration amongst others. This comprises a heterogenous group of persons who may have intersecting challenges in terms of background risk, religious, linguistic, social and cultural norms which could impact sexual behaviours and risk in terms of sexual health outcomes. According to the latest 2021 census, more than one in five Maltese residents are foreign born, with the largest proportion being Italian followed by British and subsequently the Indians and the Filippinos are most populous. Besides these economic migrants, Malta received a number of irregular migrants since the 1990s who may have been granted asylum in Malta (1) and continued to reside here whilst others may have lived here temporarily and relocated.

Across Europe/ EEA, migrants represent 42% of new HIV diagnoses. (41) A review of the HIV outcomes amongst migrants from low- or middle-income countries to high income countries by Ross et al. (2018) found that a good proportion of the migrants acquire the infection post-migration and that these are more likely to experience worse outcomes as compared to the native population. Factors driving the disparities include stigma and limited access to care which result from social isolation, linguistic barriers, poor health literacy, hostility, and undocumented status. (88)

Migrants are a key population since they could be born in a country where certain STIs/ HIV are endemic and at higher prevalence rates. It is also known that migrants may be more likely to be affected by sexual violence, be involved in prostitution, or forced genital mutilation (FGM) in the case of the African migrants. Besides the minority stress which they may face, they are known to have increased difficulty in access to culturally competent care in view of cultural and linguistic barriers and once in treatment, they are also known to be a more volatile population who is more easily lost to follow-up or is non-compliant to treatment. Migrant groups are also often under-represented in research and poorly targeted when developing health prevention and promotion messages.



Persons who experience sexual violence

Currently persons who are raped or sexually assaulted are supported at Mater Dei Hospital through the coordinated action of the medical professionals, psychosocial professionals (an NGO engaged through a Public Social Partnership with the Ministry for the Family and Social Solidarity) specialised in this care, the Malta Police Force, and appointed forensic experts as nominated by the Judiciary.

Multidisciplinary meetings including all stakeholders have taken place in recent years to draft coordinated pathways and continuously improve the management of victims of sexual assault irrespective of the gender of the victim, ensuring a victim-centred approach. All victims of sexual assault are offered free emergency contraception and post—exposure prophylaxis for HIV, GU follow up, medical and psychosocial support. This policy action builds upon the November 2020 recommendations of the GREVIO commission who were tasked with evaluating the country's implementation of the Istanbul Convention. (89) The Ministry for Health and Active Ageing continues to actively collaborate in the Interministerial committee on Gender Based Violence and Domestic Violence. Attention must be paid to the increased risk that certain persons in situations of vulnerability, such as persons with particular disabilities, face in respect of sexual violence and gender-based violence, especially women, girls and non-binary persons falling within this category. (90)

Transgender and Gender Diverse persons

Following the launch of the transgender healthcare policy in 2018, the Gender Wellbeing Clinic (GWC) has welcomed well over 400 clients to the clinic. Transgender and gender diverse persons are referred to the GWC to be able to access the medical and psychosocial support which would enable one to safely change one's physical appearance to match one's felt gender identity through individualised care pathways aligned with the Standards of Care Version 8. Over the years, progressive investment and new medical, psychosocial and surgical treatments were increasingly made available to transgender and gender diverse persons in line with the policy whilst investment in training of the multidisciplinary professional team took place in parallel.

The original transgender health care policy (2018) committed to explore the best means of provision of masculinizing and feminizing genital surgeries[2]. Transgender and gender diverse persons would be able to access to such specialized and complex surgeries after having been followed and known by the local GWC team who would ensure that the client is well informed of the expectations, risks and possible complications of such surgeries. It is recommended that surgeons consider gender affirming surgical interventions for transgender and gender diverse individuals where there is evidence of a multi-disciplinary approach comprising both mental health and medical professionals in the decision-making process.

In accordance with the Standards of Care Version 8 document, surgeons who perform such surgeries should fulfil the following criteria- training and documented supervision of gender affirming procedures, maintenance of an active practice of gender affirming procedures, knowledge about gender diverse identities and expressions, continuing education in this area of practice and also an exercise of tracking of surgical outcomes (91).

[2] This document can be accessed on https://health.gov.mt/wpcontent/uploads/2023/04/Transgender_Healthcare_EN-MT.pdf.

Policy Measures

To provide key populations, persons with specific vulnerabilities and gender diverse with targeted action to address their needs

Key Populations

For MSM

- To continue working with stakeholders to reinforce and deliver the best targeted campaigns for this population with a focus on prevention, early diagnosis and treatment, combatting stigma, and mitigating barriers to care. This aims to be achieved by working with frontliners to increase awareness and knowledge of the specific needs of MSM, continue promoting the condom as a basic means of prevention against HIV and STIs.
- Increase knowledge as regards PEP and PrEP and also as regards the health and other support services available.
- To provide free condom scheme at a population level as a basic prevention tool.
- To update guidance and entitlement to free antiretroviral treatment as post-exposure prophylaxis to include occupational and non-occupational exposures.
- To offer HPV vaccination to MSM and also explore the implementation of anal screening as part of specialist GU services.

For persons involved in sex work or prostitution

- To develop a multidisciplinary clinic by exploring options for shared clinics with other governmental entities and NGOs with a holistic patient-centred focus in order to tackle the medical, psychosocial, substance abuse needs of sex workers with a non-judgemental approach which does not discriminate on the basis of gender, race or sexual orientation.

For persons who reside in custodial and residential group settings

To ensure that the same comprehensive programmes available in the community are also available in custodial settings and group residential settings including:

- Provision of condoms and behavioural interventions promoting safer sex.
- Provision of opioid substitution treatment and clean drug injectable equipment to IVDUs.
- Offering testing for blood borne viruses and STIs if indicated at entry and periodically throughout incarceration or residential stay as indicated.
- Ensuring adequate linkage to care in a sensitive and confidential manner where the privacy of the individual is respected.
- Setting up a collaboration between community and prison or residential medical care providers to ensure that all preventative, screening, and curative aspects of care which are available in the community are also accessible in prison, detention or group residential settings.

- Care and support should, additionally, be designed and delivered in a manner that is sensitive to the needs of the populations in question, with professionals and other staff also receiving appropriate training.

For migrants

- To specifically target this key population with efforts to identify and mitigate the inequities and barriers in access to care in terms of sexual health related services, including the provision of linguistic and culturally competent care and access to preventative and curative services.
- To continue to support and engage with community champions and already existing governmental and NGO (such as the Migrant health liaison unit within PHC), including through outreach projects, to mitigate the barriers in access to care.

For persons who experience sexual violence

- To continue and consolidate the multidisciplinary collaboration between stakeholders involved in the management of sexual assault to ensure that the legislation, policies and procedures adopt a victim-centered approach, including sensitive interviewing of victims to prevent secondary-victimisation and adequate collection and storage of forensic specimens.
- To continue supporting professional training both at a generic and more specialised level among health care professionals on matters related to sexual assault, gender-based violence and domestic violence.
- To work with all stakeholders to identify and mitigate the barriers to reporting of sexual assault by all but particularly the more vulnerable categories, including key populations mentioned in this chapter but also other groups such as persons with disabilities.

Transgender and Gender Diverse persons

For Transgender and Gender Diverse persons

- To explore and formalise agreements with expert overseas centres where for gender affirming genital surgeries also referred to as 'bottom surgeries' can be carried out by specialists with expertise in such surgeries, in accordance with latest international best practices.

Persons with high-risk behaviours

For Key Populations with high-risk behaviours

- To provide free PrEP in addition to the currently available PrEP monitoring programme, based upon clearly defined eligibility criteria for those whose are at risk of acquiring HIV infection.
- To draft and communicate to the relevant clinicians eligibility criteria for PrEP based on current international best practices as part of a harm-reduction programme which includes behavioural interventions and regular screening for HIV.
- To adopt a harm reduction approach in persons who engage in practices involving sexual content and psychoactive substances (chemsex) by developing a specific service comprising an interdisciplinary team of professionals with easier referral pathways comprising GU specialists, urologists, hepatologists, and psychologists.

Chapter 6
Governance, Research, and Innovation

Throughout this strategy document, a variety of behavioural and biomedical interventions have been proposed as measures to enhance the current services already provided both within the public health sector and also those provided by NGOs and other entities. The adapted Consolidated Guidelines on HIV prevention, diagnoses, treatment and care for key populations 2016 update the biomedical and behavioural intervention strategies for combination prevention for HIV/STIs and the individual measures can be summarised graphically below:

Biomedical intervention strategies

- Diagnosis and treatment of sexually transmitted infection
- Needle and syringe programmes designed to present HIV prevention and opioid toxicity
- Voluntary medical male circumcision
- Male and female condom provision
- (both biomedical and behavioural)
- Vaccination (e.g. HPV vaccine, hepatitis B vaccine)
- Immediate ART for all people diagnosed with HIV
- Pre-exposure prophylaxis
- Antiretrovirals in PMTCT services
- Prevention and management of comorbidities, including hepatitis, tuberculosis, and mental health conditions
- Blood safety, standard precautions in health care settings

Behavioural intervention strategies

- Promotion of sexual well-being through brief sexual-related communication
- Behavioural intervention to promote:
  - Partner reduction
  - Condom use
  - Uptake of sexually transmitted infection & HIV testing, counselling and treatment
- Comprehensive sexuality education
- HIV testing and risk-reduction counselling
- Interpersonal communication, including peer education and persuasion
- Social marketing of prevention commodities and condom
- Cash incentives for individual risk avoidance

How behavioural interventions can complement and strengthen biomedical interventions

- Awareness: demand creation, peer outreach, social media
- Self-efficacy: reducing stigma and discrimination, legal social issues
- Uptake: risk perception, risk screening, choice
- Ability: providing motivation and skills to enable safe behaviours
- Adherence: disclosure, peer support, reminders
- Retention: combination of all the above

Figure 11 Biomedical and behavioural intervention strategies for combination prevention (29)

Governance

The challenges often lie in the integration and coordination between all the services provided at a national level and also to ensure appropriate funding and research to support the policy action and its implementation. Toskin et. al (2020) have listed the key priorities to advance behavioural interventions for sexually transmitted infections and/ or HIV prevention and reduction (Figure 11). It is proposed that this function of integration of care across entities and coordination is supported by an appropriate governance structure to ensure implementation and evaluation of the measures included.

- Train health-care providers in communication and culturally sensitive-competence around sexuality.
- Develop an intervention manual and guidelines, including provider training on behavioural interventions and brief sexuality-related communication in particular.
- Tailor behavioural intervention to various target groups through close collaboration with the target population and their health-care providers.
- Gain understanding of the technical capacity of health-care providers and their supervisors to integrate new activities at their health centres.
- Simplify all interventions for easier integration into existing services and systems.
- Make interventions affordable and more accessible.
- Strategically link biomedical and (brief) behavioural interventions in the process of planning and implementation.
- Engage decision-makers, civil society groups and all gatekeepers, from policy level to the facility and community level, in the initial stages of programme development and implementation.
- Take advantage of opportunities to use information and technologies and mobile health applications to reduce, though not replace, or complement the time required for human interaction with a client.
- Set up appropriate study designs, including randomized controlled trials and mixed-method studies, and disaggregate the data on each component or active ingredient of each intervention, to examine what is or is not actually effective.
- Develop, evaluate and promote behavioural interventions in a way that is linked to the currently available and forthcoming biomedical interventions (pre-exposure propylaxis; circumcision, point-of-care, community-based and self-administered testing; and multi-purpose prevention technologies).

Figure 12 Key priorities to enhance behavioural interventions for sexually transmitted infections and/or HIV prevention and reduction (29)

Surveillance and Research

During the compilation of this strategy, some key areas were identified for research opportunities. These include:

- Continue periodic national sexual health research initiatives to characterise population level knowledge, attitudes and behaviours in relation to sexual health and monitor trends over time
- To include indicators related to sexual and reproductive health in other national surveys conducted
- To analyse available data on PrEP users and persons who participate in chemsex who attend GU services
- To encourage research on underrepresented populations in sexual health research- LGBTIQ+ persons, elderly, persons with disabilities migrant populations, sex workers.
- To continue research to evaluate the sexual health education outcomes in schools according to the perceptions of educators, students, and parents
- To incorporate audit and evaluation of the initiatives already existing and also those proposed in this strategy document, once implemented, to be able to direct funding to where it is truly impactful.

Innovation

Information and communication technologies (ICT) as applied to sexual health are being increasingly used and researched with an aim to increase access to services and care. With increasing demand for sexual health services, health ICT are necessary to automate workflows and care where possible. ICT in relation to sexual health has been used successfully in the following instances:

- 'Digital doors' to sexual health services have been used in healthcare settings, with risk assessment algorithms guiding patients to the appropriate services according to their medical complaints and risk.
- Similarly, telemedical services could be considered to replace some of the physical patient encounters, making more efficient use of time, decreasing travelling costs whilst also facilitating access to those who may be reluctant to attend for such services due to stigma.
- Partner notification apps are available on the market and can be considered to complement/ or incorporated as a function in the existing electronic patient records for GU services to inform potential contacts of the need to access health care for STI testing.
- Sexual health education- information is already available through the dedicated Sexual Health Malta webpage; however, further enhancements including a chat bot with frequently asked questions, an anonymous chat box could be considered to allow the public to ask some sensitive questions in complete anonymity.
- Contraception: The provision of free condoms and modern contraceptives requires to be supported by the IT infrastructure to audit consumption and provide linked educational material on appropriate use.
- Opportunities for self-testing or self-sampling of STIs are well implemented in various settings, and once the efforts to increase capacity through decentralised services are well established, these options for self-management of STIs could be considered. (91,92)

Policy measures

- To set up an implementation steering group comprising representatives from MHA, health care entities, other Ministries, civil society groups, NGOs with an aim to devise action plans, human resource plans, budgeting plans for the implementation of the measures within this strategy.
- To continue to invest in research in relation to sexual health both at a national level and amongst specific key populations, and also to evaluate any current or new services which are introduced.
- To invest in the supporting ICT infrastructure and digital tools to enable the integration of sexual health care services between the various clinics, laboratories, public health department- through interoperable IT systems ensuring patient-centred and integrated care. To build on and invest strategically in ICT to enable improved access to sexual health services in terms of prevention and clinical services based on the measures outlined in this strategy and international best practices.
- To ensure that all relevant actions undertaken are participatory in nature, and follow best practices such as through the principle of co-production, further to Malta's obligations in terms of the UN Sustainable Development Goals (14) to 'Leave No One Behind', and to specific requirements of instruments such as the UNCRPD, (18) which mandates 'Nothing About Us, Without Us', while being in line with appropriate ethical guidelines.

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