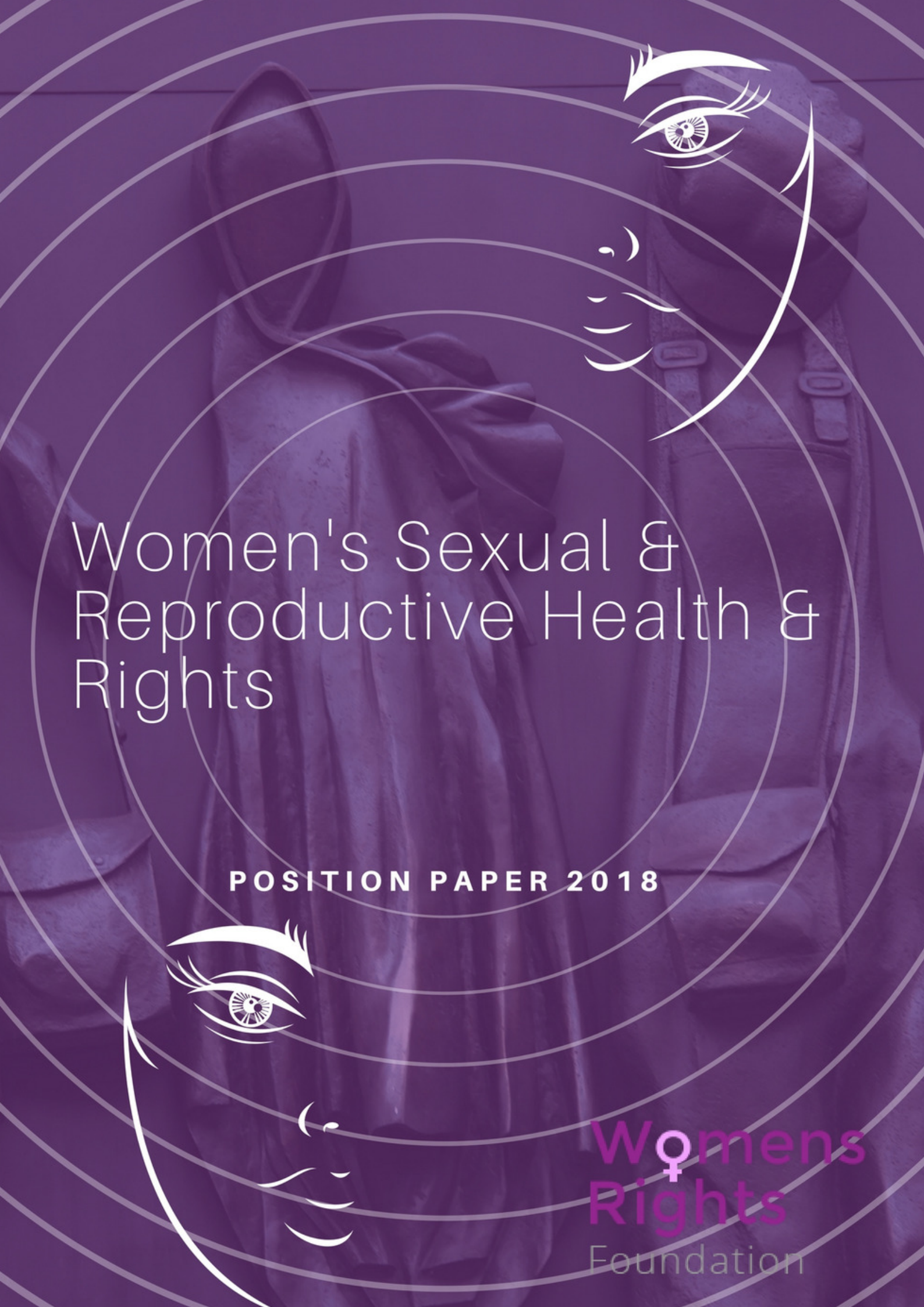

Women's Sexual & Reproductive Health & Rights

POSITION PAPER 2018

Womens Rights Foundation

About The Foundation

Women's Rights Foundation (WRF) is a voluntary organisation committed to informing, educating and empowering women concerning their legal rights.

WRF aims to ensure that women's rights are protected through policy and law reform, raise awareness and offer training to end violence against women.

WRF also provides free legal advice and initial legal representation to women who are survivors of domestic violence, sexual assault, human trafficking and discriminated against due to their gender.

Training to individuals and organisations on issues related to women's rights is also provided and can be customised on request.

This Position Paper was produced by Women's Rights Foundation Malta
Written by Dr.Lara Dimitrijevic (founder) & Dr.Andreana Dibben. Further editing was done by other members of the Foundation.

Designed by Proteus Malta Ltd.

Table of Contents

Executive Summary

Women's sexual and reproductive health and rights are recognised worldwide as a priority health issue. Women are more likely to fall victims to sexual violence, make decisions on contraceptive use and carry sole responsibility for pregnancy.

This paper advocates for all women and girls in Malta to have access to comprehensive sexual and reproductive health and explores areas through which good sexual and reproductive health can be achieved.

Since Women's Rights Foundation is a rights-based organisation, this paper follows a rights based approach and gives recommendations pertaining to the following areas:

1. A National Action Plan for Sexual and Reproductive Health
2. Comprehensive sexuality education with gender equality and human rights at its core
3. Contraception and family planning
4. Access to safe and legal abortion

The following recommendations are being put forward:

Recommendation 1: Revise the National Sexual Health Strategy to reflect legal and societal changes occurring since 2011. A National Action Plan needs to be developed with clear responsibilities, timelines and measures of monitoring and evaluation to ensure accountability and quality standards in services. Actions should be assessed on the basis of structural, process and outcome indicators using the AAAQ approach (availability, accessibility, acceptability and quality). The development and implementation of this Action Plan needs to involve stakeholders from different fields and maximise participation of civil society and citizens. Knowledge platforms are recommended to place more emphasis on sharing and documenting knowledge through interdisciplinary dialogues.

Recommendation 2: Develop family, school and community-based sexuality education and awareness raising programmes and strategies that place gender equality and human rights at the centre and use methods that foster participation and critical thinking. It is important to ensure that information provided is accurate, evidence-based and tackles and dispels myths and misconceptions.

Recommendation 3: Enable access to sexual and reproductive health services through a number of community-based clinics that provide services that are gender and age appropriate and that further conduct outreach for marginalised groups. The provision of sexuality education and SRH services should be closely linked and their delivery should be combined with efforts to build awareness and acceptance for their provision among gatekeepers. Such services need to be monitored and evaluated and staff need to be provided with regular, specialised, and evidence-based training.

Recommendation 4: Eliminate practical, financial and legal restrictions on the provision of contraceptives especially for young people and persons on low income. Subsiding contraception should be considered as a public health investment and should be extended for all brands and methods of modern contraception. Requirements for third-party authorisation that impede access to contraception for adolescents under the age of 16 should be removed. People should have access to contraception services at times, and in places, that are convenient to them.

Recommendation 5: Guarantee the practical availability of a wide range of contraceptives including LARCs (e.g. implants, patch and injection) which are currently only available from certain pharmacies on a named patient basis.

Recommendation 6: Decriminalise abortion so that Maltese women who access abortion in other countries or through telemedicine do not face criminal proceedings and risk three years imprisonment especially when accessing local health services for possible post-abortion complications.

Recommendation 7: Provide access to safe and legal abortion to all women in Malta through the public health system and licensed private providers at least in the following circumstances:

a. To save a woman's life;
b. To preserve a woman's physical and mental health;
c. In cases of rape or incest;
d. In cases of severe fatal foetal impairment.

Introduction

Sexual and reproductive health and rights are fundamental to individuals, couples, and families, and to the social and economic development of communities and nations. Various international bodies (United Nations, WHO, Lancet Guttmacher Commission, Council of Europe) have claimed that access to high-quality, affordable sexual and reproductive health services and information, including a full range of contraceptive methods, is fundamental to realizing the rights and well-being of women and girls, men and boys (WHO, 2018).

When it comes to women, reproductive control is central to their health and autonomy, and where services are inadequate, cost in health, life and personal freedom can be enormous. Some women may be further marginalised because of individual characteristics (such as disability or sexual orientation), family characteristics (such as single-parent households), community characteristics (such as ethnicity) or societal characteristics (such as poverty or homelessness). Marginalised women are more likely to experience health and social problems and less likely to obtain preventive and curative health services.

Key global initiatives, including the Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health, call for universal access to family planning services as a right of women and girls and as crucial to a healthy life (WHO, 2018).

A Rights-Based Approach

A rights-based approach recognises that women have the right to self-determination, privacy, consent, information and to make decisions about their health and their lives. Malta is signatory to a number of international treaties and laws that have enshrined women's sexual and reproductive rights.

The International Conference on Population and Development Programme of Action (1994) establishes that:

Reproductive rights "embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."

Sexual and reproductive health is "a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Sexual and reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant"

The ICPD PoA contains a range of thematic issues that together constitute a comprehensive approach to SRHR. These include: a satisfying sex life, capability to reproduce, the freedom to decide if, when and how often to reproduce, information and counselling, appropriate health care services, family planning and sexual health.

The Beijing Declaration and its Platform for Action (1995) further recognises that human rights of women are fundamental to their well-being and health:

'*The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women* and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (United Nations, Fourth World Conference on Women, Beijing, 1995'.
The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) also affirms that women have a right to 'decide the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rigths' (CEDAW, Article 16)

Adolescence has been given special attention by international bodies working in the area of SRHR. In 2012, the Commission on Population and Development in its final resolution emphasised the following points:

a. The right of young people to comprehensive sexuality education (CSE) to decide on all matters related to their sexuality;

b. Access to Sexual and Reproductive health services, including access to safe abortion, where legal, that respect confidentiality and do not discriminate;

c. The protection and promotion of young people's right to control their sexuality free from violence, discrimination and coercion.

A National Plan
For Sexual & Reproductive Health

Malta launched its first National Sexual Health Policy in 2010 and went on to set a National Sexual Health Strategy in 2011. Through this strategy a sexual health website was set up and a national study on sexual attitudes and behaviours was conducted. While these were important steps forward, we note that since then not much has been done on a national level in this area. Many of the measures outlined in the document, which are all measures that we support, have not been implemented. Local research in SRHR is scarce and there are various knowledge gaps as will be highlighted in subsequent sections of this paper. Interdisciplinary dialogue and joint creation of knowledge is encouraged to advance SRHR research, policies and practices (Haas and Van der Kwaak, 2017).

Recommendation 1

Revise the National Sexual Health Strategy to reflect societal changes occurring since 2011. A National Action Plan needs to be developed with clear responsibilities, timelines and measures of monitoring and evaluation to ensure accountability and quality standards in services. Actions should be assessed on the basis of structural, process and outcome indicators using the AAAQ approach (availability, accessibility, acceptability and quality). The development and implementation of this Action Plan needs to involve stakeholders from different fields and maximise participation of civil society and citizens. Knowledge platforms are recommended to place more emphasis on sharing and documenting knowledge through interdisciplinary dialogues.

Comprehensive sexuality education
(with gender equality and human rights at its core)

Adolescents' vulnerability to poor SRH is compounded by their insufficient, inaccurate or complete lack of knowledge and information about safe sex and contraceptive use. In the National Health Survey of 2012, amongst the 16 - 18 year old age group there were greater misconceptions and uncertainties about contraception than in older age groups. The lack of knowledge and misconceptions about contraception among adolescents was also reflected clearly in studies carried out by Bugeja (2010), NCPE (2012) and Dibben (2015).

A comprehensive approach to sexuality education helps young people to not give in to peer pressure and gain skills to build healthy, responsible, and mutually protective relationships when they become sexually active. Comprehensive sexuality education programmes do not increase sexual activity but delay onset of sexual activity, decrease the number of sexual partners and increase use of contraception (SEICUS 2009). On the contrary, evidence shows that sex education programmes that are based on abstinence do not lead to healthy sexual behaviour. Sex -ed programmes should not only focus on sex and sexuality but also on healthy consensual relationships, communication, gender roles, and making responsible decisions, including how to avoid unwanted verbal, physical, and sexual advances (SEICUS 2009).

Violence against women and girls increases the risk of poor SRH outcomes including unintended pregnancies and acquisition of STI's among adolescent girls. Young men are turning to pornography to experience sex that is in turn affecting negatively their perception of sexual relationships (Flood, 2010). This is in turn increasing violent and aggressive sexual behaviour against women and girls (Guy et al, 2012).

Adolescent girls have less power to negotiate safe sex with their partners, especially if they are in a relationship with older men. In a doctoral study by Bugeja (2010), carried out with over 1000 fourteen and fifteen-year olds in Malta, a salient finding was that girls were much more likely to engage in sexual activity with older boys. In fact, 49% of sexually active girls had had intercourse with a partner aged over 17 and 14% of sexually active girls had had intercourse with a partner older than

20. Dibben (2015)'s doctoral study with teenage mothers further concluded that young men's behaviour within intimate relationships are influenced by gender attitudes and stereotypes and that gender inequality in intimate relationships weakens female adolescents' abilities to negotiate contraceptive use. Violence also starts early in the lives of many girls and in most cases, the perpetrators are peers or influential adults within – or in close contact – with their families. This makes it harder for girls to refuse unwanted sex or to resist coerced sex. Gender norms further lead women and girls to bear this burden in silence by shaming and stigmatising them.

The National Action Plan, Vision 2020, Gender Based Violence and Domestic Violence Strategy and Action Plan, is the first national action plan to set out a zero tolerance approach towards violence. Article 12 of the Istanbul Convention ratified by Malta in 2014, states that the question of imbalance of power in personal relationship needs to be addressed through preventive programmes. It is a prerogative that sexual and relationship education is based on the premise of creating relationships that are power equal and gender equal.

While we acknowledge that the Guidelines for Sexuality and Relationship education for Maltese Schools published in 2013 by the Ministry for Education is a positive step, we note that teachers do not receive sufficient training as part of their continuous professional development on this issue and are not provided with adequate resources to implement the guidelines. We reiterate our statement published in a press release in January 2017 that such sessions are delivered by educational professionals and that anti-choice organisations that rely on obsolete evidence are not invited by schools to deliver sessions on reproductive health. A system of monitoring and evaluation should be in place to ensure that learning objectives are being reached across all schools.

When it comes to adults, reluctance to discuss sexuality openly and honestly increases health costs and limits the effectiveness of health promotion. Positive approach to sex and sexuality is based on the premise that women and men are both sexual beings and have equal right to intimacy and pleasure. A healthy sexual relationship involves mutual consent, equality, respect, trust and safety. Women have equal right to find pleasure and engage freely in sexual activity, without feeling shame or pressure to please.

Recommendation 2

Develop family, school and community-based sexuality education and awareness raising programmes and strategies for all ages that place gender equality and human rights at the centre and use methods that foster participation and critical thinking. It is important to ensure that information provided is accurate, evidence-based and tackles and dispels myths and misconceptions.

Contraception and Family Planning

Universal access to effective contraception ensures that all adults and adolescents can avoid the adverse health and socioeconomic consequences of unintended pregnancy and have a satisfying sexual life.

Women who can plan the number and timing of their births enjoy improved health, are less likely to have an abortion, and have more educational and employment opportunities, which may enhance their social and economic status and improve their well-being (Shrestha & Manandhar, 2003; Barnett & Stein, 1998; Singh et al., 2004; author's reference). To achieve these benefits, it is important that women have access to a wide range of contraceptive methods at all stages of their reproductive lives.

We do not know whether or the extent to which men, women and adolescents in Malta face an unmet need for contraception since to our knowledge, no studies have been carried out in this regard. However, for 64% of participants in Abela et al.'s (2015) study with lone parents and for two thirds of the participants in Dibben's study (2015) with teenage mothers, pregnancy was unintended. There is no data on the rate of unintended pregnancies among married/cohabiting couples.
A reproductive health report in 2011 showed that only 55.4% of respondents used modern contraceptive methods with condoms being the most preferred method at 39%, while the use of the oral contraceptive pill was at 15.6% and the use of IUD was very low at 0.5% (The European Society of Contraception and Reproductive Health, 2011). Other forms of long-acting reversible contraception such as hormonal subdermal implants and the contraception injection did not even feature since these are not available in Malta.

The National survey on sexual attitudes, knowledge and behaviour held in 2012, in Malta also showed that the rates of effective contraception use is low (less than 40% among those with at least 2 sexual partners in the last six months). In this study, the method of contraceptive use was not specified.

A comprehensive approach to sexuality education helps young people to not give in to peer pressure and gain skills to build healthy, responsible, and

Men and women of all ages can face financial, cultural or social barriers in accessing sexual and reproductive health but young people face additional challenges especially if providers and communities are biased against youth access to contraception and if services are not youth-friendly.

According to the latest international HBSC survey (2016), that 25% of boys and 19% of girls have had penetrative sexual intercourse. This is above the HBSC average of (24% of boys and 17% of girls) . Even more worrying are the rates of contraception use. When it comes to the use of condoms, Malta fares the worst of all countries except for Poland with 41% reported use during last intercourse. It is interesting that when young people were asked whether they or their partner had been on the contraceptive pill, only 5% of girls reported that they were, compared to 16% of boys. It is very likely that boys might think that their partner is on the pill when in fact, they are not. From Bugeja's study in 2010, the rate of condom use remained more or less the same (60% of his participants had reported never using a condom), while the rate of girls on the pill increased slightly (2.5% of sexually active girls reported being on the pill in 2010). The National Health Survey in 2012 showed that 30% of sexually active young people aged 16 -18 did not use any form of contraception.

From an ecological framework there needs to be interventions at the individual level to strengthen agency and facilitate empowerment; at the relationship level to promote supportive relationships; at the community level to change social norms to enable women and girls, boys and men to learn about sexuality, access services and challenge harmful practices; and at the societal level (laws, policies and media campaigns) to create both state and institutional accountability and broad structural change in support of sexual and reproductive health (Svanemyr et al, 2015). Interventions that promote gender equitable norms and power relationships as well as human rights need to be central to all programmes and policies.

It is clear from the above that as highlighted by the Commissioner for Human Rights report (2017), access to effective methods of modern contraception continues to be impeded by a range of affordability and availability deficits, information shortfalls and policy barriers. In line with this report, the following recommendations are therefore aimed at increasing the affordability, availability and accessibility of modern contraception.

Recommendation 3

Enable access to sexual and reproductive health services through a number of community-based clinics that provide services that are gender and age appropriate and that further conduct outreach for marginalised groups. The provision of sexuality education and SRH services should be closely linked and their delivery should be combined with efforts to build awareness and acceptance for their provision among gatekeepers. Such services need to be monitored and evaluated and staff need to be provided with regular, specialised, and evidence-based training.

Recommendation 4

Eliminate practical, financial and legal restrictions on the provision of contraceptives especially for young people and persons on low income. Subsiding contraception should be considered as a public health investment and should be extended for all brands and methods of modern contraception. Requirements for third-party authorisation that impede access to contraception for adolescents under the age of 16 should be removed. People should have access to contraception services at times, and in places, that are convenient to them.

Recommendation 5

Guarantee the practical availability of a wide range of contraceptives including LARCs (e.g. implants, patch and injection) which at the moment are only available from certain pharmacies on a named patient basis.

Access to safe and legal abortion

One cannot talk about sexual and reproductive health and ignore the issue of abortion even though we acknowledge that in Malta, this topic remains highly controversial.

The UN Human Rights Committee states that the right to life is jeopardized where women's lives and health are at risk as a result of lack of access to safe and legal abortion services. They have further added that restrictive abortion laws lead women to seek unsafe abortions, thus putting them at risk. Complete ban and restrictions on abortion by means of criminal laws and legal restrictions is tantamount to inhumane or degrading treatment or punishment as violating women's right to privacy. The Human Rights Committee Observations on Malta further held that abortion should at least be made available in cases where a woman's life is in danger and in cases of incest and rape. It further called upon Malta to ensure that reproductive health services are accessible to all women and girls throughout the country.

In 2015, at 4.2% Malta was one of the top 10 countries in Europe when it comes to the proportion of teenage mothers. Up until 2010, Malta had even higher rates of teenage births (7.85% in 2005, 6.38% in 2010). In the past five years, the rate of teenage births has decreased significantly. The fact that teenage births are in decline is quite perplexing, considering what seems to be increasing sexual activity and low contraceptive use. According to Dr Valeska Padovese, consultant at the GU Clinic, the decline may be related to the increased use of emergency contraception or abortion in the past few years, despite the complete ban on abortion in Malta (Times of Malta, 2017). A recent study by the Grech et al (2017) found that pregnant students in state schools outnumber those in non-state schools at a ratio of 6 to 1. While there are a number of possible reasons for this situation as highlighted by Dibben (2015), given that students in non-state schools tend to come from more affluent backgrounds may also indicate that abortion is more accessible to this population.

A complete ban does not stop Maltese women from seeking abortion. It is a fact that the internet has made it easier to arrange a safe abortion. Travelling to abortion clinics in other countries has become much easier through low-cost airlines. Others who cannot or do not wish to travel opt to carry out a medical abortion in the comfort of their homes through the use of abortion pills which they can purchase online.

To date there is no official data that indicates the number of Maltese women who undergo clandestine abortions. From actual data that is available, we know that around 50 to 80 women travel every year to the United Kingdom. We also know that between January 2013 till January 2018, 465 women living in Malta contacted Women on Web to purchase abortion pills online [Personal communication with R. Gomperts, 2018].

If one were to compare Malta with a territory that have very restrictive abortion laws and a strong religious influence such as Northern Ireland, adjusts the numbers for the Maltese population and extrapolates figures, one would conclude that on a yearly basis around 200 women purchase abortion pills online, whilst around 370 travel for an abortion. These figures have recently been highlighted in the media by the AD Chairperson, Carmel Cacopardo, who upon consultation with medical professionals estimated the number of women accessing abortion to be around 300 to 400. As he clearly concluded, this makes the rates of abortion by Maltese women at par, if not higher than other European countries (Cacopardo, 2017). As has been continuously pointed out by the World Health Organisation, if the aim of a country is to make abortions rarer, zero tolerance achieves zero results and the only way to reduce the number of abortion is through investing in measures that increase the use of contraception.

Furthermore, a total ban on abortion creates social inequality and discrimination. In limiting women's choice to reproductive rights, women who have the financial and practical means to seek abortion can do so elsewhere, while those who cannot, either risk three years imprisonment and a criminal record when they access medical abortion online, apart from the potential health risks involved or are forced to carry on with an unwanted pregnancy. This situation grossly affects adolescents, asylum seekers and undocumented migrants as well as women who are in violent relationships. Abortion is still a taboo topic in Malta.

It has for decades been shrouded in secrecy, with myths and misconceptions being promulgated by various organisations and individuals. It makes the situation of those thousands of Maltese women who have accessed an abortion feel isolated, humiliated and stigmatised as well as living in fear of possible criminal and social consequences. As a result, this inadvertently incurs a physical, psychological, financial and social burden on women that impacts their health and well-being.

Recommendation 6

Decriminalise abortion so that Maltese women who access abortion in other countries or through telemedicine do not face criminal proceedings and risk three years imprisonment especially when accessing local health services for possible post-abortion complications.

Recommendation 7

Provide access to safe and legal abortion to all women in Malta through the public health system and licensed private providers at least in the following circumstances:

a. To save a woman's life
b. To preserve a woman's physical and mental health
c. In cases of rape or incest
d. In cases of severe fatal foetal impairment

References

Abela, A., Bezzina, F., Casha, C., Azzopardi, R.M. (2015). Improving the quality of life of lone parents in Malta.

Presentation at the National Conference: Single Parenthood in Malta: Key Findings from two research studies (23 January 2015).

Allen, R. H. (2007). The role of family planning in poverty reduction. Obstetrics and Gynaecology, 110(5), 999-1002

Barnett, B. and Stein, J. (1998). Women's Voices, Women's Lives: The Impact of Family Planning, Research Triangle Park, NC, USA: Family Health International (FHI).

Bernstein, S. and C. J. Hansen. 2006. Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. New York: United Nations Millennium Project.

Bugeja, R. (2010). Assessing young people's learning needs related to sexuality and relationships on the Maltese Islands. PhD. School of Education, University of Southampton.

Cacopardo, C. (2017). L-abort: X'inhu jigri hawn Malta? Carmelcacopardo.wordpress.com

Carabott, S. (2017). When it comes to birth certificates, is it two genders, two measures? Times of Malta: December, 18.

Casterline, J.B., & Sinding, S.W. (2000). Unmet need for family planning in developing countries and implications for population policy. Population and Development Review, 26(4), 691-723.

Commissioner for Human Rights (2017). Women's sexual and reproductive health and rights in Europe. Council of Europe: Commissioner for Human Rights.

Convention on preventing and combating Violence against women and girls and domestic violence. Council of Europe 11th May, 2011.

Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment: Resolution adopted by the General Assembly 10th December 1984.

Convention on the Elimination of all forms of Discrimination Against Women. United Nations High Commissioner for Human Rights, adopted 1979.

Council of Europe, Women's sexual and reproductive health and rights in Europe, Issue Paper 2016

Dibben, A. (2015). Teenage pregnancy and motherhood in Malta: A feminist ethnography. PhD. School for Policy Studies, University of Bristol.

Eurostat Press Office. (2017). Teenage and older mothers in the EU. [online].
Fisher, W.A and Barak, A (2001). Internet pornography: A social psychological perspective on internet sexuality.

Flood, M. G. (2010). Young men using pornography. In K. Boyle (Eds.), Everyday Pornography (pp. 164-178). London: Routledge.

Grech, V., Gatt, M., Camilleri, R. & Calleja, N. (2017). Teenage pregnancy in Malta. Malta Medical School Gazette, Vol. 1, Issue 4.

Guy R, Patton G, Kaldor J (2010), Internet pornography and adolescent health: Early findings on effects of online pornography on adolescents show associations with risky behaviour, Medical Journal of Australia (MJA 196(9)) pp. 546-7.

Haas, B.D. & van der Kwaak, A. (2017). Exploring linkages between research, policies and practice in the Netherlands: perspectives on sexual and reproductive health and rights knowledge flows. Health research policy and systems, 15: 40.

Harris, C. (2017). Which EU country has the most teenage mothers? Euronews: www.euronews.com/2017/09/02/which-eu-country-has-the-most-teenage-mothers
Health Behaviour in School Aged Children (2016). Growing up unequal: gender and socioeconomic differences in young people's health and well being. International report from the 2013 / 2014 Survey. World Health Organisation.

Human Rights Committee, Concluding Observations: Poland, para. 8, U.N. DOC. CCPR/CO/82/POL (2004)

Human Rights Committee, General Comment No. 28, para.10; Human Rights Committee, Concluding Observations: El Salvador para. 14, U.N. Doc. CCPR/CO/78/SLV (2004)

Human Rights Committee, Concluding Observations: Malta, para. 13, U.N. Doc. CCPR/C/MLT/CO/2 (2014)

Lindberg L.D., Boonstra H.D., Guttmacher Institute. Despite New Branding, Abstinence-Only Programs Have Same Old Problems.

Ministry for Education and Employment. (2015). Guidelines on sexuality and relationship education in Maltese Schools. Malta: Directorate for Quality and Standards in Education.

Ministry for Health, Elderly and Community Care (2011). National Sexual Health Strategy. Malta: Ministry for Health, Elderly and Community Care.

Ministry for Health, Elderly and Community Care (2010). The National Sexual Health Policy for the Maltese Islands. Malta: Coop

National Commission for the Promotion of Equality. (2012). The life prospects of teenage parents: Research findings report. Malta: Outlook Coop.

SIECUS (2009), What research says...Comprehensive sex education, Fact Sheet.
Singh, S., Darroch, J. E., Vlassoff, M., & Nadeau, J. (2004). Adding it up: the Benefits of Investing in Sexual and Reproductive Health Care. New York: The Alan Guttmacher Institute/UNFPA.

Svanemyr, J., Amin, A., Robles, O.J. & Greene, M. P. (2015). Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches. Journal of Adolescent Health, 56, 7 - 14.

The European Society of Contraception and Reproductive Health. (2011). The reproductive health report 2011. The European Journal of contraception and reproductive health care [online]. 16 (1) 1 - 70. Available from: http://www.informalhealthcare.com

Trussel, J. (2007). The cost of unintended pregnancy in the United States. Office of Population Research, Princeton University, Princeton.
World Health Organization (2010). Social Determinants of Sexual and Reproductive Health: informing future research and programme implementation.

World Health Organisation (2018). Family Planning: A global handbook for providers.