



Women's Health Victoria

# Models of good practice in sexual and reproductive health for women

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## Acronyms

- ATSI** Aboriginal and Torres Strait Islander
- CALD** Culturally and linguistically diverse
- CSE** Comprehensive sexuality education
- DfES** Department for Education and Skills (UK)
- IPPF** International Planned Parenthood Federation (UK)
- IUD** Intra Uterine Device: A small plastic device with copper stem inserted into the uterus for contraceptive purposes.
- TOP** Termination of pregnancy or abortion refers to a procedure designed to end a pregnancy prior to full term.
- PSHE** Personal, social and health education (UK)
- SRE** Sex and relationships education (UK)
- SRH** Sexual and reproductive health
- STI** Sexually transmitted infections. STIs are any infection or disease that is transmitted by sexual or genital contact. This may include vaginal secretions, semen, blood or contact with infected skin around the genital area.
- UK** United Kingdom
- US** United States
- WHO** World Health Organisation
- WHV** Women's Health Victoria

## Introduction

Australian experts in the field of sexual and reproductive health (SRH) state that no single policy exists for this in Australia. They also argue that current disparate policies across states, territory and national government are not consistent with good practice<sup>1</sup>.

This document provides some examples of current good practice in sexual and reproductive health as revealed from the literature across a range of factors that emphasise a positive relationships and wider community approach. It takes a rights based approach to sexual and reproductive health in accordance with World Health Organisation (WHO) guidelines.

### Aim

The aim of this paper is to provide an overview of some national and international good practice models for specific sexual and reproductive health areas that could be applicable to Victoria.

### Method

A review of international literature was performed, which included material from countries with comparable social, political and economic conditions to Australia. Common themes and principles of good practice in sexual and reproductive health were identified from these resources and are summarised herein.

The paper is formatted according to five categories of sexual rights drawn from the World Health Organisation (WHO).

The WHO states that sexual rights embrace human rights already recognised in international laws, international human rights documents and other consensus statements. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health and access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and,
- pursue a satisfying, safe and pleasurable sex life<sup>2</sup>.

For the purpose of this document these rights have been grouped into five categories. Most fit neatly into one category, some overlap categories and others such as 'consensual marriage' are broader than the scope of this document and have not been addressed.

The five categories are:

1. The right to the highest standard of sexual health and access to sexual and reproductive healthcare services

This category also addresses the right to 'seek, receive and impart information related to sexuality', and looks at good practice models in this area.

2. The right to freedom from coercion, discrimination and violence

This category includes good practice models in relation to childhood sexual abuse, the sexualisation of girls by the media, and prevention strategies related to sexual coercion, assault and rape.

3. The right to sexuality education

This category also includes the right to 'seek, receive and impart information related to sexuality' and highlights good practice models related to the spectrum of sexuality education, including the biological and social aspects of sexual and reproductive health and sexual relationships.

4. The right to decide whether or not and when to have children

This category looks at good practice models related to contraception and termination of pregnancy services.

5. The right to a satisfying, safe and pleasurable sex life

This category encompasses good practice models related to safe and respectful relationships, and a positive approach to sexual and reproductive health.

## Good practice

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'Good practice' can refer to any model that comprises the most beneficial outcomes for a particular field or discipline. What passes as good practice is dependent upon what is required and will differ across and within disciplines according to different objectives and priorities.

The elements of good practice for any area will be subjective, based on the lens being used and the framework within which that lens is situated. For example elements of good practice may be culturally, ideologically, financially, or religiously driven, to name a few. The lens used might be a gender lens, a health lens, a Christian lens, an economic lens, a rights-based lens and so on.

The elements of good practice in sexual and reproductive health will also be subjective. In the United States for example, it is not uncommon for particular groups to advocate for abstinence as an element of good practice. Agreement or disagreement with this stance may be based on religious or other ideological views.

The subjective nature of good practice is tethered somewhat by empirical research. Research assists investigators to more readily discern which elements are more likely to constitute good practice based on their effectiveness in relation to desired outcomes.

This paper provides a review of some good practice models for women's sexual and reproductive health based on national and international research literature. Good practice models are grouped within the five rights-based categories drawn from the WHO and outlined in Section 1.

# 1. The right to the highest standard of sexual health and access to sexual and reproductive healthcare services

## 1.1 Good practice: a rights based approach to young women's sexual and reproductive health

High standards of sexual health and access to sexual and reproductive health services are aided by good policy. This section outlines a framework of good practice as used by the International Planned Parenthood Federation (IPPF). The IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights. Their vision is:

...a world in which all women, men and young people have access to the information and services they need; a world in which sexuality is recognized both as a natural and precious aspect of life and as a fundamental human right; a world in which choices are fully respected and where stigma and discrimination have no place<sup>3</sup>.

The IPPF emphasises the importance of consistent policy that meets the needs of those it is designed to assist and protect. To this end, the IPPF has created a ten-year framework for 2005 to 2015. Within this they list five priority areas:

1. Adolescents and young people
2. HIV and AIDS
3. Abortion
4. Access
5. Advocacy<sup>3</sup>

The following is taken directly from the IPPF's priority area for adolescents and young people. Areas not relevant to an Australian context have been omitted. The example encapsulates good practice elements associated with the highest standard of sexual health and access to sexual and reproductive healthcare services:

**Good practice**

The goal is:

'All adolescents and young people are aware of their sexual and reproductive rights, are empowered to make informed choices and decisions regarding their sexual and reproductive health, and are able to act on them'<sup>3</sup>.

Program strategies are:

1. To strengthen commitment to, and support for, the sexual and reproductive health and rights and needs of adolescents/young people:
  - a) Advocacy:
    - for positive attitudes towards young people's sexuality, recognising their specific rights, and sexual and reproductive health needs
    - for a supportive and enabling environment
    - for upholding the sexual and reproductive health and rights of young people
    - for resources
    - for increased provision of sexual and reproductive health information, education and services for all young people
    - for legal change/supportive legislation

- to promote the Convention on the Rights of the Child
  - b) Empowerment and mobilisation of young people to be advocates for the advancement of their own rights
  - c) Work in partnership with youth organisations, civil society organisations, the private sector and governments
2. To promote participation of adolescents/young people in governance and in the identification, development and management of programs that affect them:
    - a) Advocacy:
      - to promote the involvement of young people in community policy and decision making
    - b) Sensitise adults to work with young people as equitable partners
    - c) Review/establish governance structures at all levels to facilitate youth involvement
    - d) Institutionalise youth participation and in different capacities (volunteers, staff)
    - e) Promote and support youth initiatives
    - f) Initiate and promote leadership program for young people
  3. To increase access to comprehensive, youth friendly, gender-sensitive sexuality education:
    - a) Advocate for and provide education, promoting a positive approach to young people's sexuality and a non-prescriptive, evidence-based, rights-based approach
    - b) Identify and implement programs to reach young people with diverse needs and sexual orientations
    - c) Pilot, evaluate and scale-up innovative approaches aimed at the provision of integrated sexual and reproductive health and rights information, sexuality education and life skills for young people
    - d) Encourage partnerships and dialogue with parents, teachers, local authorities, etc
    - e) Encourage youth participation in the development and implementation of information and education provision
    - f) Develop evidence-based, good practice guidelines on sexuality education
  4. To increase access to a broad range of youth friendly services:
    - a) Provide comprehensive youth friendly high quality services that meet the specific needs of men and women
    - b) Pilot, evaluate and scale-up innovative approaches aimed at the provision of integrated sexual and reproductive health services that meet the diverse needs and sexual orientations of young people
    - c) Establish effective referral systems and partnerships for young people
    - d) Encourage youth participation in the development, implementation and monitoring and evaluation of services
    - e) Sensitise, motivate and build capacity among service providers to ensure staff commitment
  5. To reduce gender-related barriers and practices which affect the sexual and reproductive health and rights of young women:
    - a) Advocate for and mobilise civil society to challenge gender-related barriers and practices that restrict young women's sexual and reproductive health and rights
    - b) Create opportunities which will empower young women, enhance their decision making skills and enable them to participate in mainstream development debates
    - c) Engage boys and men in addressing gender equality<sup>3</sup>

## 1.2 Good practice: government commitment to reducing adolescent pregnancy

Despite contraceptive services in the United Kingdom (UK) largely being free, the UK still has one of the highest rates of teenage fertility across Western Europe<sup>4</sup>. In the UK, the Teenage Pregnancy Independent Advisory Group (TPIAG) makes recommendations to the Minister for Children, Young People and Families and helps inform the UK Government's Teenage Pregnancy Strategy<sup>i</sup>.

The UK Department of Health in its *National Health Service Operating Framework 2008-9* recently announced £26.8 million for contraceptive services, including a focus on the reduction of teenage pregnancy<sup>4</sup>. However, TPIAG argues that reducing teenage pregnancy needs to be included across all relevant government and private sectors.

The latest TPIAG annual report for 2007/08 records a national decline of 13.3 percent in the conception rate for under eighteen year olds. It states that the teenage pregnancy rate is the lowest it has been in the UK for twenty years and continues to fall in 89 percent of local authorities<sup>4</sup>.

The report identified seven points that each of the local areas, which had made significant progress, had in common. These are outlined below:

### **Good practice**

1. A strong senior champion or a team of champions is in place to take the strategic lead and be accountable.
2. Children and young people's services work together effectively to reduce teenage pregnancy.
3. Accessible, 'young people friendly' contraceptive and sexual health services are provided and publicised, offering a full range of contraceptive methods including long-acting contraceptives.
4. All schools provide Personal, Social and Health Education (PSHE) which includes comprehensive programs of Sex and Relationships Education (SRE).
5. Young people at greatest risk of teenage pregnancy are identified and supported through effective targeted intervention.
6. The provision of multi-agency training to ensure that everyone working with children and young people are confident and competent in addressing relationships and sexual health.
7. A well resourced youth service which addresses sexual health and related risk behaviour<sup>4</sup>.

In 2008, the Department of Children, Schools and Families responded to recommendations made by an external steering group, which had conducted a review of the UK's school-based sex and relationships education (SRE)<sup>ii</sup>.

<sup>i</sup> More information about the UK Teenage Pregnancy Strategy can be found at the Government website: <http://www.everychildmatters.gov.uk/health/teenagepregnancy/about/>

<sup>ii</sup> The full reports of the Steering Committee and the UK Government's response can be viewed at: <http://www.teachernet.gov.uk/docbank/index.cfm?id=13030>

The Sex and Relationships Education Guidance can also be downloaded for free from: <http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DfES%25200116%25202000>

In the Department of Children, Schools and Families (UK) reply to the steering group's 2008 report, the Government responds to six areas focused on by the steering group:

***Good practice***

1. Improving the skills and confidence of those who deliver sex and relationships education
2. The role of external contributors in supporting schools' delivery of sex and relationships education
3. The need for further guidance and support for schools
4. Involving young people in the design of sex and relationships education programs
5. How best to maximise the impact of wider programs and initiatives and
6. Improving school leadership on sex and relationships education<sup>5</sup>.

In October of 2008, the UK Government, in an adoption of the Dutch model of sexual and reproductive health education<sup>6</sup>, announced that Personal, Social and Health Education (PSHE) would become a compulsory part of the school curriculum for 5 to 16 year olds. This incorporates sex and relationship education (SRE) and will come into effect by 2010, but a number of schools have already started to implement it. An independent review into making PSHE statutory is due to be published at the end of April 2009<sup>iii</sup>.

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<sup>iii</sup> See the UK National Curriculum site for more information: [http://curriculum.qca.org.uk/News-and-updates-listing/News/PSHE\\_end\\_of\\_KS\\_statements.aspx](http://curriculum.qca.org.uk/News-and-updates-listing/News/PSHE_end_of_KS_statements.aspx)

## **2. The right to freedom from coercion, discrimination and violence**

### **2.1 Good practice: media literacy in school-based education programs**

In recent years in Australia there has been an increased focus on the sexualisation of younger women and girls in the media and popular culture. Researchers from the Australia Institute describe the sexualisation of children and young people as:

‘...the process whereby the slowly developing sexuality of children is prematurely advanced and moulded into stereotypical forms of adult sexuality as a result of inappropriate advertising and marketing’<sup>7</sup>.

The sexualisation of girls and women in the media and popular culture often reflects a view of women as objects, a commodity with no other intrinsic worth. Children receive messages about image and behaviour that is portrayed to be desirable. The sexualisation of children also risks normalising and possibly encouraging paedophilic sexual desire for children<sup>7</sup>.

A recent Australian Senate Committee investigation<sup>8</sup> into the sexualisation of children in the contemporary media noted that repeated messages from a variety of media have a cumulative negative impact on young people. This has also been identified by earlier research conducted by the American Psychological Society.

The negative effects include:

- harm to girls’ self-image and healthy development<sup>9</sup>;
- diminished sexual health<sup>10</sup>;
- reduced assertiveness<sup>10</sup>;
- a decrease in protective behaviours<sup>10</sup>;
- body dissatisfaction<sup>9</sup>;
- low self-esteem, and other mental health factors including depression<sup>9</sup>;
- decreased physical health, for which they cite a link between body dissatisfaction and cigarette smoking<sup>9</sup>;
- diminished sexual health and an adverse affect on the development of sexuality<sup>9</sup>; and,
- an adverse affect on girls’ overall beliefs and ideas about women and gender roles, resulting in them adopting more of the stereotypes about women<sup>9</sup>.

The literature states that media literacy taught in schools will better protect young girls against sexualising images. Comprehensive sex education can also address the issue of sexualising media, culture, and peers, and counter their influence by teaching girls and boys the importance of autonomy and mutual respect in sexual relationships<sup>9</sup>.

An outline of this approach is shown below:

### **Good practice**

Australian submissions to the Senate Committee outline the benefits of:

1. Comprehensive age-appropriate, sequential sexuality education
2. Education that encompasses broad issues such as social and cultural factors rather than a purely biological approach
3. Media literacy programs that teach girls to critique and understand the salience of sexualising images in the media.

The Australian Senate Committee made recommendations along similar lines:

‘...that state and territory governments, which have the responsibility for education, consider the introduction into all Australian schools of comprehensive sexual health and relationships education programs which are inclusive of both young people and parents, adopting a consistent national approach to the question’<sup>11</sup>.

## **2.2 Good practice: school-based sexual violence prevention**

Sexual coercion is a common experience that has detrimental effects on various aspects of people's lives. It most generally occurs at the ages at which people become sexually active, with women more likely than men to be sexually coerced<sup>12</sup>.

In the 2003 report *Sex in Australia*, the authors state that there is a need to reduce the incidence of sexual coercion and for more accessible services responding to the effects of sexual coercion<sup>12</sup>.

In the article *Working with adolescents in the education system to prevent sexual assault*<sup>13</sup>, past and current notions of prevention strategies are reviewed, with the author concluding that schools need to be the site of prevention. This was a common theme across the literature.

Elements drawn on in the review come from two programs run by CASA House, one of the fifteen Centres Against Sexual Assault (CASA), in Victoria, and research related to the *share* (sexual health and relationships education) program in South Australia.

Below is a snapshot of the sexual coercion prevention activities that promote good practice in sexual and reproductive health.

### ***Good practice***

From the CASA House model:

1. Emphasis on discussion about sex not rape or violence
2. Separate classes for girls and boys until the final session where girls and boys debate their opinions with each other
3. Open debate about how to differentiate between sex and sexual assault
4. Discussion about the impact of media representations of violence, sex, and sexuality
5. Discussion about the meaning of consent and social pressures that influence communication
6. Discussion about the impact of sexual assault on female and male victims
7. Social action strategies to prevent sexual assault in society
8. Inclusion of local police officers at some point to reinforce that sexual assault is both harmful and criminal<sup>13</sup>

Themes across the literature:

1. Be positive about sexuality
2. Move beyond information provision
3. Address the social and cultural world in which young people make decisions
4. Address the issue of gender
5. Refrain from teaching abstinence alone
6. Promote an understanding that sexuality and sexual behaviours are diverse
7. Address the issue of risk
8. Focus on skill development
9. Incorporate peer education and peer support
10. Involve wider community, particularly parents<sup>13</sup>

### 3. The right to sexuality education

#### 3.1 Good practice: comprehensive sexuality education

The International Planned Parenthood Federation (IPPF) describes comprehensive sexuality education as equipping young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality—physically and emotionally, individually and in relationships<sup>14</sup>. Within this framework, sexuality is viewed holistically and in the context of emotional and social development. Information provision is deemed inadequate on its own. Comprehensive sexuality education or CSE aims to give young people the opportunity to acquire essential life skills and develop positive attitudes and values.

#### *Good practice*

The IPPF states that there are seven essential components of CSE:

1. Gender – exploring gender roles and attributes; understanding perceptions of femininity and masculinity within the family and across the life cycle; society's changing norms and values; manifestations and consequences of gender bias, stereotypes and inequality
2. Sexual and reproductive health – understanding STIs and HIV, what they are and how to prevent them; pregnancy options and information; sexual response; living with HIV; how to use condoms; anatomy; sexuality and the life cycle (puberty, menopause, sexual problems)
3. Sexual citizenship – knowledge of international human rights and national policies, laws and structures; understanding that culture is dynamic; available services and resources and how to access them; participation; practices and norms; advocacy; choice; protection; consent and the right to have sex only when you are ready
4. Pleasure – understanding that sex should be enjoyable and not forced; that it is much more than intercourse; sexuality as part of everybody's life; the biology and emotions behind the human sexual response; gender and pleasure; masturbation; love, lust and relationships; interpersonal communication; the diversity of sexuality; the first sexual experience; consent; alcohol and drugs and the implications of their use
5. Violence – exploring the various types of violence towards women and men, and how they manifest; rights and laws; support options available and seeking help; community norms (power, gender) and myths; prevention, including personal safety plans; self-defence techniques; understanding the dynamics of victims and abusers; appropriate referral mechanisms for survivors
6. Diversity – recognising and understanding the range of diversity in our lives (e.g., faith, culture, ethnicity, socio-economic status, ability/disability, HIV status and sexual orientation); a positive view of diversity; recognising discrimination, its damaging effects and dealing with it; developing a belief in equality; supporting young people to move beyond just tolerance
7. Relationships – different types of relationships (e.g., family, friends, sexual, romantic, etc.), emotions, intimacy (emotional and physical), rights and responsibilities, power dynamics, and recognising healthy and unhealthy or coercive relationships .

Based on these seven principles, the IPPF provides the following as a good practice model for comprehensive sexuality education. It comprises planning; delivery; and assessment and evaluation:

## ***Good practice***

### **Planning**

1. Partnerships – A working group with youth representatives can act as advocates, assist the development of CSE policies and programs, train and support educators and share the responsibility for delivering parts of the program.
2. Participation – Ensure that young people are involved in all elements of CSE policy and program development.
3. Needs – Map out the needs of young people within the community in terms of their emotional, social and sexual health and well-being. For example, rates of STIs and unintended pregnancy, violence, media and peer pressure, average age of first sexual activity, etc.
4. Challenges – Map out the challenges and opposition to CSE and develop a plan of how to work constructively to overcome these. For example, there may be concerns about the reactions of community or faith groups.
5. Policy Statement – Update an existing policy or develop a new policy statement which includes a clear definition. This policy and definition will form the basis of future programs.
6. Sexual and reproductive health & HIV linkages – Guidelines and policies incorporate and highlight the links between sexual and reproductive health and HIV.
7. Gender Sensitive – Policies and programs are gender sensitive and culturally sensitive.
8. Clear Objectives – Develop CSE programs with a clear aim and purpose, and be precise about what is to be achieved:
  - Measurable: Quantify your objectives
  - Achievable: Are you being realistic?
  - Resourced: Do you have the resources to make the objective happen?
  - Timed – When will you achieve objective?
9. Clear messages – Be clear about the message being conveyed.
10. Informed choices – Promote free choice and informed consent, and make sure the focus is not on abstinence as the sole method for prevention.
11. Peer educators – Work with peer educators or youth representatives and take into account their training and support needs.
12. Training – Train ‘educators’ who are committed; Look to partner agencies, such as other sexual health services, local universities and voluntary groups that have expertise in certain topic areas to support training educators.
13. Community participation – Ensure that systems are in place for community participation, whether for developing policy or programs, in delivering appropriate parts of CSE or simply in supporting CSE activities.
14. Links to services – Make links to health and advice services
15. Target audience – Have a clear idea of who this program aims to reach

### **Delivery**

1. Environment – Establish a safe learning environment in which open and non-judgmental discussions about sex, sexuality and sexual health can be held.
2. Group agreement - Develop a ‘group agreement’ prior to starting any work to ensure

acceptable boundaries for discussion that safeguard young people and educators.

3. Boundaries – Ensure one-to-one work also acknowledges the need for boundaries and ensure child protection procedures are followed.
4. Confidentiality – Respect the privacy and confidentiality of young people and inform them of their rights.
5. Participatory methods – Use methods that encourage children and young people to participate in learning such as active methods – don't talk AT them!
6. Accessing services - Ensure that information is given about advice services that young people can access if they need help and make referrals if necessary.
7. Be honest – If an answer to a question is not available, always refer to alternative sources of information.
8. Choosing curricula and resources – Ensure they are appropriate for needs, comprehensive and include all CSE components.
9. Materials and resources – Ensure they are correct and up to date, and avoid stereotyping.

### **Assessment and evaluation**

1. Focus on learning and effectiveness – Include assessments of learning and an evaluation of program effectiveness, for e.g. quizzes, poster making, role-play, discussion, debates, presentations, interviews and questionnaires.
2. Pre- and post-assessment – This will identify the needs of individual young persons, provide them with opportunities to reflect on what they have learnt and provide evidence that the young person has developed a greater understanding of a topic.
3. Process and outcome evaluation – Conducting an evaluation at the end of the program will also establish what methods have or have not worked (process evaluation) and whether the program has been effective in the short, medium and long-term (outcome evaluation). It is vital that SMART objectives are stated at the beginning of the program and that milestones are set .

## 4. The right to decide whether or not and when to have children

### 4.1 Good practice: contraceptive convenience

Across the literature the ways in which contraception is accessed is raised as an issue. One good practice model based on the concept of 'contraceptive convenience' was found to address most of the concerns highlighted in the literature. 'Contraceptive convenience' means that contraception is better integrated into the everyday lives of women, and access to contraception is simplified<sup>15</sup>. This American paper advocates for the 'demedicalising' of contraception; a proposition that 'seeks to strip away layers of medical intervention or requirements deemed outmoded or immaterial and that impede access and inhibit use'<sup>15</sup>.

Certain contraceptive methods will always require a medical provider: IUDs for instance. However, it is argued that adopting a 'contraceptive convenience' approach would 'increase women's access, lower discontinuation rates, decrease financial and logistical hurdles for women, and ultimately reduce rates of unintended pregnancies'<sup>15</sup>.

Advocates of contraceptive convenience state that the measures below would result in 'real, meaningful and practical support, which would enable women to avoid unwanted pregnancies, improve their health and better plan and pursue their lives'<sup>15</sup>.

Below is the model of good practice based on contraceptive convenience:

#### ***Good practice***

Contraception convenience would involve:

1. Removal of the requirement of a prescription for hormonal contraceptives
2. Making oral contraception available directly from a pharmacy
3. Providing advance supplies of contraceptives
4. Online health assessments for contraceptive use with follow-up telephone call by a nurse
5. A change in the labelling of emergency contraception, so that product labels are simple, comprehensible and accurate—user-friendly and up-to-date<sup>15</sup>

The literature also states that changes to access needs to coincide with changes to the attitudes, knowledge and practices of service providers. On a broader level it was deemed necessary to create a cultural environment that highly values contraception, not merely accepts it<sup>16</sup>. This was seen to include service providers, with the following suggestions offered by one set of researchers:

#### ***Good practice***

1. Curriculum based contraception training for medical students
2. Continuing education for primary healthcare providers and pharmacists in evidence-based and practical hands-on experience
3. Availability of service providers to answer method-based contraceptive questions<sup>16</sup>.

## 4.2 Good practice: Abortion care pathway

With termination of pregnancy no longer in the Victorian Crimes Act the focus now is on state-wide good practice strategies for abortion services. The literature reveals that women want support for the duration of their unplanned pregnancy experience<sup>17,18,19</sup>. Access to services, interpreters and unbiased information is necessary. Counselling that is supportive, non-judgemental and which provides all options (abortion, adoption and parenting) is deemed to be helpful<sup>17</sup>. Follow-up after termination of pregnancy is also important<sup>18</sup>.

The London based Royal College of Nursing (RCN) produced the *Abortion care pathway* report in 2008. The document includes a reference guide to good practice for access and referral to abortion services, pre-abortion assessment, abortion methods and post-abortion care. While some of the guide is location-specific, much of it is more broadly applicable. An adapted version of the guide is included below, with some of the language changed and references to UK law and UK legal forms removed<sup>iv</sup>.

### **Good practice**

#### **Access**

1. Easily accessible and designated location
2. Central information and booking services
3. Direct access and referral within 5 working days
4. Promote awareness and provide information about procedures and services
5. Provide interpreters and female practitioners where possible
6. Referral from a wide range of health care services/agencies as per local policy/contracts

#### **Pre assessment**

1. Assessment should be in clinic time dedicated to women requesting abortion
2. Nurse led clinics using locally agreed care pathways, with access to medical support
3. Comprehensive and unbiased information regarding options and methods of abortion (including potential complications).
4. Provision of written information to include information regarding disposal of foetal remains
5. Manage patient expectations by clear explanation of what the procedure(s) involve.
6. Refer to specialised counselling if appropriate
7. Prophylactic treatment for STIs +/- screening
8. Accurate gestational assessment including access to sonography services away from antenatal services
9. Screening for haemoglobin concentration, haemoglobinopathy (where appropriate) and rhesus blood groups
10. Prompt referral to other abortion providers if required
11. Medical assessment and speedy referral if preexisting medical conditions
12. Counselling and initial supply or plan of contraception to be used post-abortion
13. Consent for procedure by appropriately trained staff
14. Ascertain communication lines for confidentiality
15. Ensure the national rulings or local guidelines are followed where indicated:
  - Local child protection procedures
  - Domestic abuse (may be helpful to see woman alone at some point during consultation)

<sup>iv</sup> The original may be viewed at: [http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0008/194282/003270.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0008/194282/003270.pdf) in Appendix 1 on page 17.

based on nurse's assessment)

16. Provide written information so that women with specific wishes on disposal of foetal material know how to make those wishes known

#### **Abortion**

1. Choice of method which takes into account gestation and individual circumstances
2. Terminate Pregnancy as necessary
3. Dedicated clinic
4. Privacy and dignity. Ideally women undergoing second trimester abortion should have the privacy of a single room
5. Oral and parenteral analgesia should be available
6. Administration of long acting reversible contraceptive (LARC) methods at time of abortion
7. Care and procedure provided by appropriately trained and qualified staff
8. Anti-D prophylaxis if required

#### **Post-abortion care**

1. Written information regarding possible symptoms and emergency care if required
2. Access to a 24- hour telephone helpline
3. Planned follow up appointment to:
  - Discuss ongoing contraceptive needs
  - Assess physical condition post-abortion
  - Refer to specialised counselling services if appropriate
4. Antibiotic/ prophylactic antibiotic treatment
5. Referral to next tier sexual health services for women who screen positive for STIs
6. Prompt discharge summary to GP/ referring practitioner or to patient if no contact with GP or referrer
7. Sensitive disposal as consented (verbal or written) of foetal remains.
8. Provide written information<sup>19</sup>

## 5. The right to a satisfying, safe and pleasurable sex life

### 5.1 Good practice: ethical, respectful relationships

A 2006 Australian study into ethical relationships discussed the role of education in helping to foster safe and respectful relationships<sup>20</sup>. The researchers concluded that key elements that need to be part of such education include:

#### **Good practice**

1. Communication skills
2. Complexity of consent and skills to do this
3. Respect for self and other
4. Self reflection
5. Relationship skills
6. More info on all forms of violence and impacts on young people
7. Challenge violence & more support for victims in rural areas
8. Positive role models promoting non-violence
9. Single gender classes
10. Real life stories<sup>20</sup>

### 5.2 Good practice: safer sex, positive development, empowerment and choice

Of the international literature reviewed, one program, the *SAFE Project*, captured the themes of others. The *SAFE Project* involved twenty-six European countries united in developing new ways for information provision, service, support, and policy development around the sexual and reproductive health and rights of young people. It was a joint project run by the International Planned Parenthood Federation European Network (IPPF-EN), the Lund University (Sweden), the World Health Organisation Regional Office for Europe and the European Public Health Alliance (EPHA)<sup>21</sup>.

The *SAFE Project* states that sexuality education must help young people to acquire accurate information, develop like skills and nurture positive attitudes and values<sup>21</sup>.

According to the IPPF, sexual and reproductive health education:

- Does not result in early or increased sexual activity
- Does not encourage young people to engage in risky behaviour
- Can delay the onset of sexual activity and decrease overall sexual activity
- Can lead to safer sexual practices among those already sexually active
- Provides a forum for open discussion on gender and sexuality roles in society
- Can enhance intercultural dialogue among young people<sup>22</sup>.

The IPPF states that too much emphasis has been placed on the biological aspects of sex and reproduction, and that what is needed is more guidance on the emotional and social aspects of sexual relationships<sup>21</sup>.

The IPPF's minimum standards for sexuality education are based on a positive approach to sexual and reproductive health that links safer sex with positive development, empowerment

and choice rather than traditional approaches that link sex with risk taking and the prevention of pregnancy and infections.

As outlined in section 3.1, important elements of this good practice include:

- Gender: roles, perceptions, social norms, bias, stereotypes etc
- Sexual and reproductive health: STIs, HIV, pregnancy, use of barrier contraception
- Sexual citizenship: human rights, laws, advocacy, consent and choice
- Pleasure: understanding sex in context of sexuality, emotions, relationships etc
- Violence: types of violence, laws, support, myths, prevention, power dynamics
- Diversity: recognising diversity, discrimination, equality
- Relationships: types of relationships, emotional intimacy, power dynamics, healthy versus unhealthy relationships<sup>14</sup>

One of the key factors of good practice in sexual and reproductive health education for young people is deemed to be the participation of young people in the planning, development and implementation of policy, programs and practice<sup>22</sup>. The following two examples of good practice in action are programs that were developed in consultation with young people and implemented with the participation of young people.

Below are two program examples from the *SAFE* Project of good practice in action:

### ***Good practice***

#### **UK**

The *Speakeasy programme* run by the UK Family Planning Association provides training to enable parents and carers to become sex and relationship educators at home. Topics include puberty, contraception, STIs, social pressures and abuse. Additional training is available to parents who want to then teach other parents. This program has been adopted by Ireland, Lithuania, Bosnia and Russia among others<sup>22</sup>.

#### **Belgium**

In 2004, Sensoa, a member of the International Planned Parenthood (IPPF) Association, produced the *Laura* campaign. Based on a comic book story about a 16-year-old girl who becomes pregnant, *Laura* was targeted at 13-year-olds and their parents. It used television and cinema commercials, created a website with free podcasts of a radio show on youth and love. The show could also be added to online chat programs such as MSN. Upon opening MSN they'd receive a safer sex question to test their knowledge<sup>22</sup>.

## Summary

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This document has outlined some examples of good practice models for women's sexual and reproductive health as identified from a national and international literature review. It has been organised along the lines of five categories in accordance with the World Health Organisation's definition of sexual health rights.

Common themes across the literature have been the involvement of women in the planning and management of their sexual and reproductive health needs. Greater access to services, a requirement to attend to the diversity within population groups, and participation of young people in the planning and development of strategies that attend to their sexual and reproductive health needs were also repeatedly referred to. One of the single most dominant themes was the need for all-inclusive and comprehensive education programs that involve peer educators, parents and the wider community. The literature also revealed that good practice involves a commitment by governments to fund sexual and reproductive health programs for the longer term. Policy review and change were deemed necessary to for this and to help ensure the highest standard of sexual and reproductive health.

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