

MRC/CSO Social and Public Health Sciences Unit   
Consultation Response

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| **Title of consultation** |
| Sexual Health Standards |
| **Name of the consulting body** |
| Healthcare Improvement Scotland |
| **Link to consultation** |
| <https://www.smartsurvey.co.uk/s/SexualHealthStandardsSurvey/> |
| **Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?** |
| The MRC/CSO Social and Public Health Sciences Unit, University of Glasgow is an interdisciplinary group of sociologists, anthropologists, psychologists, epidemiologists, geographers, political scientists, public health physicians, statisticians, information scientists, trial managers and others. The Unit receives core-funding from the Medical Research Council and the Scottish Government Chief Scientist Office, as well as grant funding for specific projects from a range of sources. We conduct research to understand the determinants of population health and health inequalities, and to develop and test interventions to improve health and reduce inequalities, using a wide variety of methods including qualitative research, the collection, linkage and analysis of social survey and routinely collected data, evidence synthesis, randomised controlled trials and natural experimental studies. The unit includes a team of researchers engaged in social science research to understand and address sexual health issues. Further information about the Unit is available at [http://www.sphsu.mrc.ac.uk/.](http://www.sphsu.mrc.ac.uk/) |
| **Our consultation response** |
| **Standard 1: Each organisation demonstrates effective leadership, governance and partnership working in the management and delivery of sexual health services**  *Standard 1.2 “effective data collection” AND Standard 1.6 “the effective collation of anonymised data in support of sexual health care governance.”*  **Comment:** Should these standards also recommend improvements to tools needed to facilitate effective collection and collation of data?  *Standard 1.6 “the use of a national IT system such as the National Sexual Health System (NaSH) for reporting, benchmarking and performance” and standard 1.11 “systems in place to monitor and respond to sources of sexual health concern – determinants of poor sexual health”*  **Comment:** NaSH provides good monitoring data for STIs and BBV; however, national indicators specifically on sexual health – and national level systems for reporting them – are less well developed. Progress against outcomes 4 and 5 of the previous Sexual Health  framework (coercion/stigma) was difficult to ascertain because of a lack of nationally agreed |

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| indicators and a system for reporting against them. We would support the extension of NaSH (or other information systems) to sexual health indicators including coercion and stigma.  Researchers in the MRC/CSO Social and Public Health Sciences Unit have developed and validated a 13-item measure of sexual wellbeing that could provide relevant indicators (published soon; available from [Kirstin.mitchell@glasgow.ac.uk](mailto:Kirstin.mitchell@glasgow.ac.uk)). The measure includes items on: sexual safety and security, sexual respect; sexual self-esteem, resilience in relation to sexual experience; forgiveness of past sexual experience; comfort with sexuality; self- determination in one’s sexual life. |
| **Standard 2: All individuals receive accessible information to facilitate informed choice and support decision making**  **General comment:** The criteria listed under standard 2 appear to refer only to information provided during a clinical consultation. The recently published CONUNDRUM study highlighted young people’s need and interest in having access to honest and evidence -based information on sexual health, including on sexual health services prior to consultations. Young people engage critically with different sources of information about condoms and contraception (e.g.  NHS websites, friends, unknown others on social media), yet describe challenges navigating the complexity of incomplete or contradictory messages within this information landscape. And while many young people reportedly turn to official healthcare sources (e.g. NHS websites, GPs, nurses) for accurate information on condoms and contraception, they do not always trust that they will receive the most honest input (e.g. on side effects) from these sources. Adding criteria about the availability of information outside of consultations could help ensure young people are fully involved in all decisions (criteria 2.2) and are made aware of what services are available to them.  Supportive of the currently suggested standards, an unpublished review by Baxter (PhD student at MRC/CSO Social and Public Health Sciences Unit) has found that improved clinic access, sensitive engagement and provision of alternative contraceptive methods are components of service delivery most likely to contribute to young people’s reduced risk of pregnancy.  **Reference:**  Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixedmethods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONtraception UNDerstandings: Researching Uptake and Motivations).  MRC/CSO Social and Public Health Sciences Unit: University of Glasgow. Available at: [www.gla.ac.uk/conundrum](http://www.gla.ac.uk/conundrum) |
| **Standard 3: Each organisation demonstrates commitment to the education and training of all staff involved in sexual health care, appropriate to roles and workplace setting**  *Criteria 3.4 Staff providing sexual health care have access to training covering: […] communication skills which focus on person-centred care, […]*  **Comment:** We welcome the inclusion of training on communication skills which focus on  person-centred care under criteria 3.4 The CONUNDRUM study highlighted young people’s perspectives on the various types of sexual health services, including specialised sexual health |

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| clinics and GP surgeries. Findings highlight some dissatisfaction with the quality of services received in terms of the interaction experienced with staff. Despite clear preferences for consultations about contraception in specialist sexual health settings, three-quarters of contraception-using survey respondents had their most recent consultation at a GP surgery. Causes for dissatisfaction with contraceptive consultations include feelings of being pushed towards certain methods, not being heard or respected, dismissal of side effects, a dismissal of interactions between contraception, other medication and health conditions, and limited time given to discussions. These findings emphasize the need for communication skills which focus on person-centred care of all involved staff working in sexual health care.  Relatedly, standard 3 and its criteria, do not clarify whether training refers to all services (including pharmacies, GP surgeries) and whether this refers to medical staff only, or if this applies to 'support’ staff as well (e.g. receptionists). In addition, does education and training also include pre-service settings (I.e. medical and nursing education curriculum)? Our research suggests that training of GP clinic staff is particularly important given their role in contraceptive consultation.  We welcome the list of training that should receive. We would request that unconscious bias training includes biased expectations based on age; our research on people repartnering on mid-life suggests that they can experience a disconnect from services culturally coded as being for young people (Lewis, 2019). We note the absence of training in psychosexual issues. Our research has shown that sexual problems are common in young people (Mitchell,2016) and reassurance from professionals can relieve anxieties.  **Reference:**  Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixedmethods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONtraception UNDerstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow. Available at: [www.gla.ac.uk/conundrum](http://www.gla.ac.uk/conundrum)  Lewis, Ruth et al. “Navigating new sexual partnerships in midlife: a socioecological perspective on factors shaping STI risk perceptions and practices.” Sexually transmitted infections vol. 96,4 (2020): 238-245.  Mitchell KR, Geary R, Graham C, et al. Sexual Function in 16- to 21-Year-Olds in Britain. J Adolesc Health. 2016;59(4):422-428. |
| **Standard 4: All individuals have equitable and consistent access to sexual health care**  *Criteria 4.4 NHS boards and IJBs demonstrate a commitment to identifying health inequalities in sexual health care by: completing comprehensive population needs assessments, and identifying the specific needs of different groups of individuals who are accessing sexual health care.*  **Comment:** We welcome the suggestion to complete both population needs assessments and focused needs-assessments of clinic attenders. In the short to medium term, population studies will be important in building a comprehensive understanding of the scale of unmet need for  sexual health services; ie those who do not make it to the door. A recent quasi-representative |

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| UK population study (Natsal COVID), co-led by MRC/CSO Public Health Sciences Unit found in the first four months of the pandemic, 1 in 10 participants reported an unsuccessful attempt to use a service they sought, but most of these also reported successful use of one or more services (either a different type of service or a separate attempt to use the same service). Also, 1 in 5 sexually-active men reported needing condoms but being unable to access them in the first four months of lockdown."  We also welcome a focus on the specific needs of different groups, such as gay, bisexual, and other men who have sex with men (GBMSM). Research by McDaid and colleagues provides evidence on the clustering of ill health amongst populations of GBMSM, and of the salutogenic, community assets that can have a protective effect on ill health.  We welcome a commitment to timely access and referral for PEP, STI testing, LARC but we wondered why time-commitments have not been given for other acute needs such as sexual assault?  **References:**  McDaid, L.M. et al (2019) Informing theoretical development of salutogenic, asset-based health improvement to reduce syndemics among gay, bisexual and other men who have sex with men: Empirical evidence from secondary analysis of multi-national, online cross- sectional surveys. *SSM Population Health*, 10.  Dema et al (2021) Initial impacts of COVID-19 on sexual and reproductive health service use and unmet need in Britain: findings from a large, quasi-representative survey (Natsal- COVID). Submitted to Lancet Public Health. |
| **Standard 5: All individuals are empowered to maintain positive sexual health, well-being and function**  **General comment:** We noted that in this section ‘sexual health’ and ‘sexual wellbeing’ are used interchangeably. We are concerned that this adds to confusion – both in research and practice – between these two concepts, each of which is fundamental to the standards.  There is growing interest in sexual wellbeing in sexual health research. Researchers at MRC/CSO Social and Public Health Sciences Unit recently contributed to these efforts via a paper (in press @Lancet Public Health) which seeks to clarify sexual wellbeing as distinct from sexual health. The paper also sets out why sexual wellbeing in particular, is important to Public Health. The paper argues that there are four overlapping ‘pillars’ underpinning public health focused work on sexuality: sexual health; sexual justice; sexual pleasure and sexual wellbeing. The paper focuses on sexual wellbeing but also briefly describes the first three:  Sexual health: Fertility management; sexual violence prevention; STI prevention and management; sexual function, desire and arousal  Sexual justice: Sexual rights; sexual citizenship; sex positive practice Sexual pleasure: Event-related; person-related  Sexual wellbeing: ‘how we’re doing sexually’, reflected in seven key domains: sexual safety and security, sexual respect; sexual self-esteem, resilience in relation to sexual experience; |

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| forgiveness of past sexual experience; comfort with sexuality; self-determination in one’s sexual life.  We believe these categories could provide a helpful organising framework for Standard 5, and would make Scotland the first country in the world to adopt this novel framing. Although some of the pillars (sexual health, sexual justice) are currently reflected in the standard, sexual pleasure is noticeably absent (despite its centrality both to wellbeing and sexual health), and sexual wellbeing is not proposed as an aim that is distinct from sexual health. Some of the domains of sexual wellbeing are reflected in the standard (e.g. sexual respect) but others (e.g. self-esteem) are not. From an in-depth review of literature, the PH Lancet paper shows how each domain of sexual wellbeing links to key public health functions (such as interventions to support recovery from sexual trauma). In the paper we include a table which links each of these domains to relevant public health and clinical functions.  We are unsure why motivational interviewing and behaviour change interventions are being promoted (in main text and 5.3) above other approaches. We could not find any reference to sexual behaviour in the cited NICE recommendation and so the cited evidence did not feel like strong support for this recommendation. Given that sexual behaviour is inherently relational we would encourage HIS to include standards that reflect the importance of holistic, integrated biopsychosocial approaches that recognise the structural causes of poor wellbeing and function (e.g. minority stress) (see Berry et al 2013). There is also growing evidence for the importance of trauma informed care in the literature (e.g. see O’Loughlin et al and Akhtar et al below).  There is an ongoing need for rigorous evaluation of non-pharmacological treatment options to support these decisions regarding provision of effective and equitable treatment.  *Criteria 5.1 Staff empower individuals and support good sexual health and well-being by:*   * *supporting informed choices and assessment of personal risk* * *promoting safe relationships* * *promoting healthy sex* * *assessing an individual’s psychosexual health and sexual function* * *being compassionate, and* * *addressing stigma and inequality.*   We welcome this list. Based on our Lancet Public Health paper we would like to add that professionals recognise and acknowledge without prejudice, the range of motivations and reasons that people have sex (including for paid employment).  *Criteria 5.3 Individuals who express concerns about their sexual well-being are referred, with their consent, to appropriate support services, including behavior-change interventions.*  As above, we are concerned about the focus on behaviour change interventions here (which put responsibility on the individual to solve problems) when many of the key influences on sexual wellbeing are structural (e.g. cultural stigma) or are largely outside of individual control (e.g. sexual coercion, infertility)  *Criteria 5.5 Staff have access to information and referral pathways to support individuals presenting with sexual dysfunction.*  Our research has shown strong association between poor sexual function and other aspects of  sexual health (including risk behaviour, non-volitional sex and STIs). It is also evident from the literature that simple reassurance from a health professional can be effective in addressing |

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| issues or preventing them from developing (e.g. anxiety around erectile function) We have found – particularly among older patients – that patients and clinicians typically wait for the other to raise matters such as sexual function. For this reason we suggest that clinical staff in sexual health clinics should be encouraged to raise sexual function routinely with patients, rather than simply ‘have access to information’.  *Criteria 5.6*  We welcome a time target for referral to sexual dysfunction services. Our research suggests that about 4.2% of men and 3.6% of women in UK meet clinical diagnostic severity criteria (based on distress, severity and duration of problems, DSM5). Of these, just over a third seek help. Any effort to reduce barriers to care is welcome, although 18 weeks feels like a long time compared with the targets set for other sexual health issues.  **References**  Akhtar S, Barlow J. Forgiveness therapy for the promotion of mental well-being: a systematic review and meta-analysis.*Coercive Trauma Violence Abuse* 2018; 19: 107–22).  Hinchliff et al. Pathways to help-seeking for sexual difficulties in older adults: qualitative ﬁndings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Age and ageing* 2021: 50(2)546  Berry MD, Berry PD. Contemporary treatment of sexual dysfunction: reexamining the biopsychosocial model. *J Sex Med*. 2013 Nov;10(11):2627-43. doi: 10.1111/jsm.12273. Epub 2013 Aug 12. PMID: 23937720.  Mitchell at al. (In press) What is sexual wellbeing and why does it matter for public health? The Lancet Public Health |
| **Standard 6: All individuals can access safe, high-quality and person-centred services for the prevention and treatment of sexually transmitted infections**  *Criteria 6.3 Individuals are able to consistently access a range of testing options, including testing at home and in the community.*  **Comment:** In particular, we would encourage a proactive testing approach that allows individuals to test in between sexual partners, and at the start of a relationship, as well as strategies targeting STI transmission amongst those over 40. Research by Lewis and colleagues (2020) explored the barriers to STI testing amongst mid-lifers and recommends age-sensitive interventions to address the barriers, and harness the potential for improved sexual health amongst this group. This will require careful research and evaluation to establish the most effective approaches.  **Reference:**  Lewis, Ruth et al. “Navigating new sexual partnerships in midlife: a socioecological perspective on factors shaping STI risk perceptions and practices.” Sexually transmitted infections vol. 96,4 (2020): 238-245. |
| **Standard 7: Young people can access safe, high-quality and person-centred sexual health care which upholds their rights.** |

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| *Criteria 7.1. Young people accessing sexual health care are assessed in a dedicated service by staff with the knowledge, skills and competencies required to address their needs.*  **Comment:** We welcome the move to dedicated services but the service referred to under 7.1 seems unclear. There is a mention of a dedicated service. Does this refer only to specialised sexual health clinics or all services (GP surgeries, pharmacies, etc)? The CONUNDRUM study highlighted that a majority of young people access contraception services at GP surgeries and not sexual health clinics. Could the criteria clarify where these dedicated services will be located?  *Criteria 7.4 Young people receive care, information and support which is: accessible, holistic, rights based, and joined up.*  **Comment:** The CONUNDRUM study highlighted young people’s desire for more evidence- based and honest information. While many young people reportedly turn to official healthcare sources (e.g. NHS websites, GPs, nurses) for accurate information on condoms and contraception, they do not always trust that they will receive the most honest input (e.g. on side effects) from these sources. For this reason we suggest that criteria 7.4 might also include the term ‘neutral’  *Criteria 7.5. NHS boards and IJBs work in partnership with organisations, such as schools, and with youth workers and social workers to support and empower young people and promote good sexual health.*  **Comment:** Research in MRC/CSO SPHSU and elsewhere has shown that working in partnership with a variety of organisations at community level is important in the delivery of safe, high-quality and person-centred sexual health care. We would welcome greater clarity on the purpose of these partnerships. Is it to provide knowledge and skills, or also to strengthen the linkages between community organisations and health services? The CONUNDRUM study highlighted the need to improve referrals between sexual health services. Young people described weak referral mechanisms between settings providing contraceptive services (e.g. not being clearly directed to an alternative service if a preferred method was not available via a GP surgery), which left them feeling that they had to navigate the complex system alone.  *Criteria* 7*.10. Young people, including those in remote and rural areas, can access free condoms.*  **Comment:** We welcome the emphasis on making free condoms accessible to young people in rural and remote areas of Scotland. We suggest that this provision to rural and remote areas should be extended to all contraceptive methods. The CONUNDRUM study highlighted that the distance to sexual health services can be a barrier for young people in more rural areas.  **Reference:**  Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixedmethods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONtraception UNDerstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow. Available at: [www.gla.ac.uk/conundrum](http://www.gla.ac.uk/conundrum) |

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| **Standard 8: Gay, bisexual and other men who have sex with men have access to safe, high-quality and person-centred sexual health care**  *Criteria 8.5 Sexual health services for GBMSM are promoted in ways which are person- centred, non-judgemental and inclusive.*  *Criteria 8.6 NHS boards and IJBs ensure that person-centred and relevant information about the prevention, testing and treatment for STIs and bloodborne viruses is available to GBMSM.*  **Comment:** We welcome the criteria on person-centred, non-judgmental and inclusive promotion of sexual health services for GBMSM. Research in SPHSU has identified a range of visual and behavioural change techniques typically used in testing campaigns (Riddell *et al.*, 2020; Langdridge *et al.,* 2021; Flowers et al., 2019; McDaid *et al.*, 2019). Our work suggested that the use of social marketing principles, in particular the use of focus groups/ pre-testing of materials and messages would be key to any future campaign/ intervention and may produce novel techniques which would be received better by the target population (Riddell *et al.*, 2020, McDaid *et al.,* 2019).  Sexual health campaigns should be co-produced in consultation with both target service users and the service providers to encourage regular testing (McDaid *et al.*, 2019; Riddell *et al.*, 2020*)*. A key aspect of intervention/ campaign development is that those targeted are not given unrealistic expectations of services as this may only serve to further disengage them, it is therefore essential that all intervention development/ campaign development involve consultation with service users AND providers.  **References:**  Riddell, Julie, et al. "Mass media and communication interventions to increase HIV testing among gay and other men who have sex with men: Social marketing and visual design component analysis." *Health* (2020).  Langdridge, Darren, et al. "A qualitative examination of affect and ideology within mass media interventions to increase HIV testing with gay men garnered from a systematic review." *British Journal of Health Psychology* 26.1 (2021): 132-160.  Flowers, Paul, et al. "What are mass media interventions made of? Exploring the active content of interventions designed to increase HIV testing in gay men within a systematic review." British journal of health psychology 24.3 (2019): 704-737.  McDaid, Lisa, et al. "The effectiveness of social marketing interventions to improve HIV testing among gay, bisexual and other men who have sex with men: a systematic review." AIDS and Behavior 23.9 (2019): 2273-2303. |
| **Standard 9: Women receive a holistic assessment of their needs and have access to a full range of contraception methods**  *Criteria 9.4 Information about contraception is provided on:*   * *the benefits of contraception* * *the range of methods and how they work* * *the effectiveness of each method if used optimally* * *potential side effects and how to minimise them* * *how to access initial contraception and ongoing supply, and* |

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| * *the options and responsibilities for all individuals in relation to preventing unintended pregnancy.*   **Comment:** Similar to our comments at Standard 7, information about contraception should be given to all women in a manner that is respectful of their preferences, motivations and choices. For example, women should have the option to accept or decline a method or choose an alternative method as per their preference.  The CONUNDRUM findings highlighted causes for dissatisfaction with contraceptive consultations include feelings of being pushed towards certain methods (especially the pill), not being heard or respected, dismissal of side effects, a dismissal of interactions between contraception, other medication and health conditions, and limited time given to discussions.  Other research (Morgan et al, 2017) suggests that women in more deprived areas are more likely to be offered LARC.  *Criteria 9.4 is welcomed, as it addresses some of the key challenges identified*.  *Criteria* 9.6 *Organisations have enchanced or tailored services for women with complex social needs or who face barriers to accessing contraception.*  **Comment:** We agree with the principle of this criterion. Sp here – ‘enchanced’ should be ‘enhanced’.  **General comment:** Whilst the standard does reference trans and non-binary people later on in the text, we support the use of inclusive language throughout (women, trans men, and non- binary people / or women and other people who can get pregnant) in the same vein as standard 8, which uses the language of GBMSM to include all men who have sex with men. As others have suggested, using accurate language is an important part of service delivery which would help minimise some of the barriers trans men and non-binary people face in accessing pregnancy prevention (Moseson et al, 2020).  We welcome standards on the specialist knowledge/services required to provide contraception to trans men and non-binary people, as practitioners will need knowledge on how contraceptive options interacts with hormone replacement therapy, as well as how contraception might interact with mental health needs to minimise gender dysphoria.  **References**  Lewis, R., Blake, C., McMellon C., Riddell J., Graham C., Mitchell K. (2021). Understanding young people’s use and non-use of condoms and contraception: A co-developed, mixedmethods study with 16-24 year olds in Scotland. Final report from CONUNDRUM (CONdom and CONtraception UNDerstandings: Researching Uptake and Motivations). MRC/CSO Social and Public Health Sciences Unit: University of Glasgow. Available at: [www.gla.ac.uk/conundrum](http://www.gla.ac.uk/conundrum)  Morgan CR, Liu H. The relationship between area deprivation and prescription of long-acting reversible contraception in women of reproductive age in Lothian, Scotland, UK *Journal of Family Planning and Reproductive Health Care* 2017;43:281-288. |

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| Moseson, H. Noah Zazanis, Eli Goldberg, Laura Fix, Mary Durden, Ari Stoeffler, et al. (2020). [The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond Women's](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170432/) [Health](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170432/). Obstetrics & Gynecology, 135(5), 1059–1068. |
| **Standard 10: Women can access safe, timely and person-centred abortion care services**  *Criteria 10.1 Women who have chosen to have an abortion can self refer to the assessment appointment*  **Comment:** We suggest avoiding use of language of ‘choice’ (e.g. ‘chosen’) as this implies responsibility. We suggest using instead: ‘Women who have sought abortion’. Language use is significant in the context of abortion, given the acute stigmatisation of the procedure of those who have it, and it would be highly beneficial for the standard to use language which contributes to its normalisation (Purcell et al 2020).  *Criteria 10.4 Women have access to information on both medical and surgical abortion to enable an informed choice.*  **Comment:** We welcome this criterion, and note that this needs to extend not only to *information* on each procedure but actual options as per women’s preference (and per RCOG guidance). Our data from studies of abortion in Scotland over several years suggest that patient preference for surgical/MVA may be an unmet need and that many women are not aware this could/should be an option (Purcell et al., 2017a; 2017b; 2017c).  *10.6 Women are provided with a clinically appropriate choice of abortion method, including early medical abortion at home.*  **Comment**: As at 10.4, this should be clinically appropriate but also as per their preference. Data from our studies of abortion in Scotland (and research from elsewhere) indicate there are many reasons a woman may not want or may be unable to go through the EMA process at home.  *Criteria 10.7 NHS boards and IJBs provide local abortion services up to at least 20 weeks gestation.*  **Comment:** Women should be able to obtain abortion as close to home as possible up to the legal limit, to avoid the additional distress and potential discrimination identified in our research on women in Scotland travelling for abortion (Purcell et al 2014, Heller et al 2016). As such, the standard should be to the legal limit of 24 weeks.  *10.8 Where an NHS board or IJB cannot offer abortion services above 20 weeks gestation within their area, they work in partnership to provide an appropriate and person-centred care pathway for all women requiring an abortion up to the legal limit.*  **Comment:** Where care cannot be provided locally to 24 weeks, this criterion could specify ‘as close to home as possible’. Processes for arranging travel (and accommodation if applicable) must be clearly established and communicated to women, so that they are not financially  penalised for a healthcare service not being provided close to home (see Purcell et al 2014). |

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| *Criteria 10.10 All organisations only share information about a woman’s abortion care with other organisations to promote safety while ensuring concerns around privacy and confidentiality are addressed in line with data protection guidance.*  **Comment:** Can it be specified or an example given of what other organisations this might be?  *Criteria 10.11 Staff sensitively and appropriately assess and respond to:*   * *risk of STI* * *areas for health promotion* * *risk of gender-based violence* * *risk of trafficking, and* * *risk of sexual coercion.*   **Comment:** Our research on abortion provision in Scotland suggests the vast majority of those working directly with women seeking abortion wish to treat them sensitively and appropriately, but that the pervasiveness of abortion stigma can make this challenging for some (Maxwell et al. 2021). Staff need to be adequately trained and supported to provide non-stigmatising, person-centred abortion care, as with any other component of SRH. A key aspect of this – and challenge for health professionals in different roles - relates to presenting abortion as part of routine healthcare, in a way which also recognises that undergoing abortion is nonetheless not an everyday event in women’s lives. Training should also foster awareness that some women will already be very clear and comfortable with their decision. This applies to all health professionals that women may encounter on the abortion pathway, as well as specialist staff. (Please refer to our research briefing: [https://www.sassproject.org.uk/normalising-abortion-](https://www.sassproject.org.uk/normalising-abortion-what-role-can-health-professionals-play-2/) [what-role-can-health-professionals-play-2/](https://www.sassproject.org.uk/normalising-abortion-what-role-can-health-professionals-play-2/))  We suggest that it might also be appropriate to include ‘risk of further unintended conceptions’ in the list under this criterion.  **General comment:** Whilst the standard does reference trans and non-binary people later on in the text, we support the use of inclusive language throughout (women, trans men, and non- binary people / or women and other people who can get pregnant) in the same vein as standard 8, which uses the language of GBMSM to include all men who have sex with men.  Using accurate language is an important part of service delivery, helping to minimise some of the barriers trans men and non-binary people face in accessing abortion care (Moseson et al, 2020).  Additionally, we would welcome standards on the specialist knowledge/services required to provide abortion services to trans men and non-binary people, as practitioners will need knowledge on how their treatment might interact with hormone replacement therapy, as well as how it might impact their mental health, potentially amplifying their gender dysphoria.  **References**  Heller, R., Purcell, C., Mackay, L., Caird, L., & Cameron, S. T. (2016). Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study. *BJOG: An International Journal of Obstetrics & Gynaecology, 123*(10), 1684-1691. |

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| Maxwell, K. J., Hoggart, L., Bloomer, F., Rowlands, S., & Purcell, C. (2021). Normalising abortion: what role can health professionals play? *BMJ Sexual & Reproductive Health, 47*(1), 32-36.  Moseson, H.,. Noah Zazanis, Eli Goldberg, Laura Fix, Mary Durden, Ari Stoeffler, et al. (2020).  [The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170432/) [Women's Health](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170432/). Obstetrics & Gynecology, 135(5), 1059–1068.  Purcell, C., Cameron, S., Caird, L., Flett, G., Laird, G., Melville, C., & McDaid, L. M. (2014).  Access to and Experience of Later Abortion: Accounts from Women in Scotland.  *Perspectives on Sexual & Reproductive Health, 46*(2), 101-108.  Purcell, C., Brown, A., Melville, C., & McDaid, L. M. (2017a). Women’s embodied experiences of second trimester medical abortion. *Feminism & Psychology, 27*(2), 163-185.  Purcell, C., Cameron, S., Lawton, J., Glasier, A., & Harden, J. (2017b). Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences. *BJOG: An International Journal of Obstetrics & Gynaecology, 124*(13), 2001-2008.  Purcell, C., Riddell, J., Brown, A., Cameron, S. T., Melville, C., Flett, G., . . . McDaid, L. (2017c). Women's experiences of more than one termination of pregnancy within two years: a mixed-methods study. *BJOG: An International Journal of Obstetrics & Gynaecology, 124*(13), 1983-1992.  Purcell, C., Maxwell, K., Bloomer, F., Rowlands, S. and Hoggart, L. (2020) Toward normalising abortion: findings from a qualitative secondary analysis study, Culture, Health and Sexuality 22(12) 1349-1364. |
| **When was the response submitted?** |
| 21st of June 2021 |
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