

# Irish Contraception and Crisis Pregnancy [ICCP] Study A Survey of the General Population

*Kay Rundle, Collette Leigh, Hannah McGee and Richard Layte*

RESEARCH

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## Foreword

It is a great pleasure to introduce the first nationally representative survey of crisis pregnancy in Ireland: the Irish Contraception and Crisis Pregnancy Study (ICCP).

This groundbreaking study establishes, for the first time, current attitudes, knowledge and the experience of crisis pregnancy amongst women and men living in Ireland. This survey examines the factors that lead to crisis pregnancy and the services women and men need to support them during and after a crisis pregnancy.

It is essential for the Agency to have reliable data that allows it to quantify the extent to which men and women in Ireland have experienced crisis pregnancy. The findings enable us to understand more clearly the factors that give rise to crisis pregnancy. We now have data identifying the knowledge and information needs of women and men; we have clearer direction in terms of the supports that women and men require when they have a crisis pregnancy.

More importantly, the findings of the ICCP survey, based on robust data, allow for effective planning and development of appropriate preventative and supportive initiatives. Significantly, these findings provide critical baseline measures for the Agency that will help us to monitor our work. We will also be in a better position to assess shifts in public opinion, over time.

Research has always been a key focus of the Agency since its establishment and we realise the importance and the need to include men and to reach them fully in the work we do. By developing an evidence base inclusive of the voices and opinions of men, we are in a strong position to achieve real progress.

An essential part of our research activities involves disseminating research findings to as wide an audience as possible. As we move from research into practical solutions which will make a real difference to people's lives, it is our hope that these findings will be of benefit to service planners, policy makers, statutory and non-statutory service providers, researchers, practitioners, educators and the general public. An important strand of our vision is to ensure that the findings from the Agency's research programme combine to build an accurate and compelling picture of sexual health and crisis pregnancy and one that does not cloud the complexity of sexual behaviour in a changing modern Ireland.

I would like to thank the authors of the study, Professor Hannah McGee, Ms. Kay Rundle, and Ms. Collette Leigh, from the Royal College of Surgeons in Ireland, and Dr. Richard Layte from the Economic and Social Research Institute, for their expertise and commitment in conducting the research to such a high standard.

I would also thank and acknowledge the input of the Agency's research staff, Dr. Stephanie O'Keeffe and Ms. Mary Smith, and Research sub-group members, Dr. Linda Hogan, Mr. Anthony O'Gorman, Dr. Margret Fine-Davis, Dr. Davida De La Harpe, and the Agency's Director, Ms. Sharon Foley.

Most important of all, we sincerely thank the 3,317 individuals who participated in such a sensitive survey – one which helps the Crisis Pregnancy Agency to capture the reality of crisis pregnancy and to plan its work accordingly.

It is my sincere hope that the findings of this report will contribute to further development of appropriate responses and relevant services for crisis pregnancy and its prevention in Ireland.

*Olive Braiden*  
*Chairperson*

### *About the authors*

Ms. Kay Rundle studied psychology at Exeter University. She has worked as a research officer in the Health Services Research Centre, Royal College of Surgeons in Ireland since 2001, working on a range of projects including a national survey of sexual health and relationships. She is currently completing a Masters at the RCSI.

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Professor Hannah McGee is the founding director of the Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland. She has been president of the Psychological Society of Ireland and the European Health Psychology Society. Recent research projects directed by Professor McGee include SAVI - the first national survey on sexual violence in Ireland and HeSSOP - a study of health and social service needs and experiences of almost 1,000 community-dwelling older people throughout Ireland.

Richard Layte is a Senior Research Officer at the Economic and Social Research Institute (ESRI). He is a sociologist and his work centres on the social and economic structuring of health behaviours and health inequalities.

### *Acknowledgements*

This study was commissioned by the Crisis Pregnancy Agency. The Health Services Research Centre (HSRC) at the Royal College of Surgeons in Ireland (RCSI) and the Economic and Social Research Institute (ESRI) conducted the research. The study was completed between July 2003 and April 2004.

We thank many individuals for their assistance in completing the study. Firstly, we acknowledge the co-operation of over 3,000 members of the public who gave of their time and discussed very personal aspects of their lives with us. Without them, there could be no meaningful evaluation of contemporary patterns of contraception and crisis pregnancy. The study protocol was devised with advice from a CPA Steering Group [Dr Linda Hogan, Mr Tony O’Gorman, Dr Davida De La Harpe, Dr Margret Fine Davis, Ms Sharon Foley, Dr Stephanie O’Keeffe and Ms Mary Smith]. Particular thanks to Dr Stephanie O’Keeffe (Crisis Pregnancy Agency), who co-ordinated liaison between the funders and research team.

The study was completed in association with the ESRI’s Survey Unit. Professor James Williams and Ms Amanda Quail ensured a good survey response rate. At RCSI, Ms Rebecca Garavan and Mr Ronan Conroy provided general advice on study safety and distress management, and on statistical issues. Ms Deirdre Fullerton, independent research consultant, provided valuable advice on international crisis pregnancy research and intervention activities.

We hope the findings of this study - the first comprehensive national profile of contraceptive knowledge, attitudes and behaviour, and of crisis pregnancy - will enable those charged with promoting responsible sexual health behaviour to best plan their

initiatives. We thank the Crisis Pregnancy Agency for funding this Irish Contraception and Crisis Pregnancy (ICCP) Study and are pleased to be able to contribute to an Irish evidence base on sexual health issues.

*The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the sponsors*



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## Executive Summary

### Background

Crisis pregnancy is a complex challenge for individuals and societies alike. Its prevention and management need to be informed by up-to-date and locally applicable information on knowledge, attitudes and behaviours concerning sexual practices and contraception.

Studies of aspects of sexual health in Ireland offer the prospect of vastly increasing our understanding of the pattern of health behaviours in the area of sexuality and their relationship to both the attitudes/beliefs and socio-demographic characteristics of individuals. Such surveys can also provide guidelines on where and how to intervene to improve sexual health outcomes. They offer a benchmark against which to gauge success and to plan for future work in the area of sexual health promotion in Ireland.

A number of recent Government initiatives have highlighted the need for national data on sexual health issues. In October 2001, the Government established the Crisis Pregnancy Agency (CPA). Its primary focus is the development of a strategy to deal with crisis pregnancy, and more specifically to provide for:

- a reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services
- a reduction in the number of women with crisis pregnancies who opt for abortion by offering services and supports which make other options more attractive
- the provision of counselling and medical services after crisis pregnancy.

*(Statutory Instrument No. 446, 2001)*

Information on contraceptive and crisis pregnancy service availability and utilisation, and on antecedents of crisis pregnancy, is needed for the optimal planning and evaluation of services. Research findings can provide evidence-based recommendations for planning and development of appropriate initiatives.

### Aim of the present study

The aim of the present study was to establish nationally representative data on current attitudes, knowledge and experience of contraception, crisis pregnancy and related services in Ireland. More specifically, the research aimed to provide nationally representative data on:

- current attitudes, knowledge and experience of crisis pregnancy and crisis pregnancy supports and services
- current attitudes, knowledge and experience of contraception and contraceptive services
- current attitudes and experiences of sex, crisis pregnancy, options facing those in crisis pregnancy and lifestyle choices
- current awareness, recognition and understanding of the Crisis Pregnancy Agency's Positive Options public information campaign.

## Methodology

A cross-sectional national survey of the young adult population, using a telephone interview methodology, was selected as the most appropriate methodology to meet the aims of this study.

### Sample

- A sample size of 3,000 members of the public was targeted, to include equal numbers of women and men.
- The sample included people aged 18-45 in order to focus on those for whom contraceptive practices, service perceptions and service usage are most relevant. The age profile of the sample means that results will be particularly relevant to contemporary evaluation of services and in planning for the future.

### Measures

- An interview schedule, informed by key concepts relating to crisis pregnancy, was devised. Where concepts had previously been assessed elsewhere, use of questions from relevant national and international questionnaires was considered to maximise comparability of the data to be collected here. The questionnaire was refined through discussion with a CPA steering group. Using this process, the final interview schedule was best able to address the specific issues and key constructs of interest to the CPA.

### Ethics

- The study received ethical approval from the Royal College of Surgeons in Ireland's (RCSI) Research Ethics Committee.

### Procedure

- The chosen method for data collection was telephone interview. Telephone interviews were conducted by an experienced telephone interview team from the Economic and Social Research Institute (ERSI). All interviewers participated in a training session consisting of technical and operational issues and sensitivity training. The team of telephone interviewers received ongoing support from the core research team throughout the interview phase.
- Telephone interviews provide respondents with a sense of anonymity, once it has been explained and understood that their number has been chosen at random. A sense of anonymity was considered of particular relevance due to the sensitive subject matter of this survey. The procedure for obtaining telephone numbers was briefly explained at the start of the telephone call. Telephone numbers were not recorded on the questionnaire.
- Study verification procedures (e.g. freephone telephone access, Garda confirmation) were established in order that participants could confirm the legitimacy of the research. Interviewers monitored distress and used a range of strategies throughout the interview process to manage participant distress.

## Results I – Sex and contraception

### *Response rates*

- 3,317 interviews were completed (1,356 men and 1,961 women).
- Overall response rate of completed interviews was 63.8%.

### *Demographic profile*

- The sample was re-weighted to match the structure of the Irish population. The results, therefore, can be considered representative of the general population.
- The study sample comprised 40.9% men and 59.1% women.

### *Sexual history*

- 93% of study participants reported having experienced sexual intercourse (vaginal or anal).
- 98.7% had experienced only heterosexual sex, with 0.2% experiencing only homosexual sexual intercourse and 1.1% having experienced both.
- Women reported a significantly older age at first intercourse than men (median nineteen vs. eighteen years respectively).
- Age at first sex decreased for men (median age nineteen to seventeen years of age) and for women (median age twenty to eighteen years of age) from older to younger age cohorts (year of birth 1956-60 and 1981-85 respectively).

### *Contraceptive use in the last year*

- The most common methods of contraception and precaution used in the last year to avoid pregnancy were condoms (55%) and the contraceptive pill (38%).
- Most participants (80%) said that they had always used a method of contraception or precaution when having sex in the last year.
- Those who first had sex at a younger age were less likely to have always used contraception in the last year (e.g. 70% of those who had first had sex at fifteen years of age or younger compared with 85% who first had sex when aged 20-24 years).
- Younger (18-25 year old) participants were less likely to report always (74%) using, and more likely to report mostly (19%) using, contraception. A concern relating to contraceptive use among 18-25 year olds is that they did not consistently use contraception every time they had sex.
- The two main explanations for non-use of contraception during the last year by those who did not want to become pregnant were that sex was not planned/they were not prepared (48%) and/or they were drinking alcohol or taking drugs (21%). These reasons were significantly more likely to be reported by younger age cohorts.

### *Contraceptive use with most recent partner*

- 10% of those at risk of unplanned pregnancy did not use any method of contraception on the most recent occasion of sexual intercourse.
- Correlates of non-use of contraception on the most recent occasion were older age, lower educational level, lower social class and casual (as distinct from permanent) relationship status.

- Of those who used contraception on the most recent occasion of sexual intercourse, most used the condom (53%) or contraceptive pill (34%).
- On the most recent occasion of sexual intercourse, the most common reasons cited for non-use of contraception among those at risk of unplanned pregnancy were that sex was not planned/they were not prepared (31%) and/or because they had been drinking or taking drugs (15%).

#### *Emergency contraception ('morning-after pill')*

- Knowledge of the existence of the emergency contraceptive pill (ECP) was high (96%). However, specific knowledge relating to correct usage was lacking (only 38% identified the correct time-period for use; 44% underestimated the time limit).
- Of those who had heard of the ECP, 29% of women had previously used it and 24% of men reported that a partner had used it.
- 31% of those who had heard of the ECP thought it would be difficult to obtain. They suggested major barriers to accessing the ECP were locality/accessibility (66%) and attitudes of professionals (29%).

#### *Contraceptive services*

- More men (14%) than women (9%) reported that they had never obtained contraceptive supplies or sought advice. Women were more likely than men to have used a health professional route (e.g. GP, family planning clinic) to access contraceptive supplies or advice (79% vs. 37%) and less likely to have used a commercial route (e.g. chemist, vending machine) (48% vs. 73%).
- More older men and women (37% and 82% respectively) had used a health professional route to contraceptive advice or supplies than younger men and women (16% and 71%, respectively). Younger participants were more likely to have used commercial routes than the older groups (men, 78% vs. 64%; women, 51% vs. 41%).
- 95% did not find it difficult to get contraception. Those who reported difficulty in obtaining contraception explained that accessibility and embarrassment were barriers.

#### *Role of alcohol*

- 58% of men and 38% of women agreed that drinking alcohol had contributed to them having sex.
- Furthermore, almost half (45%) of men and 26% of women agreed that drinking alcohol had contributed to them having sex without using contraception. Correlates of agreement were male gender, lower educational level, lower social class and currently being in a casual relationship or not in a relationship.

#### *Learning about sex*

- Most participants (80%) agreed that it is mainly the responsibility of parents to educate their children about sexual matters.
- 82% of parents of twelve to eighteen year olds had spoken to their children about sexual matters. Of the remainder, 43% indicated that they planned to talk to them about sexual matters in the future, with 23% stating that someone else had already provided sex education to their children.

- While most parents (75%) felt confident as sex educators of their own children, they would also welcome support to carry out this role. Suggested supports were leaflets/booklets (84%), parent meetings in the school/community (67%) and classes/training (65%).

#### *Attitudes to using contraception*

- 43% of men and 27% of women agreed that condoms reduce sexual pleasure.
- Half of participants (50%) agreed that the contraceptive pill has dangerous side effects, with older participants more likely to agree.
- Two-thirds of participants (67%) agreed that taking a break from the contraceptive pill is a good idea, with older age groups more likely to agree.
- More women (38%) than men (23%) agreed that using the contraceptive pill (or their partner using it) did not appeal to them, with older participants more likely to agree.

#### *Social context of contraceptive use*

- Most participants (79%) disagreed that it is mainly the man's responsibility to ensure that contraception is used regularly, with more men (19%) than women (7%) agreeing.
- Nearly one-quarter (23%) of participants agreed that if a woman carries condoms while not in a relationship it gives the message that she is looking for sex or is "easy".
- Very few participants (6%) agreed that they would find it difficult to talk to a sexual partner about contraception, with the majority (92%) disagreeing.
- Most participants (83%) disagreed with the statement that 'it would be too embarrassing for someone like me to buy or obtain condoms'.

#### *Knowledge of fertility*

- 54% of participants correctly identified the most fertile time in a woman's menstrual cycle (i.e. about half way between menstrual periods), with women and older participants more likely to respond correctly.
- A high number of female participants (35%) could not identify when they were most likely to become pregnant during the menstrual cycle.

#### *Crisis pregnancy services*

- Almost half of participants (47%) indicated that the preferred way to find out information about crisis pregnancy services was face-to-face or one-to-one. Over a quarter of participants (28%) felt that they preferred to access information via the telephone/ a helpline.

#### *Crisis pregnancy information - "Positive Options" campaign*

- A minority of all participants (23%) had seen or heard advertising for the Crisis Pregnancy Agency's Positive Options campaign. However, a larger percentage (36%) of the agency's target group (18-30 year old women) had seen or heard advertising or promotions for Positive Options.

- Half of participants (52%) thought that counselling or advice for women with a crisis pregnancy would be available from the Positive Options service; 40% gave the correct response (a list of crisis pregnancy agencies).

#### *Current attitudes to pregnancy*

- 41% felt it would be positive or very positive if they or their partner became pregnant now, despite the pregnancy being unplanned.
- Most (70%) of those at risk of pregnancy stated that the most likely outcome of an unplanned pregnancy would be parenthood, with 2% stating adoption and 4% abortion. 24% did not know what they would do in this situation.

#### *Attitudes to outcomes of crisis pregnancy*

- 84% of participants agreed that in today's society, it is acceptable for a woman to rear a child as a lone parent, without a stable relationship with the father.
- Over half of participants (59%) agreed that children of lone parents do just as well as children of two-parent families, with 26% disagreeing.
- 61% agreed that there are sufficient supports to help a woman who chooses to have a child on her own.
- A large majority (89%) agreed that in today's society, there should be no pressure on a lone mother to have her child adopted.
- A minority of participants (20%) agreed that adoption is a positive experience for the mother, with 58% disagreeing.
- One-third of participants (32%) agreed with the statement that adoption is not a positive experience for the child; 38% disagreed.
- Half of participants (51%) thought that a woman should always have a choice to have an abortion, regardless of the circumstances.
- Two-thirds of participants (68%) knew someone personally who had experienced a crisis pregnancy, 58% knew someone who had experienced a crisis pregnancy and kept the baby, 6% knew someone who had had the baby adopted and 24% knew someone who had had an abortion.

#### *Disclosure of crisis pregnancy*

- The majority of women (91%) said they definitely or probably would tell the sexual partner involved if they experienced a crisis pregnancy.
- 75% reported that they would definitely or probably tell family about a crisis pregnancy. More women (73%) than men (66%) indicated that they would definitely or probably tell friends.
- More women (92%) than men (78%) would definitely or probably tell a doctor if they experienced a crisis pregnancy, and 43% of women and 37% of men would definitely or probably tell a crisis pregnancy service.
- The majority of participants (66%) indicated that they would prefer to go to a GP for professional help if they were to experience a crisis pregnancy in the future.

## Results II – Crisis pregnancy

### *Overview of pregnancy experiences*

- Over half of all participants (54%) had had sexual intercourse that had resulted in a pregnancy, with more women (61%) than men (46%) having had sex that resulted in a pregnancy.
- Of participants who had experienced pregnancy, younger participants were more likely than older participants to have experienced an abortion (women: 15% vs. 2% respectively; men: 10% vs. 4%). Conversely, they were less likely to have experienced a live birth than older groups (women: 77% vs. 98%; men: 51% vs. 96%).
- Of participants who had experienced pregnancy, 28% of women and 23% of men had experienced crisis pregnancy.
- 55% of 18-25 year old men and women had experienced one or more crisis pregnancies, compared with 21% of women and 14% of men aged 36-45 years.
- Of participants who had experienced crisis pregnancy, 14% of women (range 1-6 crisis pregnancies) and men (range 1-3) had experienced more than one crisis pregnancy.
- Of all pregnancies reported by women, 83% ended in live birth, 12% in miscarriage, 2% in abortion, 1% in stillbirth and <1% adoption, with 2% currently pregnant.
- 79% of pregnancies reported by men resulted in live birth, 14% in miscarriage, 3% in abortion, 1% stillbirth and <1% adoption, with 3% having a partner who was currently pregnant.
- 12% of all pregnancies experienced by women were experienced as a crisis. The percentage experienced as crises decreased with age (42% for 18-25 year olds vs. 7% for 36-45 year olds).
- 10% of all pregnancies experienced by men were crisis pregnancies, with 31% of 18-25 year olds, compared with 7% of 36-45 year olds reporting experience of a crisis pregnancy.
- The percentage of crisis pregnancies resulting in live births increased across age groups for both men and women. Abortion as an outcome of crisis pregnancy decreased with age for women, but not for men.

### *Crisis pregnancy outcomes*

- 245 women and 90 men completed additional questions recounting their experience of their most recent crisis pregnancy.
- Of the women who recounted their experience of a crisis pregnancy, 75% gave birth, 15% had an abortion, 6% had a miscarriage, 1% a stillbirth and 3% were currently pregnant.
- 57% of crisis pregnancies reported by men resulted in birth, 24% in abortion, 17% in miscarriage and 2% were currently experiencing a crisis pregnancy.
- The most recent crisis pregnancy was experienced at a mean age of 23.4 years for women and 24.6 years for men.

- There were significant differences in pregnancy outcomes across age at crisis pregnancy: 22% of 18-25 year olds chose abortion, compared with 7% of those under eighteen years of age, 7% of 26-35 year olds and 8% of 36-40 year olds.

#### *Describing a crisis pregnancy*

- When describing why the pregnancy was a crisis, women (41%) and men (39%) explained that it was not planned. Other common themes were being too young, being unmarried, having relationship difficulties or being in a relationship that was new or not steady.
- Older women (at time of crisis pregnancy) were more likely to report that the pregnancy was experienced as a crisis because they believed that their family was already complete.
- Younger participants were more likely to report actual or anticipated negative family reaction, not being married and being too young as reasons that it was experienced as a crisis.

#### *Relationship status*

- 41% of women had a steady relationship with the sexual partner at the time of conception, 24% had known the sexual partner for a while but did not have a steady relationship, and 24% were married or engaged.
- 47% had a steady relationship with the sexual partner at the time, with 22% married or engaged and 12% who knew each other but who were not having a steady relationship.
- The majority of women who were married or engaged (99%) and living together (93%) at the time of conception gave birth, compared with 69% of those who were not in a relationship.

#### *Contraceptive use*

- 36% of women reported that contraception had been used when the crisis pregnancy occurred. 62% said that it had not been used, and 2% were unsure. 44% of men reported that contraception had been used and 56% that it had not been used.
- Of those who had used contraception, 31% of women and 20% of men said they did not know why it had failed. Others reported condom failure (23% of women, 22% of men), contraceptive pill failure (20% of women, 7% of men), or that they had thought it was a safe period (9% of women, 16% of men).
- Of those who had not used contraception, women (51%) and men (52%) said that the reason for non-use was that sex was not planned or they were not prepared, with 17% of women and 26% of men explaining that non-use was as a result of drinking alcohol or taking drugs.
- In total, 41% of women and 55% of men reported alcohol or drug use at the time of the crisis pregnancy conception.

#### *Confirming the crisis pregnancy*

- 57% of women first thought they might be pregnant in the month following the sexual experience, with 89% having the pregnancy confirmed in the first three months following the sexual experience.

- Their GP confirmed the pregnancy for 38% of women, with 34% visiting a family planning or Well Woman clinic and 17% using a home testing kit.

#### *Emotional experience of crisis pregnancy*

- Women experienced a number of negative emotions during their crisis pregnancy: 43% reported mostly feeling 'very nervous' or 'downhearted and blue' and 29% mostly felt 'so down in the dumps that nothing could cheer them up'.

#### *Personal and professional supports and services*

- 16% of women and 13% of men had contact with a family planning or Well Woman clinic during their crisis pregnancy. A further 9% of women and 1% of men had had contact with Cura, and 2% of women with Cherish. No participants reported contact with LIFE or PACT.
- Over half of women (55%) first told the sexual partner involved about the crisis pregnancy, with 19% first telling a friend.
- There were differences in the supportiveness of sexual partners across pregnancy outcomes, with 71% of those who gave birth and 66% of those experiencing a miscarriage or stillbirth reporting that the sexual partner had been supportive, compared with 34% of those who had an abortion.
- More (72%) of those who gave birth reported that their parents had been supportive or very supportive than those who had an abortion (30%) or a miscarriage/stillbirth (20%). Many of those who had an abortion (45%) or a miscarriage/stillbirth (52%) did not tell their parents about the pregnancy.
- 46% of women said there was nothing that would have made the situation easier at the time, 26% said that counselling or having someone to talk to at the time would have helped, with 10% suggesting information on all their options. 7% said that money would have helped, 6% suggested local pregnancy services, 6% family support and 5% that partner support or a committed relationship may have made the situation easier at the time.
- 71% of women felt they did not need ongoing support or services after the crisis pregnancy.

#### *Outcome of crisis pregnancy*

- Women who gave birth reported partner/family/relationship support and moral/personal beliefs as factors influencing the outcome of the pregnancy.
- Women whose crisis pregnancy resulted in abortion reported existing life commitments/plans, being too young or having relationship difficulties/no stable relationship as factors influencing the outcome. Not being ready for motherhood/not wanting a child was another influencing factor.
- The majority of women who gave birth (98%) and of those who had an abortion (95%) felt that the outcome of the pregnancy was the right one.
- 92% of women who gave birth and 68% of those who had an abortion reported no regrets at the final outcome of the crisis pregnancy.

### Recommendations

- **Recommendation 1:** Health promotion strategies are needed to reduce the number of unprotected sexual encounters where pregnancy is not intended or desired.
- **Recommendation 2:** Health promotion strategies concerning contraception need to be targeted appropriately to reach distinct groups in Irish society.
- **Recommendation 3:** Health promotion strategies need to encompass the concept of contraceptive choice, given the very varied range of attitudes concerning the acceptability of various forms of contraception.
- **Recommendation 4:** Health promotion strategies need to foster more responsible public attitudes to planning for contraception and safe sex.
- **Recommendation 5:** Health promotion strategies need to foster more responsible public behaviour concerning alcohol and drug use, given their role in unprotected sexual encounters.
- **Recommendation 6:** Education concerning pregnancy risk and decisions about when and how to use contraception, including emergency contraception, is needed.
- **Recommendation 7:** Knowledge about basic aspects of reproduction, sexual behaviour and contraception, and protection practices in distinct population sub-groups, should be evaluated.
- **Recommendation 8:** Parents need to be acknowledged as primary sex educators of their children and supported in this task through school and community based initiatives.
- **Recommendation 9:** A public debate on unprotected sex, contraception and crisis pregnancy and its outcomes in contemporary Ireland is needed.
- **Recommendation 10:** Counselling and other support services need to be available to, and accessible by, women and their partners both during and after crisis pregnancy.
- **Recommendation 11:** Accessibility of information on crisis pregnancy services needs to be assessed.
- **Recommendation 12:** Research activities concerning contraception and crisis pregnancy in Ireland should be integrated to ensure the best use of public resources in developing a knowledge base capable of informing policy and practice.

## 1.0 Introduction

### 1.1 General introduction

Crisis pregnancy is a complex challenge for individuals and societies alike. Its prevention and management needs to be informed by up-to-date and locally applicable information on knowledge, attitudes and behaviours concerning sexual practices and contraception. The first national survey of sexual behaviour was completed in the US in 1948 (the Kinsey Report). This was followed in 1949 by Mass-Observation's Little Kinsey Report in Britain. In the last two decades over seventeen national surveys of sexual behaviour have been carried out in Europe. The largest of these is the National Survey of Sexual Attitudes and Lifestyles (NATSAL), which was conducted in Britain in 1990 and repeated in 2000. To date there has not been a national survey of sexual knowledge, attitudes and behaviour (KAB) in Ireland.

Studies of aspects of sexual health in Ireland offer the prospect of vastly increasing our understanding of the pattern of health behaviours in the area of sexuality and their relationship to both the attitudes/beliefs and socio-demographic characteristics of individuals. Such surveys will provide guidelines on where and how to intervene to improve sexual health outcomes. They also offer a benchmark against which to gauge success and to plan for future work in the area of sexual health promotion in Ireland. A number of recent Government initiatives have highlighted the need for national data on sexual health issues. The report of the National AIDS Strategy Committee (Department of Health and Children 2000) recommended that a national sexual health study be carried out, in line with other European countries. More recently (October 2001), the Government established the Crisis Pregnancy Agency. Its primary focus is the development of a strategy to deal with crisis pregnancy, and more specifically to provide for:

- a reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services
- a reduction in the number of women with crisis pregnancies who opt for abortion by offering services and supports which make other options more attractive
- the provision of counselling and medical services after crisis pregnancy.

*(Statutory Instrument No. 446, 2001)*

The Crisis Pregnancy Agency has commissioned a number of studies to inform their work and the development of service initiatives. Information on contraceptive and crisis pregnancy service availability and utilisation, and on antecedents of crisis pregnancy is needed for the optimal planning and evaluation of services. The aim of the present study was to establish nationally representative data on current attitudes, knowledge and experience of contraception, crisis pregnancy and related services in Ireland. This included assessment of contraception and crisis pregnancy service needs, perceived availability and utilisation of services, antecedents of crisis pregnancy and CPA-campaign awareness. A key objective was to examine the relationship of key demographic and socio-psychological factors with contraception and pregnancy-related data. The study also aimed to enable comparison with similar evidence from other countries and to form a foundation for comparison with future Irish work. This large-scale general-population study aimed to provide the basic 'epidemiology' concerning

contraception and crisis pregnancy in contemporary Ireland. It will complement other ongoing CPA studies, such as those researching women's experiences of crisis pregnancy counselling services and experiences of adoption and adoption services, to provide a more comprehensive understanding of the nature and context of crisis pregnancy in Ireland. It will also complement a larger, ongoing epidemiological study of the sexual health of the Irish population (to be completed by late 2005), which focuses on a wider range of issues, including protection from sexually transmitted infections.

## 1.2 Fertility and contraception in Ireland – recent historical context

From the 1970s onwards, the wider availability of popular media (particularly television) both brought about and documented greater liberalism in relation to sexual conduct in Ireland. It was not until the late twentieth century that Irish women and men were able to avail of contraceptive developments such as condoms and the contraceptive pill, which were, by then, widely available in other European countries. Fertility patterns of the Irish population have dramatically changed over the course of these decades. Ireland has moved into the twenty-first century with a much-changed demographic and family-planning profile. Table 1.1 outlines a brief chronology of change in legislation concerning contraceptive availability in Ireland over the twentieth century.

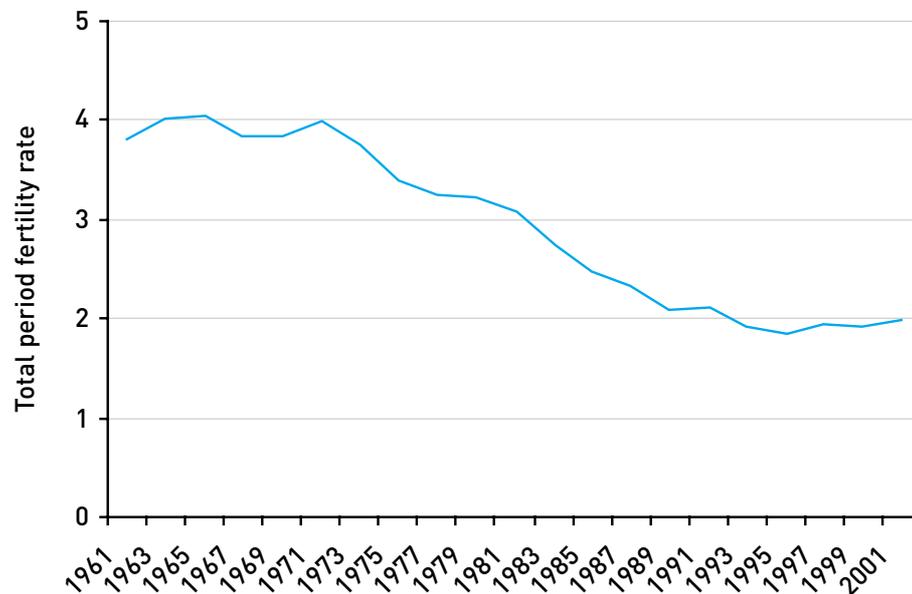
**Table 1.1 Key developments in the availability of contraception in Ireland, 1929-1992**

Year	Event	Detail
1929	Censorship of Publications Act	All literature on contraception and birth control banned
1935	Criminal Law Amendment Bill	Section 17 prohibited the sale, advertisement and importation of contraceptives
1973	Supreme Court	Constitutional right to marital privacy – right to obtain contraceptives for personal use
1979	Health (Family Planning) Act	Contraceptives available on prescription from a doctor for medical reasons
1985	Health (Family Planning) Amendment Act	Sale of spermicides and condoms to persons over eighteen, without prescription, at range of named outlets
1992	Health (Family Planning) Amendment Act	a) Sale of condoms deregulated b) Health boards obliged to provide family-planning service

[Source: Mahon, Conlon and Dillon 1998]

Figure 1.1 depicts the declining total period fertility rates over recent decades.

**Figure 1.1 Total period fertility rates (1961-2001)**



[Source: Central Statistics Office 2003]

### 1.3 Crisis pregnancy

Despite the increased social acceptability of family planning and the availability of contraception, there are still high levels of non-use of contraception among couples not wanting pregnancy. Others use unreliable contraceptive methods or use methods incorrectly, and contraceptive methods can fail. This frequently results in unplanned pregnancy. A problem inherent in unplanned pregnancy is that a woman experiencing such a pregnancy does not have the opportunity to benefit from pre-pregnancy and early antenatal health promotion activities. These activities, such as giving up smoking and alcohol and taking folic acid, have been indicated in improved infant outcomes (Crowley 1999, Barrett and Wellings 2002).

It has been estimated that worldwide, approximately 38% of pregnancies are unplanned, and 22% of all pregnancies are terminated (Alan Guttmacher Institute 1999). Similarly, data from the US National Survey of Family Growth found that among American women, almost four out of ten births and six out of ten pregnancies were unintended (Forrest and Singh 1990). In the late 1980s, an Irish study of 200 pregnant women found that 20% of the married women and 89% of unmarried women had not planned the pregnancy (Greene, Joy, Nugent and O'Mahony 1989).

There are difficulties in determining the true levels of unplanned pregnancy since the terms unplanned or unintended pregnancy can describe various situations. Many women describe a pregnancy as unplanned or unintended. Yet while they may have preferred the pregnancy to occur at a different time in their life, it does not represent a crisis. Alternatively, others experiencing unplanned pregnancy may describe it as a personal crisis in their life.

A major area of research into unplanned pregnancy concerns teenage pregnancy. It has previously been assumed that teenagers do not want to become pregnant and that the majority of teenage pregnancies are unplanned. More recently, research has suggested that teenage pregnancies are not always evaluated negatively by the young women involved. Many studies have shown that substantial numbers of teenagers have a positive or ambivalent attitude towards pregnancy (Jaccard, Dodge and Dittus 2003, Condon, Donovan and Corkindale 2001, Stevens-Simon, Kelly, Singer and Cox 1996). Forrest and Singh (1990), reporting findings from the US National Survey of Family Growth, found that 82% of teenage pregnancies were unintended: thus nearly one-fifth had intended to become pregnant. Jaccard et al. (2003) found that more than 15% of adolescents in their US study showed some ambivalence towards pregnancy. This ambivalence could be used to predict occurrence of pregnancy in the following year. Similarly, Stevens-Simon et al. (1996) studied reasons for non-use of contraception in 200 predominantly poor, pregnant American teenagers aged thirteen to eighteen years. One-fifth stated the reason for non-use of contraception was that they did not mind if they got pregnant, and a further 17.5% said they wanted to get pregnant. Those who gave positive or ambivalent attitudes to pregnancy as their reason for non-use of contraception were significantly more likely to have dropped out of school. Many studies have further shown that teenage mothers are more likely to be low educational achievers or have low educational aspirations (Wellings, Wadsworth, Johnson, Field and MacDowell 1999, Richardson 2000, Frost and Oslak 1999, Manlove 1998, Kiernan 1997, Adler 1984). This was previously thought to suggest that teenage motherhood itself resulted in lower educational and career opportunities. However, recent interpretations of the findings suggest that teenagers with low educational achievement may consider that they have limited social roles besides parenthood. They therefore may view pregnancy more positively, since it offers them a social identity as a parent.

Stevens-Simon, Beach and Klerman (2001) suggest that research questioning teenagers' intentions to become pregnant should be rephrased to instead address their intention to remain non-pregnant, since remaining non-pregnant requires that they act to avoid pregnancy through contraceptive use. They recommend that teenagers' intentions regarding pregnancy should be divided into two categories, and research should then address the issues independently. Firstly, those who are certain of their intention to remain non-pregnant throughout their adolescence should be questioned about their contraceptive use, and any inconsistencies between non-pregnancy intention and contraceptive use should be investigated. The second category concerns teenagers who do not state a clear intention to remain non-pregnant, and research in this area should question the reasons for their ambivalence towards pregnancy, rather than their contraceptive behaviours.

Since much of the research into unplanned pregnancies concentrates on teenage pregnancy, the extent to which the findings relate to the wider population is limited. Barrett and Wellings (2002) studied pregnancy intentions in pregnant women aged fifteen to 43 years. They looked at the women's use of, and understanding of, terms to describe their pregnancy, such as "planned" or "unplanned", "intended" or "unintended", and "wanted" or "unwanted". The term "planned" was only considered applicable if four main conditions were met: as well as an intention to become pregnant and deliberately stopping contraception, women also considered it important to have

agreement from their partner and to be at the right stage in their life. However, the term “unplanned” was used far more widely to describe various situations, often relating to a lack of intention to become pregnant, with terms like “mistake” and “accident” also used to explain “unplanned”. The terms “wanted” and “unwanted” were not easy to define. Women generally agreed that you could want a pregnancy even if it was not planned or intended. Also, it was suggested that a pregnancy could be both wanted and unwanted to some extent, and the term “unwanted” was not generally liked.

Similar research has also identified wide-ranging definitions and understanding of the terms “intending”, “planning” and “wanting” among pregnant women. Again, the terms “wanted” and “unwanted” pregnancy were considered different to “planned” and “unplanned” pregnancy (Gerber, Pennylegion, Spice and Plough 2002, Fischer, Stanford, Jameson and Dewitt 1999, Trussell, Vaughan and Stanford 1999). These studies highlight the complexities of asking women to describe their pregnancy in terms of planning, intending or wanting. It is recommended that studies of women’s pregnancy intentions do not use solely these terms.

Mahon et al. (1998) asked pregnant Irish women to describe their first response to their pregnancy. They used four positive responses (‘planned’, ‘long-awaited’, ‘pleasant surprise’ or ‘pleased’) and four negative responses (‘unexpected’, ‘a shock’, ‘a crisis’ or ‘did not know what to do’). Overall, 36% of the women described their pregnancy using one of the broadly negative terms. The authors noted that age and marital status affected choice of response: there were fewer married women and more single women as one moved from positive to negative responses to pregnancy. Similarly, the women who gave negative responses were generally younger than those giving positive responses. While 28% of those who described their pregnancy as ‘a crisis’ were under nineteen years of age, a further 30% were over 30 years of age, thus illustrating that an initial response to pregnancy as ‘a crisis’ can apply across age groups.

The Statutory Instrument on which the Crisis Pregnancy Agency (CPA) is based uses the following definition of crisis pregnancy:

a pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her. (Statutory Instrument No. 446, 2001: 1)

In addition, the CPA suggest that crisis pregnancy can include:

the experience of those women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances. (Crisis Pregnancy Agency 2003: 6)

Since the terms “unintended” and “unplanned” are complex, the term “crisis pregnancy” is useful: it recognises those pregnancies which, while not actually planned at the time, do not represent a crisis for the woman involved. Defining pregnancies in these terms gives us the opportunity to isolate and study the antecedents of crisis pregnancy in terms of the contraceptive behaviours of women whose experience of pregnancy represents a personal crisis to them.

## 1.4 Antecedents of crisis pregnancy

Research into crisis pregnancies endeavours to understand the risk factors for non-use of contraception and for crisis pregnancy in order to advise policy and thus reduce crisis pregnancies. The international knowledge base has increased substantially in recent years, but research in Ireland and understanding of crisis pregnancies in the Irish context is limited.

Irish research in the mid-1990s (1993 data collection) suggested that 31% of sexually active women did not use any family planning method. This was further categorised by marital status, with one-third of married and 10% of single sexually active women not using contraception (Wiley and Merriman 1996). Of course, many women are not using contraception because they want to become pregnant or because they are, or believe themselves to be, infertile. However, international surveys and Irish qualitative studies have suggested that many women who do not want to become pregnant are also not using any form of contraception. A more recent study of unmarried young Irish mothers found limited use of, and a casual attitude towards, contraception (Richardson 2000). In another earlier Irish study of married and unmarried pregnant women, Greene et al. (1989) reported that 19% of the married women and 64% of the unmarried women had never used contraception. Fitzpatrick, Fitzpatrick and Turner (1997) studied Irish teenagers attending an adolescent antenatal clinic and found that 52% reported having used contraception at some point in the past, but only 8% reported having always used it.

In trying to understand contraceptive decisions and behaviours, it is necessary to consider the range of factors that may affect contraceptive behaviour. For example, knowledge of contraceptive choices, attitudes towards use of contraception or use of alcohol may greatly influence contraceptive choices in sexual relations. Research has investigated the role of relationship factors and communication. Additionally, individuals are affected by service-level factors: for example, accessibility of contraception or contraceptive services.

Factors that have been shown to influence contraceptive behaviours and crisis pregnancy, and research findings for each, will now be described. While the distinct categories represent an attempt to analyse and summarise the findings relating to each factor affecting contraceptive use and crisis pregnancy, it is clear that these factors interact to a great degree.

### 1.4.1 Demographic factors

Demographic factors such as age and social class can interact with other factors (e.g. knowledge or situational issues) to further determine contraceptive use and crisis pregnancy. Age was previously thought to be a factor in crisis pregnancy. As a result, much of the available research concentrates on contraceptive behaviour and crisis pregnancy in young people (mainly adolescents). This limits the extent to which research findings can be extrapolated to the broader population and demonstrates the need for further research. As previously discussed, research has more recently suggested that many teenage pregnancies are not unintended or crisis pregnancies and that many teenagers view pregnancy and parenthood positively, since it can provide them with a societal role and lifestyle. Thus, research into teenage pregnancy should consider that some pregnant teens may chose parenthood, while others may experience teenage pregnancy as a personal

crisis. For example, in a UK study Free, Lee and Ogden (2002) found that young women who felt most strongly about avoiding pregnancy used contraception. They also noted that these women tended to have ambitions towards lifestyles other than motherhood, including educational or career aspirations, or travel plans.

Another demographic factor shown to predict levels of teenage pregnancy is socio-economic status. Analysis of the General Household Survey of Great Britain and the OPCS Longitudinal Study found three times more births to teenagers in manual classes than in non-manual classes (Babb 1993). Analyses of data from the US National Survey of Family Growth found that poor women, and particularly poor teenagers, were less likely to use contraception than others. Additionally, unintended pregnancy rates were high among 18 to 24 year olds with low incomes (Henshaw 1998, Forrest and Singh 1990). Fitzpatrick et al. (1997) found that 89% of Irish teenagers attending an adolescent antenatal clinic were from lower social classes (classes III-V), with none from the highest social class (class I). Thus, social and economic factors may impact on pregnancy rates in young women. These findings again illustrate the interrelated nature of factors influencing pregnancy, since they can further be related to pregnancy intention. If young women with low expectations and educational achievements are sometimes more accepting of motherhood because it provides them with a societal role, it must be considered that some pregnancies, while considered by a wider society as a crisis or inappropriate, may not be defined as crisis pregnancies by those involved.

#### *1.4.2 Knowledge, attitudes and beliefs*

Another factor that may affect contraceptive use and crisis pregnancy is knowledge. While knowledge alone does not seem to be a causal risk factor in unsafe sexual practices, a number of studies have highlighted low levels of knowledge among people practising unsafe sex or experiencing unintended pregnancy. Irish research into levels of knowledge of reproduction, fertility and contraception is limited.

One area that has been shown to further increase risk of unintended pregnancy is knowledge of fertility, particularly in younger women with lower educational achievements. The Irish Family Planning Association (IFPA) has reported that it “continues to see clients who lack an understanding of bodily functions and the risks posed by casual, unprotected sex” (Irish Family Planning Association 2002: 3). This has been further supported in research in the area. For example, Richardson (2000) noted a limited ability to link sexual activity with the risk of pregnancy in young Irish mothers. Hyde (1996) recognised a similar trend in her interviews with unmarried pregnant Irish women. Some of these women had not wanted to become pregnant at the time but had never used contraception. It appeared that the possibility that they could become pregnant had not been considered. Hyde named this category of behaviour ‘fertility denial’. Women displaying ‘fertility denial’ tended to be younger than the overall study population, had lower educational achievements, and were more likely to have left school prior to Leaving Certificate. This inability to link sexual activity with pregnancy or non-recognition of the possibility of pregnancy has been noted in a number of studies, particularly in young female populations (Richardson 2000, Stevens-Simon et al. 1996). The IFPA (2002) recommends increased sexual and reproductive health education, to include coverage of safe sex and contraception.

Hyde (1996) noted a second category of behaviour within her study population, which she termed 'destiny dependence'. Women in this category recognised the possibility that they could become pregnant, and while they would mostly have preferred it to happen when their circumstances (mainly housing situations) were better, their attitude to pregnancy was 'if it happens, it happens'. These women had not been using contraception around the time of conception, but some had used it previously. They were younger than average with lower educational achievement, and were more likely to be unemployed or in unstable, unskilled employment. They also tended to be in a stable relationship at the time of conception, a fact that may have made pregnancy more acceptable to them. These women generally accepted the pregnancy when it happened.

Attitudes towards contraception have also been investigated, including negative attitudes to condom use and to the contraceptive pill. A number of studies have identified that women often hold negative views regarding the risks and side effects associated with the contraceptive pill, for example, possible medical risks including thrombosis, mood-swings and weight-gain (Mahon et al. 1998, Edwards, Oldman, Smith, McQuay and Moore 2000). Furthermore, women tend to overestimate the risks associated with pill use, and underestimated its health benefits and effectiveness (Hansen and Skjeldestad 2003, Edwards et al. 2000, Tessler and Peipert 1997).

Research has also reported dislike of using condoms, particularly among men, often due to reduced sexual pleasure or interruption of sex (Mahon et al. 1998, Abraham, Sheeran, Spears and Abrams 1992, Pleck, Sonenstein and Ku 1990, Morrison 1985). Attitudes towards condoms have been shown to predict condom use and intention to use them (Sheeran, Abraham and Orbell 1999, Nguyen, Saucier and Pica 1994, Pleck, Sonenstein and Ku 1993, Richard and van der Pligt 1991, Pleck et al. 1990). Other attitudes towards contraceptive use have a moral/judgemental perspective. One such example, illustrated in a variety of research, is that women carrying condoms gives a message that they are promiscuous or looking for sex (Mahon et al. 1998, Abraham et al. 1992).

As well as having the knowledge and ability to use contraception correctly, research has suggested the importance of self-efficacy. Self-efficacy involves a person's belief that they have the ability to determine their own behaviour, for example, having the skills to have control of one's sexual behaviour and fertility. A comparison of male and female contraceptive self-efficacy in sexually active 18-20 year olds found that both males and females had low scores for communication about sexual matters, with females also scoring low on securing the use of contraception (Van den Bossche and Rubinson 1997). It is important that both men and women feel they have the ability to discuss contraception and negotiate contraceptive use. Furthermore, it has been found that non-use of contraception may increase if a woman believes it likely that their partner would object and that this objection may jeopardise their relationship (Mahon et al. 1998). Additionally, studies have suggested the importance of relationship power in a woman's ability to negotiate safe sex (Boyd 2002, Pulerwitz, Amaro, De Jong, Gortmaker and Rudd 2002, Taylor 1995). Pulerwitz et al. (2002) found that women reporting high levels of relationship power were five times more likely to use condoms consistently than women with low levels, and they suggest that inconsistent condom use often results from women's low levels of power in sexual relationships.

### 1.4.3 *Relationship factors and communication*

It is also necessary to look at the relationship within which the sexual and contraceptive behaviour takes place. Hyde (1996) recognised a trend among unmarried pregnant women in relationships of increasing non-use of contraception throughout the course of the relationship. She termed this phenomenon “progressive remissness”. These women reported previous consistent use of contraception within the relationship, with regularity of use declining as the relationship continued. They had previously used the contraceptive pill and had discontinued use for a variety of reasons, generally using other contraception or precautions for a time, before engaging in higher risk contraceptive behaviour such as withdrawal or non-use of contraception. Unplanned pregnancy then occurred, with all women reporting not wanting to become pregnant at this stage. Hyde (1996) also suggested that each experience of unprotected intercourse that did not result in pregnancy gave these women an increased belief that they could avoid pregnancy.

A similar group identified by Hyde (1996) was the “occasional or intermittent risk-takers”. Most of these women did not want to become pregnant at that time but were occasionally or intermittently having unprotected sexual intercourse. Their pregnancies resulted from unprotected sex with a new or occasional partner, but most of the women had used contraception in the past, and some had been planning to start using a reliable form of contraception, such as the contraceptive pill, at the time of conception. Their non-use of contraception seems to have resulted from the infrequency of sex, short time-period over which it was occurring, and lack of pregnancy from previous unprotected sex, which had given them a sense that pregnancy would not occur. Alcohol was also considered by some of this group to have contributed to non-use of contraception. This group highlights a vulnerable time in the early stages of a sexual relationship when intermittent sex may result in pregnancy through non-use or occasional use of contraception.

While Hyde (1996) has provided us with a number of useful concepts with which to differentiate the reasons behind various contraceptive behaviours, the extent to which the findings can be extrapolated to wider populations may be limited. Her formulation is based on a qualitative study in which 51 unmarried pregnant women were interviewed. While age ranged from 16 to 36 years, the average age was 22.7 years. The study, therefore, reflects contraceptive practices and experiences of the younger unmarried female population. Interview data was analysed and seven categories of attitudes towards contraception and pregnancy were identified. The small number of women identified within each category (five to ten women) suggests the need for further research to determine the extent to which this identified behaviour can be applied to the general population.

As relationships develop, contraceptive requirements can change. Condom use has been shown to be greater at the start of a relationship and contraceptive pill use increases as the relationship develops (Ku, Sonenstein and Pleck 1994). Likewise, Buysse (1998) found condom use to be more common in casual than stable relationships.

Alternatively, determinants of contraceptive use have been investigated in terms of communication levels. Again, much of this research has been conducted with adolescents to investigate their ability to communicate about and to negotiate

contraceptive use. Thus, there are limitations in the extent to which the findings can be applied more generally, demonstrating the need for further research with a variety of age groups.

Research has suggested that most predictors of early sexual intercourse (e.g. parents' social class, low parental monitoring) are not predictors of contraceptive use at this time. Instead, communication factors have been indicated as more significant predictors of contraceptive use (Henderson, Wight, Raab, Abraham, Buston, Hart and Scott 2002). Studies have found that teenagers were more likely to use a condom if they had discussed contraception with their partner (Henderson et al. 2002, Rosenthal, Smith and De Visser 1997), if their relationship lasted longer than one month and if intercourse was planned (Henderson et al. 2002). Similarly, in relation to first sexual intercourse, young people were more likely to use contraception at first intercourse and first occasion with current or most recent partner if they discussed contraception prior to first intercourse together (Coleman and Ingham 1998, Stone and Ingham 2002) or if the first intercourse occurred a month or more into the relationship (compared with first intercourse in the first few days) (Coleman and Ingham 1998).

#### *1.4.4 Role of alcohol*

A number of factors specific to certain situations may further increase the likelihood of not using contraception. A major factor in relation to sexual behaviour appears to be use of alcohol. In their study of sexual behaviour in 2,754 Irish teenagers (aged fifteen to eighteen years), MacHale and Newell (1997) found that of those reporting they had experienced sexual intercourse (21%), over a third (35%) said that alcohol had contributed to them having their first sexual intercourse, with 9% reporting that drug use had been a contributory factor. Additionally, more than half of those reporting sexual intercourse had had their first sexual intercourse with a casual partner.

Strunin and Hingson (1992) carried out a telephone survey of sexual behaviours of American teenagers aged sixteen to nineteen years. Of those who had experienced sexual intercourse (66%), 64% reported having had sex after drinking alcohol and 15% after drug use. Only 37% said they always used condoms. Almost half of those who had had sexual intercourse (49%) said that sex was more probable if they and their partner had consumed alcohol, and 17% said they were less likely to use condoms if they had been drinking.

Much of the research to date into the effect of alcohol on contraceptive behaviour concentrates on the use of condoms and relates to sexually transmitted infections. A concern is the level of conflicting findings in the research. Rosenthal et al. (1997) reported no relationship between condom use and alcohol. A meta-analysis of research into the relationship between alcohol and condom use found that alcohol was not always related to contraceptive use. Alcohol use at first sexual intercourse did relate significantly to decreased use of condoms. However, use of alcohol with recent new sexual partners and in other recent sexual encounters did not relate to condom use (Leigh 2002).

#### 1.4.5 *Spontaneity of sex*

A second situational factor is spontaneity of sex, where sex is not planned and contraception may not have been planned or is not accessible because of the spontaneity of sex. Researchers have discussed these issues in relation to the need for people to have a contraceptive method to suit their sexual lifestyle (Bajos, Leridon, Goulard, Oustry and Job-Spira 2003). Thus if there is a possibility of spontaneous sex, a person's contraceptive choices should ensure contraception can be used, even in situations of spontaneity. A related issue is suitability of contraception. Recent Irish studies have highlighted situations where women became pregnant after stopping a form of contraception because of its unsuitability (Mahon et al. 1998, Hyde 1996).

These points have implications for medical practitioners when prescribing contraception, for example, they should into consideration the person's sexual and social lifestyle when suggesting contraceptive methods. Adequate advice is dependent on a number of factors, for example, the ability and/or willingness of the person to describe their contraceptive needs and their willingness to accept the suggested method (Bajos et al. 2003). However, contraceptive needs are not static. They can change due to many factors, including a change in the nature of one's sexual relationship.

#### 1.4.6 *Contraceptive failures*

Even with high levels of knowledge and careful use of contraception, contraceptive failure can still occur. The estimated levels of failure with correct and careful use of the combined contraceptive pill (<1 in 100 women) and the condom (2 in 100 women) are relatively low (Irish Family Planning Association 2004, Schering Health Care 2001). However, numerous studies have recorded high levels of technical failure of contraception across age groups. It is curious that technical failure of contraception is such a frequently cited reason for unintended pregnancy. It is firstly important to note that the social unacceptability of unintended pregnancy due to unprotected sexual intercourse may result in a 'face-saving' explanation of technical failure of contraception in some cases. Furthermore, many cases of reported contraceptive failure seem to be related to incorrect and inconsistent use of the method.

In an Irish study of the contraceptive practices of unmarried pregnant women, Hyde (1996) found that nine of 51 women interviewed said their pregnancy resulted from contraceptive failure or misuse. Seven had used condoms, with one reporting misuse. The remaining two were using the contraceptive pill. One had used antibiotics without taking further contraceptive precautions and the other was unsure as to why the pill had failed.

In a study of reasons for not using contraception in 200 predominantly poor, pregnant American teenagers, Stevens-Simon et al. (1996) found 12% reporting contraceptive failure. In a UK study, 80% of pregnant teenagers said they had used contraception at the time of conception. Most had used condoms, with 79% of the condom users knowing why it had failed. A third had used the contraceptive pill and 80% of these knew why it had failed (Pearson, Owen, Phillips, Gray and Marshall 1995). A similar study, which included older women (aged 14 to 40), found that 69% of pregnant women had used contraception, with 51% of condom users and 72% of pill users knowing why the method had failed (Randall and Lewis 1995).

While the studies appear to suggest high levels of technical failure, closer analysis of the results of Pearson et al.'s (1995) study suggests that, of those claiming to use condoms, 18% did not actually use condoms at the time of conception. Of those using the contraceptive pill, 80% said that it had failed because they had missed or forgotten pills, had stopped taking the pill or had run out of pills, or because they were taking antibiotics. Similarly, Mahon et al. (1998) found that many Irish women with crisis pregnancies reported inconsistent or incorrect condom and contraceptive pill use.

Bajos et al. (2003) studied contraceptive use in French women who had experienced unplanned pregnancies. They found that 35% had used no contraception at the time of conception, with 21% stating that they had been using the pill, 22% using natural methods (including safe period and withdrawal) and 12% using condoms. The most popular reason given for failure of the contraception was misuse of contraceptive method: 60% of pill users stated that they had not used it correctly, by forgetting pills or taking them late, with a further 18% reporting illness, medication or vomiting. Over half of women using condoms (53%) reported method failure (condom tore or slipped off), with 28% stating that a condom was not actually used on the occasion of conception. Again, the term 'contraceptive failure' is used to describe incorrect or inconsistent use. This definition of contraceptive failure originates from research studies of contraceptive efficacy in which contraceptive failure was deemed to occur when there was a risk of unintended pregnancy and when a woman stated that they were a user of a method of contraception, even if the method was used incorrectly or inconsistently (Trussell et al. 1999). This definition can be misleading, since much of the failure relates to misuse of the method or failure to use the method on the particular occasion of conception.

Research into consistency of use among 1,485 contraceptive pill users in the US has indicated that 16% of those who depended on the contraceptive pill as their only method of contraception were not consistently taking the pill. Those who began taking the pill recently and those who had previously experienced an unintended pregnancy were more likely to use the pill inconsistently (Peterson, Oakley, Potter and Darroch 1998). Inconsistency of use has been reported across all age groups. Good consistency in pill-taking has been shown to be influenced by satisfaction with clinician, absence of side effects, established daily routine for pill-taking and reading of information leaflets distributed with the contraceptive pill (Rosenberg and Waugh 1999). Findings indicate the need for better education of contraceptive pill users to ensure the pill is used correctly and consistently. Increased risk of unintended pregnancy has been identified in women who discontinue use of oral contraceptives (often due to side effects) and fail to subsequently adopt a new method of contraception (Rosenberg and Waugh 1998).

Little, Griffin, Kelly, Dickson and Sadler (1998) investigated the effect of educational leaflets on contraceptive pill users' knowledge. They found that without educational intervention, only 12% of contraceptive pill users knew the guidelines relating to correct pill use. The use of educational leaflets significantly increased knowledge. Similarly, Little, Griffin, Dickson, Sadler and Kelly (2001) noted that educational interventions were at least as important as socio-demographic factors in predicting pill knowledge. They identified predictors of good pill knowledge, including further education, previous use of emergency contraception, fewer years on the pill and level of importance attached to not becoming pregnant.

For prescription methods of contraception, intervention to improve user knowledge could be through the medical practitioner, nurse or pharmacist prescribing them. However, condom failure is also indicated in unintended pregnancy. Although condoms can fail, even when they are used correctly, it has been suggested that improved information and education on correct condom use could decrease levels of condom failure (Murty and Firth 1996). In addition, increased awareness and use of emergency contraception could reduce the number of unintended pregnancies in cases of contraceptive failure that are recognised by the user at time of failure.

#### *1.4.7 Emergency contraception*

International surveys have reported varying levels of knowledge of emergency contraception, with most reporting high levels of knowledge amongst adolescents (Graham, Green and Glasier 1996, Pearson et al. 1995). However, knowledge of correct time limits for its use is generally poor (Graham et al. 1996, Smith, Gurney, Aboulela and Templeton 1996, Bromham and Cartmill 1993). Many women do not avail of emergency contraception, despite being aware of a contraceptive failure (Pearson et al. 1995, Randall and Lewis 1995, Bromham and Cartmill 1993). Studies of women attending for abortion in England and in New Zealand found knowledge of emergency contraception to be limited and coupled with low levels of actual use (Young, McCowan, Roberts and Farquhar 1995, Bromham and Cartmill 1993).

Lack of knowledge of its existence, and barriers such as accessibility and attitudes of professionals, may reduce uptake of emergency contraception (Free et al. 2002, Young et al. 1995, Bromham and Cartmill 1993). However, research has suggested that improvements in uptake of emergency contraception would also require better assessments of personal risk of pregnancy, particularly in teenagers, in order that they are more likely to recognise the possibility of pregnancy (Free et al. 2002, Pearson et al. 1995).

Research into emergency contraception in Ireland is limited. It is essential to have local data, since levels of acceptability or access to emergency contraception in Ireland may differ from those in other European countries. Mahon et al. (1998) found that some pregnant Irish women had wanted to use emergency contraception but were unable to access it because they were refused it by a GP, they could not access it at the weekend, or because they lived in a rural area and did not know where to access it.

#### *1.4.8 Contraceptive services*

Service-level factors, which concern access to and experiences of contraception and contraceptive services, impact on contraceptive use. Irish research on levels of access to and attitudes towards contraceptive services is limited. Thus current information to inform service planning is based on mainly small Irish studies and international research. The most nationally representative research available to date (that of Wiley and Merriman (1996), based on 2,988 women surveyed in 1993) found that 51% of Irish women felt that advice on family planning was accessible in their area, with 29% thinking it was not accessible, and the remainder unsure. When focusing on sexually active women only, one-third felt that family-planning advice was not accessible in their area. It is important to know if there have been changes in the intervening ten years.

In their study of contraceptive services, Smith and Bury (2000) studied women visiting general practices in Dublin. Most women studied (73%) thought it was appropriate for

GPs or general practice nurses to ask all visiting women whether they required contraceptive advice. Some women surveyed chose specialist centres (such as Well Woman or family planning Clinics) for family-planning advice. While GPs can offer continuity of care, some women in this study reported feeling uncomfortable using their family GP for contraceptive advice. General practice surgeries were sometimes perceived as lacking in desired levels of privacy for pelvic examination.

Churchill, Allen, Pringle, Hippisley-Cox, Ebdon, MacPherson and Bradley (2000) studied pregnant teenagers' use of general practice in the UK in the year prior to their pregnancy. Pregnant teenagers had had a median of four consultations in the year prior to conception, with 93% having attended at least one consultation and 71% having had, at some point prior to conception, a consultation in which contraception was discussed. The results suggest that consulting health professionals for contraceptive advice may present less of a barrier for teenagers in the UK than was previously thought. General practice could offer an opportunity to target teenagers, particularly those at risk of pregnancy, in order to provide them with contraceptive advice.

However, the IFPA (2002) has suggested that young Irish people may be reluctant to use their family doctor for contraceptive services due to embarrassment. A number of studies have highlighted issues that were seen by adolescents as preventing them from availing of contraceptive services. For example, Dempsey, Heslin and Bradley (2001) noted that pregnant Irish teenagers listed cost, relationship with GP, locality and fear of buying contraception, and embarrassment as barriers to accessing contraceptive services. In terms of barriers to consultation with a GP regarding contraception, many adolescents report concerns about confidentiality and the possibility that their parents could be informed of their discussions with a GP (Peremans, Hermann, Avonts, Van Royen and Denekens 2000, Mahon et al. 1998, Donovan, Mellanby, Jacobson, Taylor and Tripp 1997). Additionally, it has been suggested that GPs may further block access by refusing to provide contraception because of a client's age or because of the GP's own moral attitude towards sex outside marriage. Some Irish women, particularly adolescents, have reported avoiding GP visits through fear of disapproval (Mahon et al. 1998).

Jacobson, Mellanby, Donovan, Taylor and Tripp (2000) investigated fifteen and sixteen year olds' health-related concerns and whether they had consulted a health professional about them. Nearly a quarter of the young women (23%) and 6% of men were concerned about issues relating to pregnancy. While 25% of these had seen a GP and 30% had visited a clinic in relation to their pregnancy concerns, 34% had not spoken to anyone in relation to their concerns. The authors suggest greater encouragement for teenagers to use health services if they are concerned about aspects of their health.

Another factor to consider in accessing contraception is cost. In Ireland, only holders of means-tested 'medical cards' can attend a GP and receive prescription contraception without cost. The cost of visiting a doctor and the cost of contraception itself can further limit access to contraception, particularly for young people on low incomes (Irish Family Planning Association 2002, Mahon et al. 1998). A Belgian study found that the cost of a visit to the GP and of contraceptives was one of the biggest obstacles to contraceptive access (Peremans et al. 2000). In Ireland, the IFPA have recommended free access to sexual and reproductive health services, in order to increase uptake of contraceptive services and to provide a choice of services.

Hosie (2002), in a review of sexual health policies throughout Europe, suggests a number of important issues in relation to availability of sexual health services for young people. These include convenient geographic locations with suitable opening times, services away from parental view, confidentiality, informal and user-friendly staff, approachable and respectful attitudes from professionals, youthful 'linguistics' and recognition of the needs of young men.

#### 1.4.9 Learning about sex

Relationship and Sexuality Education (RSE) is an integral part of Social, Personal and Health Education (SPHE) in Ireland. The content of an SPHE programme includes a range of topics such as healthy eating, alcohol, drugs safety and social responsibility and also RSE. RSE includes a wide range of topics appropriate to differing age groups and school years. These topics include human growth and development, human sexuality and human relationships. Currently parent associations can plan parent programmes in connection with RSE. The National Parents Council (Primary and Post-Primary) is developing resources to assist parents' associations in this work (Department of Education and Science 2004). Mechanisms to consult with parents regarding RSE are already in place (National Parents Council, the Department of Education and School Boards of Management). These are some of the questions most frequently asked by parents:

- What is Social, Personal and Health Education (SPHE)?
- Does RSE happen only in school?
- Will RSE lead to a loss of innocence in children?
- Will RSE help children make responsible choices?
- Have teachers received training to teach RSE?

*(Department of Education and Science 2004).*

These questions give us an insight into some of the concerns of parents in relation to sex education and their children. The report 'Relationships and Sexuality Education: Evaluation and Review of Implementation' concluded that there was a high level of agreement between parents and teachers regarding the content of the RSE curriculum and the Department of Education's approach towards its implementation. However, the report also found that almost one-third of primary schools had yet to draft a policy statement on RSE by 2000. On a more positive note, the report found that there was a dramatic increase (31%) in the number of schools drafting RSE policy statements from 1999 to 2000 (Department of Education and Science 2004).

School sex-education programmes can make a major contribution to sexual knowledge. There is continued debate concerning whether sex education results in increased sexual activity among teenagers, with some arguing for abstinence programmes (Stammers and Ingham 2000, Kay 1995). However, research has not found evidence to suggest that sex education increases early sexual activity (Hosie 2002, Kirby 2002, Cheesbrough, Ingham and Massey 1999, Wellings, Wadsworth, Johnson, Field, Whitaker and Field 1995, Baldo 1993). Instead it has been shown that it can actually encourage young people to delay first intercourse (Kirby 2000, Wellings et al. 1995, Kirby, Short, Collins, Rugg, Kolbe, Howard, Miller, Sonenstein and Zabin 1994). A number of school sex-education programmes have been shown to increase contraceptive use among young people (Kirby 2002, Kirby 2000, Kirby et al. 1994). Similarly, it has been demonstrated that provision of

better sex education is related to lower levels of teenage pregnancy in a number of European countries (Hosie 2002).

Thus, sex education programmes can be used to increase sexual knowledge in a number of areas, including fertility and reproduction, safe sexual practices and contraception. Sex education in Ireland is implemented in a variety of forms, and to a variety of degrees. In an Irish study, Fitzpatrick et al. (1997) found that only 39% of 120 pregnant teenagers knew the most fertile time in the menstrual cycle. Research on levels of sex education and their impact in Irish schools is limited, but international reviews of research to date suggest wide variations in the effectiveness of such programmes (Kirby et al. 1994, Baldo 1993).

Studies have shown that while parental factors do not have a significant influence on the onset of sexual activity, they can have a significant impact on contraceptive use (Nguyen et al. 1994, Casper 1990, Baker, Thalberg and Morrison 1988). However, other studies have pointed to the importance of maternal influence on adolescent sexual behaviour, arguing that maternal influence is predictive of adolescent sexual motivation, which is predictive of actual sexual behaviour (Dittus, Jaccard and Gordon 1999, Jaccard, Dodge and Dittus 2003). Parents tend to exert a stronger influence on younger adolescents (Pistella and Bonati 1998, Nguyen et al. 1994, Mueller and Powers 1990); this may be attributed to their developmental stage and the fact that they are more impressionable and more open to discussion with their parents.

The manner and style of communication used by the parent to discuss sexual behaviour and contraception is also important. For example, Mueller and Powers (1990), in a study of 234 college students, found a significant relationship between perceived parental sexual communication style and adolescent sexual behaviour, contraceptive use and sexual knowledge. Participants were more likely to use contraceptives if the parents' style of communication about sexual behaviour and contraception was perceived as friendly, attentive and open. Dittus et al. (1999) found that parents communicate to their adolescent children regarding appropriate and inappropriate sexual behaviour in a variety of ways. This communication is not always direct verbal communication: very often 'indirect transmission of maternal orientations' can occur and have an impact on behaviour.

Within the realm of family, older siblings have also been found to exert considerable influence on their younger siblings' sexual behaviour, contraceptive use and pregnancy intentions. Younger siblings were found to be more sexually active at a specific age than their older siblings (Widmer 1997, Rodgers, Rowe and Harris 1992, Rodgers and Rowe 1988). East's (1996) study sought to identify the consequences of adolescent pregnancy on younger siblings. Younger brothers and sisters of pregnant, parenting and never-pregnant teenagers were interviewed. The younger siblings of pregnant and parenting teenage girls were more accepting of adolescent childbearing, perceived younger age as more appropriate for having first sexual intercourse and ascribed more importance to childbearing than the younger siblings of never-pregnant older sisters. An Irish study found that many young single mothers had siblings and friends who also had children outside of marriage. This provided support for them in their own situation and, perhaps, again suggested that young teenage motherhood was more acceptable to them because of the experiences of their friends and siblings (Richardson 2000).

Families clearly have an impact on the sexual behaviour, contraceptive use and pregnancy intentions of adolescents. The extent of this influence varies, and largely depends on a range of important variables such as ethnicity, race, age and socio-economic status of family (Rossi 1997, Billy, Brewster and Grady 1994, Brewster, Billy and Grady 1993). A further influence on behaviour can come from peers and partners. An Argentinean study of heterosexual high-risk behaviour found condom use with regular partner to be predicted by the norm of the partner; condom use with occasional partners was predicted by the norms of friends and parents (Glasman and Albarracin 2003). Teenagers' attitudes towards the importance of birth control have been significantly related to their beliefs about their friends' use of birth control (Gibson and Lanz 1991). Whitley (1991) studied contraceptive use in college students and found that partners' support for contraceptive use, but not friends' support, was related to actual contraceptive use. The young people were more motivated to comply with their partners than their friends or parents. Additionally, young men were more willing to use a condom if encouraged to do so by their partner. These studies highlight the importance of significant others, in particular one's sexual partner, in predicting behaviours.

### 1.5 Crisis pregnancy outcomes

An understanding of the decision-making process for men and women who experience a crisis pregnancy needs to be embedded in an Irish cultural and societal context. In terms of understanding the stigma and secrecy surrounding crisis pregnancy and its outcomes, placing this process into an Irish cultural and societal context has particular importance. The influence of the State and Catholic Church over women's reproductive health is vividly illustrated in the treatment of women who gave birth outside marriage in the past. From the establishment of the State in 1927 to the mid 1970s having a baby outside marriage often resulted in young women being placed in 'Magdalen Asylums', where they provided free labour in laundries, and many lived in prison-like conditions (sometimes for the duration of their lives). The children of these women were often institutionalised in reformatories and industrial schools, which were run by the religious orders with State funding (Nic Ghiolla Phadraig 1985).

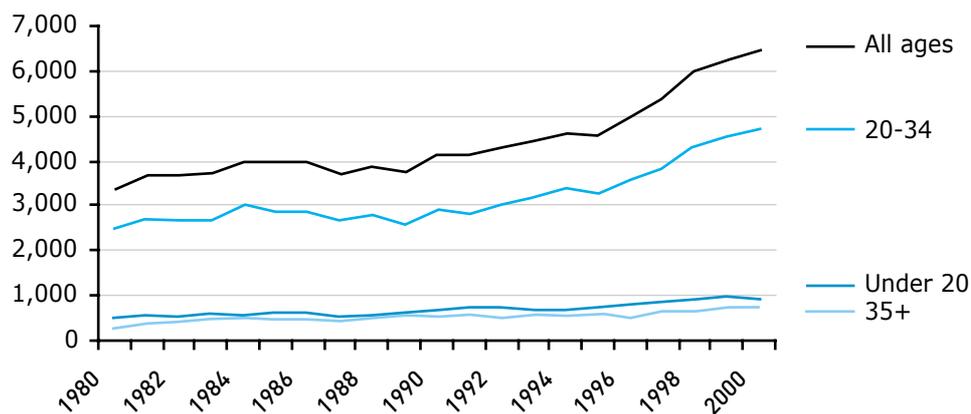
However, over the middle decades of the twentieth century, a dramatic change in the number of births outside marriage occurred. In 1961 there were 975 births outside marriage (1.6% of total births). Within the last two decades the rate of births outside of marriage in Ireland has increased from 13% (1989) to 31% (1999). This is seen as a reflection of a more liberal and permissive society (Courtney 1995). Simultaneously, society's response to a woman who has had a child outside marriage changed. 'Unmarried mothers', who had traditionally been shunned, were, by the 1980s, provided with financial support by the State to rear their child themselves. The stigma once associated with becoming pregnant outside of marriage appears to have greatly diminished. Research in the early 1990s showed that the 20% of births outside marriage were to a very diverse group of people (Flanagan and Richardson 1992, McCashin 1996). Significantly, a large number of these births were to cohabiting couples who had made a decision to choose parenthood but not marriage.

While the traditional taboos associated with single parenting have very much diminished, Irish women travelling to Britain for an abortion for the most part remain silent and invisible. From the early 1980s, legislative and constitutional changes have been enacted

in Ireland to deal with the issue of abortion. The changes made to the Constitution and to Irish law came about, for the most part, as a consequence of court proceedings and legislative changes pursued by anti-abortion lobby groups. Court rulings were made at both a national and European level (see Appendix 1 for an outline of significant events in relation to Irish legislation on abortion). While these referenda stimulated much political and public debate during the last two decades, the number of Irish women travelling to Britain for an abortion has steadily increased each year.

Because of the prohibition on abortion in Ireland (both in the Republic and Northern Ireland), Irish women travel to Britain (or beyond) for termination of pregnancy. Figures provided by the UK National Statistics Office show that the number of Irish women who have availed of abortion in Britain as an outcome of an unplanned/crisis pregnancy has been rising steadily. The number has virtually doubled from 1980 to 2001. In 2001, over 6000 women who had an abortion in the Britain identified their place of residence as Ireland (figure 1.2).

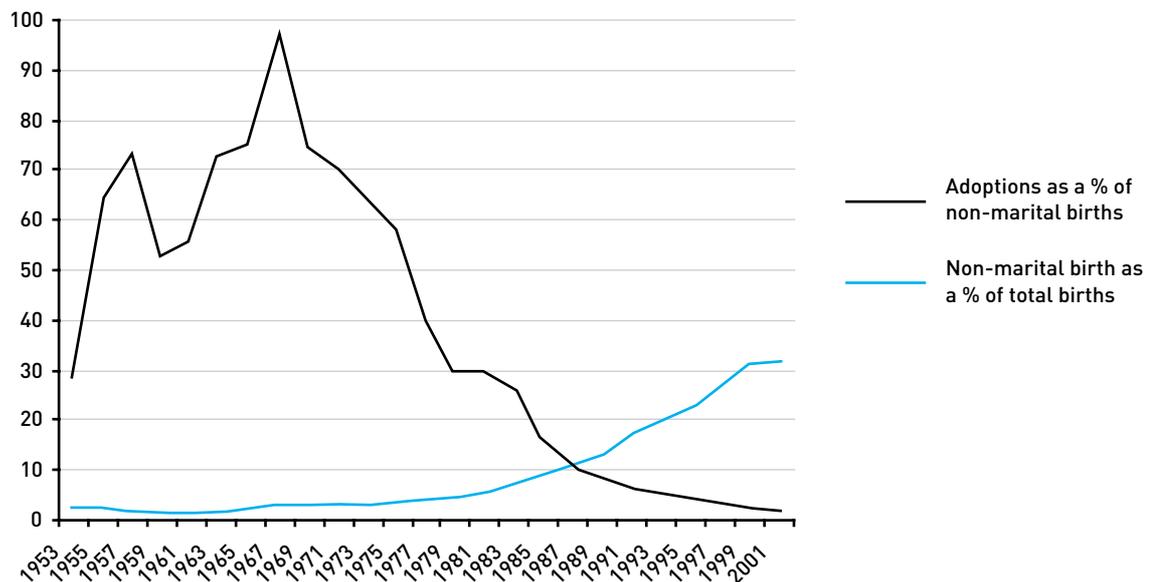
**Figure 1.2 UK National Statistics Office abortion figures for women of Irish residence**



[Source: Irish Family Planning Association 2003]

Since the introduction of adoption legislation in Ireland in 1953, a total of 42,177 adoption orders have been made. This number concerns children placed for adoption within the State. Adoptions as a percentage of non-marital births peaked in 1967, when 97% of non-marital births resulted in an adoption. From 1967 onwards, this rate steadily declined to an all-time low in 2002, when 1.41% of non-marital births resulted in adoption (An Bord Uchtála 2002) (figure 1.3). Clearly, adoption has become the least desirable option for those who experience a birth outside marriage and/or a crisis pregnancy. This decline in the number of births outside marriage that result in adoption can be explained by an increase in the number of women choosing to keep their child alongside an increase in the number of women who choose to have an abortion.

Figure 1.3 Birth and adoption trends in Ireland, 1953-2001



[Source: An Bord Uchtála 2002]

Research conducted in Ireland regarding those who place their children for adoption indicates that there are certain similarities between them and women who choose abortion: namely a fear of being stigmatised and a subsequent need to keep the pregnancy a secret. To date, research regarding the decision-making process of those who experience an unplanned and crisis pregnancy is limited. Mahon's (1998) study of Irish women experiencing a crisis pregnancy found that women do not necessarily feel that they have any real choice when deciding what to do in a crisis pregnancy situation. Greene et al. (1989) found a striking difference in time of attendance at the first antenatal visit for 100 married and 100 unmarried first-time mothers. While none of the married women delayed on their first visit to the antenatal clinic, almost one-quarter of the unmarried mothers delayed their first visit until after they were twenty weeks pregnant. Greene et al. (1989) hypothesised that this delay in attendance was partly due to "a psychological resistance to acknowledging the pregnancy". In the absence of feeling that there exists a real choice regarding the outcome of a crisis pregnancy, many women may face this difficult time in turmoil. This may be particularly true of women who decide to have an abortion or place their child for adoption. However, while it is acknowledged that unwanted pregnancy and abortion are potentially stressful life events, it is also true such life events may result in both positive and negative psychological consequences (Bradshaw and Slade 2003, Kero, Hogberg, Jacobsson and Lajos 2001, Major, Cozzarelli, Cooper, Zubek, Richards, Wilhite and Gramzow 2000, Stotland 1996).

### 1.5.1 Deciding to become a parent and keep the baby

As previously mentioned, women who give birth outside marriage do not form one homogenous group. Within the 31% of births outside marriage in Ireland in 2001, a small minority (4%) was to teenage mothers, with the remainder (96%) born to single parents and cohabiting couples. Since a significant number of cohabiting parents choose to give

birth to a child and to remain unmarried, birth outside marriage cannot be considered an indicator of crisis pregnancy. It is acknowledged that many pregnancies among those cohabiting cannot be assumed to be crisis pregnancies. However, research is now indicating that even within the category of teenage parents, a substantial minority may be ambivalent or have a preconscious motivation towards becoming pregnant and thus do not necessarily experience the pregnancy as a crisis. Some recent American studies estimate that between one-third and one-fifth of teenage pregnancies are intended (Henshaw 1998). Frost and Oslak's (1999) study also found that the male partner's pregnancy intentions had a relationship to the female's intention to become pregnant. Thus, crisis pregnancy can only be defined as such by those involved in the pregnancy. While State or other agencies may have concerns about pregnancies that are seen as challenging, such as pregnancy during the teenage years, there needs to be a clear distinction between these and pregnancies that are defined by the parties involved as problematic, because they are seen as unwanted or unmanageable.

When addressing why some women who have an unintended pregnancy choose to keep and parent the baby, access to abortion is an important factor to consider. However, it is not the defining or most important factor for many women (Frost and Oslak 1999). Abortion is not chosen for a variety of reasons. These may include moral or religious beliefs, cultural or societal influence and, in particular, the influence and attitudes of family members towards abortion and the value they place on motherhood and childbearing. Experiencing an unintended pregnancy as a young woman and choosing to give birth has been associated with economic disadvantage in the family or geographical location, living with one or neither biological parent, and, in some cases, having experienced rape or sexual abuse. Lower educational achievement and career aspirations have also been associated with unintended pregnancy and choosing to give birth (Hosie 2001, Frost and Oslak 1999, McCashin 1996, Lawson and Rhode 1993, Phoenix 1990, Adler 1984). Swann, Bowe, McCormick and Kosmin (2003), in a review of interventions to support teenage parents, concluded that while there is a vast amount of evidence highlighting the relationship between poor health, social outcomes and life chances, there is little information available on formal interventions.

Frost and Oslak's (1999) study highlights the range of emotions experienced by teenage mothers upon discovering their pregnancy. Within this group of pregnant teenagers studied, three categories emerged:

- those who had intended to become pregnant
- those who had not intended the pregnancy
- those who had not cared one way or the other.

The emotional responses outlined describe reactions to very different intentions towards pregnancy. Upon first learning that they were pregnant, 64% of all those interviewed said that they were very sure about wanting to keep the baby and 36% said that they needed more time to think about what to do. Explanations as to why they had decided to keep the baby included:

- wanting or accepting motherhood (46%)
- being against abortion or adoption (32%)
- wanting the baby and being against abortion and adoption (19%)
- keeping the baby only because other people wanted them to (3%).

Of the teenagers who had not intended to become pregnant, only 25% of them gave a positive reason as to why they had decided to keep the baby. Half (51%) said that they had decided to keep the baby because they were against abortion or placing the child for an adoption. Deciding to keep the baby was also related to perceived advantages and disadvantages of teenage childbearing; some of these are outlined above. In terms of social support, most participants (34%) indicated that the baby's father was most important in helping them decide to continue with the pregnancy, with 23% saying that they themselves were most important; 20% identified their mother. Those teenagers who had not intended to become pregnant were less likely to identify their partner as being helpful. Instead, they themselves (29%) or their mother (28%) were of key importance in coming to a decision to keep the baby. When the teenagers were asked why they had decided against an abortion or had not considered it, 65% of respondents said that they were opposed to it or had a fear of abortion. A further 24% of participants indicated that they wanted or were resigned to having the baby, and 6% said that they wanted the baby but also stated that they were opposed to abortion.

Mahon's (1998) qualitative study of 34 Irish women who chose parenthood as an outcome of an unplanned or crisis pregnancy provides an insight into the decision-making process that results in parenthood. Of the 34 women who chose to become parents, the decision-making process for six of these women, who contemplated abortion but who finally rejected it and chose parenting, is particularly important. The perceived negative aspects of becoming a lone parent usually prompted consideration of abortion as an option. The prospect of financial difficulties was also a considerable worry for the women interviewed. However, the level of consideration given to abortion as an option differed for each woman: some merely thought about it; others made an appointment and travel arrangements. Mahon (1998) makes the important point that the women who actually sought counselling or talked to abortion clinics felt empowered by the experience and more able to make their own decision, which, in these cases, was to choose parenthood. Of the six participants who gave consideration to abortion, some reasons why abortion was finally rejected included:

- a feeling that they would not be able to live with themselves after the abortion
- feeling that it was not the child's fault they had become pregnant
- always liking children
- relating to the pregnancy
- offers of support from family/partner.

Only six of this group gave serious consideration to adoption. Some reasons why adoption was rejected included:

- a belief that they would always think about the child after the adoption
- a bond developing between mother and child during the pregnancy
- relating to the experiences of others that adoption is not in the best interests of the child or the mother.

While choosing motherhood was seen as a difficult choice, the option of having an abortion or adoption was one they felt they could not pursue. While some women would have preferred to be married before they had children, only one woman in this group married her partner before her child was born. Support from family (mother/father) was

of key importance, as was partner support if the woman was in a relationship. This support included a sharing of childcare responsibilities, financial assistance, and emotional and psychological support. The existence of a relationship or living with one's partner often contributed to a lessening of the stigma traditionally attached to lone parenting. Some participants related accounts of having to resist the opinions of others, for example, parents or partners, who insisted that a woman should choose abortion or adoption to resolve the crisis. Not all women received support from parents or partners. In fact, eleven of the women had to face motherhood alone. These women usually lived alone or in residential-type housing. They reported feeling that services were not available to meet their needs as lone parents. For the majority of women, pregnancy and lone parenthood impacted negatively on career and educational aspirations.

Becoming a lone parent poses challenges and difficulties for women across all age categories. As stated above, education and career can be disrupted or suspended. Financial issues create worries and challenges in terms of coping or surviving. Young mothers face a number of difficulties generally associated with teenage pregnancy and childbearing. There is an increased risk of poverty and welfare dependence among this group of parents (Swann et al. 2003, Wellings et al. 1999, McCashin 1996). Richardson (2000), in a study of 31 mothers who had given birth to their first child under the age of eighteen, outlined some of the consequences of teenage childbearing. Living on low levels of income, mainly provided through social welfare payments, posed problems for the majority of participants. As in found in Mahon's (1998) study, family support was crucial in coping with parenthood and providing time out. In line with some US findings, Richardson (2000) noted that there was a low level of educational attainment among the participants, with many being early school leavers prior to the pregnancy. However, educational aspirations were high in relation to hopes for their own future: women envisaged returning to education or training for future employment at a later date. Unlike the women interviewed by Mahon et al. (1998), the teenage mothers in Richardson's (2000) study did not feel that they were stigmatised. They reported that both siblings and friends had also had a child outside marriage and at a young age.

### *1.5.2 Deciding to have an abortion*

It is difficult to achieve a clear understanding of the decision-making process for women who choose abortion. This is due to the dearth of Irish research available and the complexity of the process itself. The findings of international research are sometimes conflicting and inconclusive. Methodological differences make comparisons difficult (Sihvo, Bajos, Ducot and Kaminski 2003). The primary piece of research available to Irish policy makers is Mahon et al.'s (1998) study. Mahon et al. (1998) identified key factors involved in the decision-making process of women who choose to have an abortion:

- stigma attached to pregnancy and lone parenting
- rejection of other options such as adoption and parenting (not the ideal)
- importance of education and career
- financial concerns
- not being in a position (emotionally or socially) to have a child
- nature of the relationship with partner (early stages of relationship or relationship in difficulty).

Some studies conclude that the majority of women who decide to have an abortion do not find the decision difficult and that the decision is usually made almost immediately upon confirmation of the pregnancy, if not before (Boyle 2000). Other research has found that the decision to have an abortion, although often made in a very short period, is a difficult and complex one, based on a number of factors affecting the woman's life (Tornbom, Ingelhammar, Lilja, Svanberg and Moller 1999). Torres and Forrest (1988), in a study concerning why women chose abortion, found that the mean number of reasons given was four. Often, contradictory feelings are experienced simultaneously, such as anxiety and relief (Kero et al. 2001, Husfeldt, Hansen, Lyngberg, Noddebo and Petersson 1995). Ambivalence regarding the decision to abort was reported by women in some studies, where the decision-making process was marked by doubt (Tornbom et al. 1999, Husfeldt et al. 1995).

A Swedish study on the decision-making processes of 401 women having an abortion or continuing with their pregnancies found that more than half of the women decided to have an abortion upon first finding out that they were pregnant. After a few weeks of consideration, most of these had definitely decided to have the abortion. More than half of the participants said that it was a rather difficult or very difficult decision to make. Women who had contact with social services found it significantly more difficult to make a decision. Overall the majority of participants did not feel influenced by someone else in making the decision to have an abortion. Of the women who were having an abortion for the first time (n=137) and the women who were having a repeat abortion (n=64), 10% and 6% respectively felt much or comparatively influenced by someone else (Tornbom et al. 1999).

Sihvo et al.'s (2003) study of 645 women found that factors associated with abortion decisions varied strongly according to age. Younger women's abortion decisions were mainly related to being a student and being single. Women in the 25-34 year age group were more likely to explain that their decision to have an abortion was related to reproductive issues, for example, if a baby had been born in the previous year or if they already had two children. Sihvo et al. (2003) stated that women aged between 25-34 were likely to terminate a pregnancy because they already had their desired number of children. Older women in the sample were more likely to choose an abortion when having a child was not seen to 'fit' their work situation or when the relationship with their partner was in difficulty. The study also concluded that women and partners with a high level of education were more likely to choose abortion; this was found to be especially true among younger women. Finally, Sihvo et al. (2003) concluded that many factors influence a woman's decision to have an abortion and that the impact of these factors is mediated by age. Russo, Horn and Schwartz (1992) analysed data collected by Torres and Forrest (1988) and also found a number of categories of reasons for choosing abortion. Adolescents gave reasons such as lack of preparedness for parenting or motherhood. Women with children cited reasons such as existing commitments to others.

While much secrecy surrounded the women in Mahon's study, other research has shown the importance of significant others in the decision-making process. While Tornbom et al. (1999) found that that majority of women in their study reported making the decision themselves, there is a growing body of evidence to suggest that male partners do influence pregnancy intentions and reproductive decisions, particularly in teenage pregnancies (Evans 2001). Sihvo et al. (2003) reported that agreement was higher between couples who experienced an unintended pregnancy and chose to continue with

a pregnancy than between those whose unintended pregnancies ended in abortion. Interestingly, the age group most influenced by a partner was the 25-34 year olds. Holmberg and Wahlberg (2000) carried out qualitative interviews with eighteen young men (median age eighteen) and sought to gain an insight into the decision-making process of young men when faced with an unplanned pregnancy. A suggested model of the decision-making process was developed. Three main concepts emerge:

1. Reactions – (feelings, apprehensions and moral conflict)
2. Impact factors – (quality of the relationship, consideration for partner and psychosocial factors)
3. Tools for process – (communication, secrecy/confidentiality and organized support).

Feelings common to all participants upon discovering the pregnancy were anxiety and shock. Most participants valued the opportunity to talk to others, including the woman concerned and formal support organisations. As found in other studies, the main reasons for deciding on abortion included a lack of appropriate financial means, ongoing education and feeling negative towards or not ready to take on the role of fatherhood.

Kero et al. (2004), in a Swedish study about how women cope with legal abortion, interviewed 58 women who had experienced abortion. The women were interviewed at two interval points: four and twelve months after the abortion. An interview was also conducted prior to the abortion. The aim of this interview was to investigate the woman's decision-making process, living conditions and feelings concerning the pregnancy and abortion. The study identified three main categories of participant: those who did not experience emotional distress, those who experienced mild/moderate distress and those with severe emotional distress. Almost two-thirds of women did not report any emotional distress after the abortion, with ten of the 58 respondents reporting mild to moderate emotional distress and a further twelve participants experiencing severe emotional distress. Those without any emotional distress post-abortion stated that they did not want to give birth, as they prioritised other commitments such as work, studying or their existing children. The pre-abortion interview found that these women stated that their decision to abort was relatively free of conflict. None had experienced pressure regarding the pregnancy or the decision-making process. This relatively conflict-free experience contrasts with the two other groups of women who did report emotional distress. In the pre-abortion interview, over half of the group experiencing moderate emotional distress reported that they had had a conflict of conscience. The majority expressed feelings of relief after the abortion and none reported regretting the decision to abort. As expected, the group of women who experienced severe emotional distress reported that the decision to have an abortion involved a lot of conflict. This group provided explicit reasons as to why they could not continue with the pregnancy. These reasons included the partner's attitude and a lack of financial resources. Despite this conflict, ten of the twelve women in this group said that the final decision to have the abortion was their own. After a one-year follow-up of 58 participants, this study concluded that generally women are able to make the 'complex' decision to have an abortion without suffering any regret or negative psychological effects. Although the majority of women experienced relief post-abortion, this did not exclude the experience of other feelings such as grief and sadness. Mahon et al. (1998) also found that the women who underwent an abortion felt a sense of relief after the procedure. Major et al.

(2000), in their study of the psychological responses of women after abortion, found that two years after abortion, 72% of women stated that they were satisfied with their decision. Importantly, Major et al. (2000) found that the women who experience depression after an abortion tended to have a prior history of depression. Kero et al. (2004) indicated that post-abortion psychological wellbeing is linked to experiences of the pregnancy and the decision-making process, stating that:

In spite of differences in study design, there is a strong consensus, regarding results from international studies on abortion outcome, that relief is the dominant feeling in the immediate and short-term aftermath and the incidence of severe negative responses is low. (Kero et al. 2004: 2559)

### *1.5.3 Deciding to place a child for adoption*

Irish research into the decision-making process for women who choose adoption is also limited. To date, Mahon et al.'s (1998) study provides policy makers with important and insightful qualitative data on the experiences of some women who faced this difficult choice. The study reported that the first stage in the process for women contemplating adoption usually involved a rejection of abortion on moral grounds. Only two of the eleven women reported not having an abortion because of financial circumstances. Some used very strong anti-abortion terminology to explain why they were against such a decision, while others contemplated abortion but never seriously considered it. Interestingly, some decisions to reject abortion were also made on the grounds that they believed it would have a long-term negative effect on their lives, and on a new awareness of other options such as adoption. A certain emotional conflict then ensued for the women as the pregnancy progressed and they felt the baby develop. This gestation period usually involved weighing up the pros and cons of placing the baby for adoption. All eleven women in Mahon et al.'s (1998) study described the pregnancy as a crisis that had a huge impact on their lives. While fear of stigma and a desire to keep the pregnancy secret was evident from the research, some of the pregnant women did confide in family members and friends, who, in turn, provided directive advice and information about adoption services. While, for the most part, the women in this study articulated personal anti-abortion views, significant others (family, friends, professionals) did articulate their own views and provide information on services. However, women saw the decision as being their own, and as one that they did not need to decide upon finally until after the birth. For these women, lone motherhood was rejected on a number of grounds, some of which included perceived stigma attributed by others, being perceived as 'sexually deviant' by others, loss of career, educational and economic disadvantage and a life on welfare. Certain benefits were identified for the child through choosing adoption, for example, being reared in a two-parent family, and having financial and emotional security. Two of the women identified benefits for themselves in choosing adoption. For the women who did not tell their parents about the pregnancy, they felt that the crisis pregnancy agencies provided them with an opportunity to keep the pregnancy secret. Women who availed of counselling reported positive benefits in terms of greater discussion and facilitation of the decision-making process. Counselling facilitated a weighing-up of positive and negative aspects concerning whether or not they should place the child for adoption ('birth mother' only) or become a parent ('social' mother). While much secrecy and concealment of the pregnancy was evident in experiences of the women in Mahon et al.'s (1998) study, a significant number told at least one other individual. For example, seven participants

told their partners, and others told parent(s) and/or friends. Other studies have identified the most significant determinants of adoption for a woman faced with an unplanned or crisis pregnancy. These are: whether the mother herself wants to place the child for adoption, whether a close relative wants the child placed for adoption and, finally, whether there is an expectation that the quality of the mother and child's lives would be negatively impacted by choosing to keep the child. Not having a partner or having a partner who wanted adoption was significantly related to choosing adoption (Dworkin, Harding and Schreiber 1993, Namerow, Kalmuss and Cushman 1993, Resnick 1992). Namerow et al.'s (1993) study of unmarried women also found a positive association between previous adoption socialisation experiences and the decision to choose adoption.

### 1.6 Aim of the present study

The aim of the present study was to establish nationally representative data on current attitudes, knowledge and experience of contraception, crisis pregnancy and related services in Ireland. More specifically, the research aimed to provide nationally representative data on:

- current attitudes, knowledge and experience of crisis pregnancy and crisis pregnancy supports and services
- current attitudes, knowledge and experience of contraception and contraceptive services
- current attitudes and experiences of sex, crisis pregnancy, options facing women in crisis pregnancy and lifestyle choices
- current awareness, recognition and understanding of the Crisis Pregnancy Agency's Positive Options public information campaign.

#### Study objectives were:

- to explore patterns of sexual behaviour (sexual initiation, sexual practices, coercion, regret, numbers of partners, contraceptive use, pregnancy (planned/unplanned) and parenthood)
- to assess antecedents of crisis pregnancy (sources of sexual knowledge, attitudinal and behavioural data with respect to sex, unprotected sex, contraception, unplanned pregnancy, risk, abortion, adoption, lone parenthood, marriage, cohabitation, births outside marriage)
- to assess service availability, utilisation (awareness, accessibility and knowledge of services including CPA's Positive Options information campaign) and supports (crisis pregnancy counselling and related supports and contraceptive services)
- to enable comparison with similar survey data generated in other countries
- to examine the relationship of key independent variables: demographic (gender, age, relationship status, education, social class, geographic location), sources of information about sex, context (alcohol or drug use) and socio-psychological factors (peer-group pressure, stigma, sexual competence) on behaviour and attitudes
- to provide baseline data for consideration in tandem with the planned national sexual health survey.

Information obtained in the study would then be used to provide evidence-based recommendations for planning and development of appropriate initiatives. As the first such study of its kind in Ireland, key decisions about its size and scope were vital to achieve the best value and most-needed information for the resources and effort involved. It was decided to focus on the younger Irish population (those aged 18-45 years) in order to obtain maximum input from those whose contraceptive needs and practices were most relevant to contemporary service planning. While information from those aged under eighteen is obviously very important in relation to the theme of the study, the information needed from this group would need to be modified from that obtained from the older sample. Special provisions concerning access and parental permission would also need to be addressed. It was decided that this group merited a separate dedicated study. From a philosophical standpoint, since women and men share the responsibility for contraception and crisis pregnancy, both were included in the study.

Further details on the study methodology are presented in Chapter 2.

## 2.0 Methodology

### 2.1 Introduction

The overall aim was to devise a sound methodological approach that would yield scientifically reliable and nationally representative information to form the basis for evidence-based service development. To document the profile of particular beliefs, attitudes and behaviours in the population, a nationally representative survey was conducted.

A cross-sectional national survey of the young adult population, using a telephone interview methodology, was selected as the most appropriate methodology to meet the aims of this study. The study protocol received ethical approval from the Research Ethics Committee of the Royal College of Surgeons in Ireland (RCSI).

### 2.2 Sample

The sample to be included were those aged 18-45, in order to focus on those for whom contraceptive practices, service perceptions and service usage were most relevant to contemporary evaluation of services and planning for the future. Interviews were completed with quota sampling based on 2002 Census figures for gender, age, educational attainment, employment status and region. A sample size of 3,000 was targeted, to include equal numbers of women and men.

### 2.3 Measures

#### 2.3.1 Interview schedule

Since the aims of this particular study were not adequately addressed by any one pre-existing research questionnaire, a dedicated interview schedule, informed by key concepts relating to crisis pregnancy, was devised. (To view questionnaire see [www.crisispregnancy.ie/research3.php3](http://www.crisispregnancy.ie/research3.php3)) Where concepts had previously been assessed elsewhere, use of questions from relevant national and international questionnaires was considered to maximise comparability of the data to be collected here. The questionnaire was refined through discussion with a CPA steering group. Using this process, the final interview schedule was best able to address the specific issues and key constructs of interest to the CPA.

The interview schedule was separated into twelve sections, based on topic and on relevance to specific participant experiences. Table 2.1 describes these sections, with a summary of each section to follow.

#### Section 1 – Introduction [see Appendix 2]

This section provided a standardised introduction to the study, detailing who was carrying out the survey, its confidential nature and how the telephone numbers had been randomly selected. Following agreement to participate, information on study verification procedures was offered, and interviewers confirmed that the respondent was over eighteen years of age before proceeding.

#### Section A – Demographic details

The first section of the interview collected basic demographic information on age, gender and marital status.

## Section B – Learning about sex

This section gathered information from participants with children between the ages of twelve and eighteen years. The questions covered areas relating to speaking to their children about sexual matters (in this section, 'sexual matters' was defined as referring mainly to sexual intercourse and contraception).

**Table 2.1 Telephone survey topic sections**

Section	Topic	Section completed by:
Section 1	Introduction	All participants
Section A	Demographic details	All participants
Section B	Learning about sex	Only participants with children aged 12 to 18 years
Section C	Attitudes	Qs C1 – C16: All participants Qs C17 – C20: Only participants who had heard of the 'morning-after pill'
Section D	Sex and contraceptive use	Only participants who had had sexual intercourse with a person of opposite sex in last year
Section E	Contraceptive services	All participants
Section F	Most recent partner	Only participants who had ever had sexual intercourse and whose most recent sexual intercourse was with a person of opposite sex
Section G	Pregnancy and children	Only participants who had ever experienced a pregnancy, with particular reference to experiences of crisis pregnancies
Section X	Pregnancy and children (Men)	Only male participants who had experienced a crisis pregnancy
Section Y	Pregnancy and children (Women)	Only female participants who had experienced a crisis pregnancy
Section H	Attitudes and beliefs	All participants
Section J	Household classification	All participants

### Section C – Attitudes

The first part of Section C established the participant's (or partner's, in the case of men) current pregnancy status (i.e. currently pregnant, trying to become pregnant, not pregnant). This was followed by a number of attitudinal and belief statements relating to sexual behaviour, contraception and sex education, for example, 'It would be too embarrassing for someone like me to buy or obtain condoms'. Participants rated statements on a scale (strongly agree, agree, neither agree or disagree, disagree, or strongly disagree). The final questions in this section related to knowledge, use of, and access to emergency contraception (the 'morning-after pill').

### Section D – Sex and contraceptive use

The first questions in this section gathered information relating to sexual history, including experience of homosexual/heterosexual sexual intercourse and age of first sexual intercourse. The remainder of Section D applied only to participants who had had sexual intercourse with someone of the opposite sex in the last year. These questions related to methods of contraception or precautions used, regularity of use and reasons for not using contraception or precautions to avoid pregnancy.

### Section E – Contraceptive services

This section related to sources from which participants had obtained supplies or sought advice on contraception, and where they would prefer to get contraceptive supplies or advice. It also covered ease of access to contraception and any experiences of being refused contraception.

### Section F – Most recent partner

All participants who had ever had sexual intercourse and whose most recent sexual intercourse was with someone of the opposite sex were asked questions relating to their most recent experience of sexual intercourse. This concerned their use of contraception and their relationship with their most recent sexual partner.

### Section G – Pregnancy and children

This section concerned participants' experiences of pregnancy and pregnancy outcomes, including those which they considered to have been crisis pregnancies. The main purpose of this section was to determine whether the participant felt that they had experienced a crisis pregnancy, in order to ask them more detailed questions concerning their experience of the crisis pregnancy (Section X/Y – Pregnancy and children).

### Section X/Y – Pregnancy and children (To view questionnaire see [www.crisispregnancy.ie/research3.php3](http://www.crisispregnancy.ie/research3.php3))

If participants had indicated in Section G that they had experienced a crisis pregnancy, they were asked Section X (men) or Section Y (women) questions. These sections gathered more detailed information relating to their most recent experience of a crisis pregnancy. They covered the participant's sexual behaviour at time of conception, for example, use of contraception or reasons for not using contraception, including the role of alcohol and drugs. Participants were asked about their experience during the pregnancy, including services used and how supportive or otherwise important people in their lives were towards the pregnancy. The final questions in this section covered decision-making relating to the outcome of the pregnancy and experience of supports and services after the crisis pregnancy.

## Section H – Attitudes and beliefs

All participants were asked the questions in Section H. The first set of questions related to hypothetical situations relating to crisis pregnancy, for example, who they would tell, where they would go for professional help, and which pregnancy outcome they would choose if they experienced a crisis pregnancy in the future. The next questions contained a number of attitudinal and belief statements relating to pregnancy outcomes, including attitudes towards single parenting, adoption and abortion. An example is: 'Children of lone parents do just as well as children from two-parent families'. Finally, this section dealt with awareness of the CPA's Positive Options media campaign.

## Section J – Household classification

This section gathered further demographic information from participants concerning employment status, household composition, household income and nationality.

### 2.3.2 Telephone interview methodology

The chosen method for data collection was telephone interview. Telephone interviews are valuable since they provide respondents with a sense of anonymity, once it has been explained and understood that their number has been chosen at random. A sense of anonymity was considered to be of particular relevance to this survey, due to its sensitive subject matter. The telephone interview technique has been widely and successfully used in KAB surveys outside Ireland (Smith, Rissel, Richters, Grulich and de Visser 2003, Spira 1994) and in similarly sensitive surveys within Ireland (McGee, Garavan, DeBarra, Byrne and Conroy 2002). Additional details on telephone survey methodology are available in McGee et al. (2002). Telephone surveys have an advantage over other forms of interview study (in comparison to self-report) in that complex issues or questions can be clarified to ensure greater understanding of questions posed.

Telephone calls were conducted using random digit dialling (RDD), allowing for wide coverage of telephone numbers since contact with ex-directory and new numbers not listed in telephone directories was possible. Only landline telephone numbers were used since using both landline and mobile phone numbers would provide a double opportunity for some individuals to be contacted and could distort findings.

Telephone numbers were generated using the RANSAM system of the ESRI, as follows: Area codes were randomly selected from possible Irish codes, and possible "stems" were then identified. The "hundreds bank" method was used, where a local telephone number was generated, with the last two digits used to create a full set of 100 numbers ranging from "XXXXX00" to "XXXXX99".

One challenge for all survey formats is coverage of the population in question. A concern about how representative telephone survey methods are relates to the percentage of households who have landlines. Those without are necessarily excluded from participation. The most recent comprehensive statistics relating to telephone landline penetration rates for the Republic of Ireland was from the 2000 Household Budget Survey. This indicated household penetration levels of just under 90%. While this means that some households (possibly with younger/more transient occupants or newer households) cannot be contacted, it has to be compared with the merits of other methods; the electoral register and the postal register of households are less comprehensive than this telephone contact system in Ireland. The telephone method

combined the method most likely to achieve clear reporting of sensitive issues with the system to achieve widest coverage of the general population in this Irish setting.

Concern about potential exclusions from the survey due to possible reduced landline coverage within various groups (such as younger people) was balanced in the survey by using a sophisticated re-weighting or statistical adjustment procedure to ensure that the data collected were balanced by population characteristics such as age and gender. This statistical adjustment was implemented prior to data analysis. The present study used a minimum information loss algorithm to implement the re-weighting adjustment. This adjusted the data on the basis of gender, age cohort, educational attainment level, marital status, current employment status and region. Thus, the data are fully representative of the population that fall within the scope of the survey (i.e. 18-45 years). Such re-weighting of survey data is a standard aspect of sample surveying and allows conclusions of a wide generalisability.

The 'conversion call' provides an otherwise unavailable opportunity for those who have declined participation in an unsolicited ('cold call') contact by a researcher to reconsider participation. Conversion calls were made to all those who had refused participation on the first contact call. The reasons for re-contact ("It provides us and you with the possibility to reconsider your decision to participate") were provided, with an assurance that this was the only re-contact.

All interviewers were women. Previous national and international experience has indicated that response rates and general respondent acceptance of sensitive surveys such as the present one are higher for female interviewers (Tjaden, Thoennes and Allison 1996, McGee et al. 2002).

### *2.3.3 Piloting the interview schedule*

The interview schedule was piloted with 132 randomly selected members of the public. Interviewers reported positive feedback from participants. The piloting resulted in re-wording of some questions, shortening of the interview schedule and further clarification of definitions relating to crisis pregnancy and forms of contraception.

## **2.4 Procedure**

### *2.4.1 Telephone interviewer training*

Interviewer briefing focused on issues that might arise when dealing with study questions of a potentially sensitive nature concerning contraception and pregnancy. All interviewers participated in a training session comprising technical and operational issues and sensitivity training. Sensitivity training focused on issues of confidentiality and privacy, listening skills, addressing respondent distress and referral, and debriefing the respondent:

- Confidentiality and privacy: Assurance of confidentiality was particularly important in this survey in order for the respondent to trust the interviewer enough to answer some of the more sensitive questions. This was made easier by the fact that interviewers rang randomly and did not know the person's name and address. Interviewers explained this during the introduction, and also at any other point during the interview where they felt that the respondent was concerned about answering a particular question.

In order to assure privacy, interviewers only explained the content of the survey to the target respondent and not to persons who answered the telephone (accordingly, other household members were not aware of the specifics of the content of the survey – it was described as a ‘health survey’). In addition, efforts were made to ensure that the respondent was in a suitable place to talk, i.e. where they would not be overheard. This was sometimes achieved by offering to call back at a more convenient time if necessary.

- Listening skills: Basic listening skills were encouraged, e.g. verbal encouragement and bridging statements. The importance of being neutral, non-judgemental and supportive was stressed.
- Addressing respondent distress and referral: If at any stage the respondent showed signs of distress, interviewers were instructed to stop the interview and talk through the situation with the respondent. The importance of empathy and understanding was stressed. Interviewers acknowledged to respondents that they understood that what they had just told them was very difficult to talk about and asked if they had anyone who they could talk to. It was stressed that interviewers were not there to act as counsellors but to listen to the respondent and to offer the number or name and address of an agency where they could get information or help. Relevant telephone numbers and addresses were available to interviewers and were kept at hand throughout the interviews. Interviewers were to use their judgement in giving these numbers to respondents. While being encouraged to be helpful, they also understood that if someone clearly did not want help, they should not force them to seek help.
- Debriefing the respondent: Some time was spent at the end of each interview debriefing the respondent. This was to ensure that the respondent was not upset at the end of the interview. If the respondent became distressed at any time during the interview, interviewers were to check how the respondent was feeling, ask what they planned to do when the call ended and if they needed to talk to someone. Referral numbers were again offered.

#### *2.4.2 Telephone interview procedure*

Telephone interviews were conducted by an experienced telephone interview team from the Economic and Social Research Institute (ESRI). Telephone calls took place in a designated call centre at the ESRI (internal) or in interviewers’ own homes (external). A fieldwork manager monitored response rates at the level of the individual interviewer. More interviews were completed internally, as calling was done more intensively. Prior to conversion calls, 53% of interviews were completed internally and 47% externally. All conversion calls were completed internally, resulting in 59% of all interviews completed at the call centre. Differences in response rates between internal and external interviewers were low and were monitored throughout the fieldwork process.

Telephone interviewers received ongoing support from the core research team throughout the interview phase in the form of weekly meetings for internal interviewers or regular telephone contact for external interviewers. This core team has extensive experience with national sampling, population surveys, interviewing on sensitive issues and telephone surveys. Interviewers also had an emergency contact number for one of the core research team if unexpected problems concerning their own, or a participant’s, welfare emerged in the course of an interview.

When making calls, interviewers let numbers ring ten times. If there was an answering machine, no message was left (previous experiences showed that messages causes confusion or concern). Repeated call-backs were made (each number was called up to ten times). If, after this time, there was still no answer, the telephone number was recorded as 'no answer'. In order to facilitate participants who were unavailable during working hours, evening (up to 9pm) and Saturday calls were scheduled.

#### *2.4.3 Confidentiality and study verification procedures*

Telephone number selection was random, hence the address and identity of the participant was unknown. The procedure for obtaining telephone numbers was briefly explained to potential participants at the start of the telephone call. Telephone numbers were not recorded on the questionnaire.

Clear study verification procedures were necessary in order that participants could check that the interviewer was from a legitimate research organisation. This was achieved in a number of ways, offered to the participant in the Introduction section of the interview schedule (see Appendix 2). The options were freephone telephone access to the organisation (ESRI) or Garda confirmation. If requested, two forms of Garda confirmation procedure were offered. Firstly, the interviewer offered to telephone the participant's local Garda station and confirm the study, then telephone the participant back with the name of the Garda to whom they had spoken. Alternatively, the interviewer offered to fax a survey confirmation letter to their local Garda station, and agree a time to telephone again when the respondent had had the opportunity to confirm with the Gardaí that the survey was genuine.

#### *2.4.4 Participant support*

Interviewers monitored distress and used a range of strategies throughout the interview process to manage participant distress. Telephone interviewers could direct participants to information sources (e.g. helplines, website addresses) or, where participants showed distress or disclosed traumatic events, interviewers followed a protocol sheet (see Appendix 3 – Addressing Respondent Distress). These participants were re-contacted the following day (with their consent) to ensure their wellbeing (this follow-up contact procedure was successfully utilised in the SAVI Study [McGee et al. 2002]). It was significantly emphasised to the respondent that this call was not to finish the survey, but to see how the respondent was feeling.

This protocol for handling participant distress follows World Health Organisation guidelines for good practice in domestic violence research (World Health Organisation 2001). Very few respondents were upset by the content of the survey and, to the best of our knowledge, no respondents were distressed by the survey. Recall opportunities ensured that any upset could be handled by interviewers.

#### *2.4.5 Data entry and analysis*

Quantitative analysis of the data was performed using the Stata statistical program. This provided basic descriptive statistics and more complex statistical analysis to address research questions. Means are reported with confidence intervals (standard deviations are not reported for weighted data). Relationships between variables were analysed using chi-squared tests (unless otherwise stated) as they were considered to give the best

measure of significance without making assumptions concerning the direction of any possible relationship. Chi-squared test results are not listed, since the output for weighted survey data has no interpretation in the conventional sense. Logistic regression was used to explore the relationship between major demographic variables on study data.

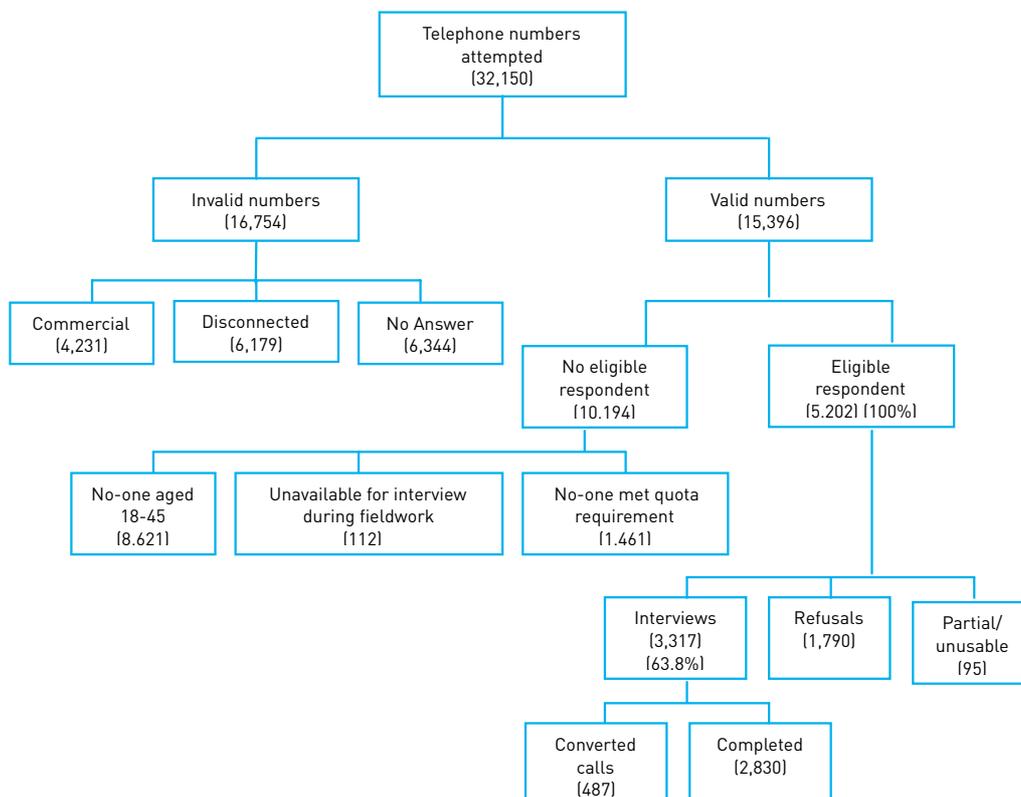
### 3.0 Results and Discussion I – Sex and contraception

#### 3.1 Response rates

- 3,317 interviews were completed (1,356 men and 1,961 women).
- Overall response rate of completed interviews was 63.8%.

In total, 32,150 unique telephone numbers were called in the study. Figure 3.1 summarises the outcome for each call and the response rates for the final dataset. In total, there were 3,317 interviews (1,356 men and 1,961 women) giving an overall participation rate of completed interviews from the 5202 eligible respondents of 63.8% (66% agreed to participate but there were some incomplete interviews (n=95) resulting in 63.8% who completed participation). This is a very satisfactory response rate considering the sensitive and potentially emotive nature of the topic. This response rate was achieved using multiple strategies to facilitate participation, including the conversion call procedure. The value of the conversion call was illustrated since, of a total of 2,277 conversion calls made, 487 (21%) of first-time refusals opted to participate on a second invitation.

Figure 3.1 Profile of unique telephone numbers called and outcome classifications for survey



Response rate varies greatly according to the type of methodology used and the subject matter being researched. A variety of surveys relating to sexual practices and beliefs have been undertaken both in Ireland and internationally (table 3.1). The International Social Survey (ISSP) in 1994 added a series of questions asking about sexual practices. A postal questionnaire was used to ask questions relating to sexual behaviour. This self-completion survey included a prepaid envelope and achieved a 53% response rate (cf. Layte, Fullerton and McGee 2003). In 2002, the Sexual Abuse and Violence in Ireland (SAVI) study asked members of the general public about their experiences of sexual abuse and sexual violence using a telephone methodology. This achieved a 71% response rate (McGee et al. 2002). The Family Planning Agency in Northern Ireland achieved a 52% response rate when asking 14-25 year olds about their sexual practices and beliefs using self-completion methodology (Schubotz, Simpson and Rolston 2002).

**Table 3.1 Sample of response rates from surveys about sexual matters and practices**

Study	Year	Response Rate%	Interview Methodology	Sample Size (n)
<b>ICCP Study</b>	<b>2004</b>	<b>64</b>	<b>Telephone</b>	<b>3,317</b>
SAVI	2002	71	Telephone	3,120
FpaNI	2002	52	Self completion	2,450
Australian Study of Health and Relationships (ASHR)	2001	73	Telephone	19,307
National Survey of Sexual Attitudes and Lifestyles (NATSAL)	2000	65	Face-to-face	11,161
ISSP	1994	53	Self completion	502
NATSAL	1990	67	Face-to-face	18,876

## 3.2 Demographic profile

### 3.2.1 Demographic profile

- The sample was re-weighted to match the structure of the Irish population. The results can be considered representative of the general population.
- The study sample comprised 40.9% men and 59.1% women.

The demographic profile of the survey data is displayed in table 3.2, with general population comparison data taken from the Census of Population 2002 and the Quarterly National Household Survey (both undertaken by the Central Statistics Office (CSO)). The study sample comprises 40.9% men and 59.1% women.

As is standard with population survey data, the information collected from the questionnaire was statistically adjusted or “re-weighted” prior to analysis. The purpose of this re-weighting procedure is to ensure that the structure of the complete sample is in line with the known structure of the population, according to the classificatory variables used in the analysis.

Statistically adjusting data prior to analysis is standard practice in surveys and addresses any potential bias, which may arise from issues related to sample design and also to differential non-response within subgroups of the population.

The re-weighting procedure used was based on a minimum information loss algorithm, which adjusts an initial weight so as to ensure that the distributional characteristics of the sample matches those of the population, according to a set of externally determined controls. These latter are based on independent national sources such as the Census of Population 2002 and the Quarterly National Household Survey (both undertaken by the Central Statistics Office (CSO)).

The variables used in the statistical adjustment or re-weighting procedure were gender, age cohort, marital status, level of educational attainment, current employment status and region. The interaction of these variables was also incorporated into the re-weighting scheme. The satisfactory response rate and subsequent re-weighting meant that results could be considered as broadly representative of the general population.

For the purposes of statistics analysis, categories containing small numbers of participants were excluded. This resulted in those categorised as ‘retired’ or ‘other’ current employment status being excluded.

**Table 3.2 Demographic comparison of study sample with general population\* by gender, age and marital status**

		Women %			Men %	
<b>Demographic Characteristics</b>	Un-weighted Sample n=1,961	Weighted Sample	General Population	Un-weighted Sample n=1,356	Weighted Sample	General Population
<b>Gender</b>	59.1	50.0	50.0	40.9	50.0	50.0
<b>Age</b>						
18-25	23.6	30.0	30.4	28.2	31.5	30.9
26-35	34.5	36.7	36.4	32.9	34.6	36.3
36-45	41.9	33.3	33.2	38.9	33.9	32.7
<b>Marital Status</b>						
Married/ Partner	62.3	50.5	49.8	52.2	45.5	44.5
Separated/ Divorced/ Widowed	4.1	4.6	5.1	1.8	2.3	3.2
Single	33.6	44.9	45.0	45.9	52.1	52.3
<b>Current Employment Status</b>						
At work	62.7	59.8	60.2	82.5	78.1	77.1
Unemployed	2.5	5.4	5.1	4.5	6.9	7.6
Student	11.1	12.3	12.3	11.3	10.7	10.5
Retired	0.2	0.6	0.1	0.1	0.3	0.1
Home duties	22.8	19.1	18.9	0.4	0.7	1.4
Other	0.8	2.8	3.5	1.1	3.2	3.3
<b>Region</b>						
Dublin	24.9	32.2	32.3	25.2	31.0	30.9
Border, Midlands & West	27.4	24.4	24.3	24.4	23.8	24.9
Rest of Country	47.7	43.5	43.4	50.4	45.2	44.2
<b>Education</b>						
Pre-Leaving Certificate	16.8	22.3	22.3	20.5	28.4	28.4
Leaving Certificate	27.7	32.0	32.0	28.7	31.5	31.5
Post- Leaving Certificate	55.5	45.7	45.7	50.8	40.0	40.0

\* Central Statistics Office (2004)

### 3.2.2 Social classification

The CSO measure of social classification was used to identify social class for each participant (Central Statistics Office 1986). Table 3.3 provides an overview of social class. Most participants belonged to social class III (20%) or IV (20%), with less in social class VI (7%) and the remainder divided between classes I, II and V (17%, 18% and 18% respectively). A further categorisation of social class into higher (social classes I-III) and lower classes (social classes IV-VI) was performed. Over half (56%) of participants were in the higher group, with 44% in the lower group.

**Table 3.3 Social class of study sample by gender**

	<b>Men</b> <b>n=1,188</b> <b>%</b>	<b>Women</b> <b>n=1,737</b> <b>%</b>	<b>Total</b> <b>n=2,925</b> <b>%</b>
Higher professional (social class I)	18	17	17
Lower professional (social class II)	17	19	18
Other non-manual (social class III)	17	23	20
Skilled manual (social class IV)	26	14	20
Semi-skilled manual (social class V)	16	19	18
Unskilled manual (social class VI)	6	8	7

The basic demographic variables outlined (gender, age, education and social class) were used to examine patterns across knowledge, attitudes and experiences concerning contraception and crisis pregnancy throughout the remainder of the Results section. It was assumed that education and social class would be associated, thus applying both variables in regression analyses would be meaningless. They are therefore analysed independently to clarify results by each of these independent but closely related indicators of social status.

### 3.2.3 Place of birth and current household location

The majority of participants (90%) were born in the Republic of Ireland, with the remainder born in Britain (England, Scotland and Wales) (5%) and Northern Ireland (1%). One-third (35%) of participants lived in a city, 33% in a rural area, 20% in a town and 12% in a village (table 3.4).

Table 3.4 Place of birth and household location of study sample by gender

	Men %	Women %	Total %
<b>Place of birth</b>	<b>n=1,356</b>	<b>n=1,961</b>	<b>n=3,317</b>
Republic of Ireland	91	89	90
Northern Ireland	1	1	1
Britain (England, Scotland, Wales)	5	6	5
Europe – EU country	1	2	1
Eastern Europe and Russia	1	<1	1
Australia and New Zealand	0	<1	<1
North America (USA, Canada)	<1	1	1
Asia	<1	<1	<1
Africa	<1	<1	<1
South Africa	<1	<1	<1
Other/ not identifiable	<1	1	<1
<b>Household location</b>	<b>n=1,287</b>	<b>n=1,865</b>	<b>n=3,152</b>
Rural area	34	31	33
Village	13	12	12
Town	20	20	20
City	33	37	35

### 3.2.4 Relationship status

While marital status was used in weighting the sample to match the general population profile (table 3.2), the data was re-categorised by current relationship status for the purposes of analysis. Current relationship status was considered to be a more useful variable in terms of current sexual and contraceptive behaviour. In total, 40% of participants were married, 8% were living with a partner, and 16% were in a steady relationship (table 3.5).

Table 3.5 Relationship status of study sample by gender

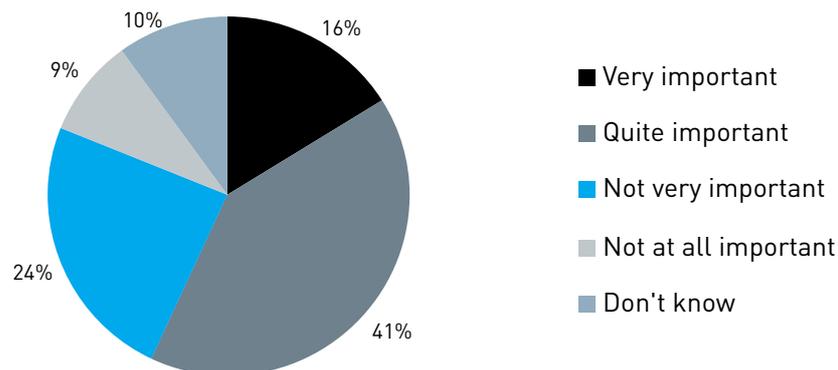
	Men n=1,339 %	Women n=1,931 %	Total n=3,270 %
Married and living with spouse*	38	43	40
Not married and living with a partner	9	8	8
In a steady relationship	14	17	16
In a casual relationship	9	5	7
Not in a relationship	30	27	29

\* If married, participants were asked if they were currently living with their husband/wife. If not, their current relationship status was ascertained.

### 3.2.5 Religious beliefs

Most participants (82%) considered themselves to belong to a particular religion at the moment. Of this group, most (93%) were Roman Catholic. Participants were asked how important religious beliefs were to them and over half (57%) said that religious beliefs were quite or very important (figure 3.2).

Figure 3.2 Participant ratings of the importance of religious beliefs (n=3,296)



## 3.3 Sex and contraception

### 3.3.1 Sexual history

- 93% of study participants reported having experienced sexual intercourse (vaginal or anal).
- 98.7% had experienced only heterosexual sex, with 0.2% experiencing only homosexual sexual intercourse and 1.1% having experienced both.
- Women reported significantly older age at first intercourse than men (median<sup>1</sup> nineteen vs. eighteen years).
- Age at first sex decreased for men (median age nineteen to seventeen years of age) and for women (median age twenty to eighteen years of age) from older to younger age cohorts (year of birth 1956-60 and 1981-85 respectively).

The majority (93%) of study participants reported having experienced sexual intercourse<sup>2</sup>. This is comparable with international findings, e.g. from the Australian Study of Health and Relationships (ASHR) (across a wider age range of 16-59 years) where 96.7% of men and 96.9% of women had had sexual intercourse (Smith et al. 2003).

Participants who had experienced sexual intercourse were asked about their sexual history. Most (99%) stated that they had experienced only heterosexual sex (table 3.6).

<sup>1</sup> The median is a statistic which tells the level above/below which 50% of a sample scores. It is more useful than average scores where results may be skewed in one direction or another.

<sup>2</sup> Participants who had never had sexual intercourse were excluded from the 'Sex and contraception' section of the interview schedule.

**Table 3.6 Participant sexual history of same and opposite sex partners**

<b>Would you say that you have had sexual intercourse:</b>	<b>Men n=1,247 %</b>	<b>Women n=1,841 %</b>	<b>Total n=3,088 %</b>
Only with people of the opposite sex and never with people of the same sex	98.6	98.9	98.7
More often with people of opposite sex, but at least once with a person of same sex	1.0	0.7	0.9
About equally often with people of the opposite sex and the same sex	0	0.2	0.1
More often with people of same sex, but at least once with a person of opposite sex	0.1	0.2	0.1
Only with people of the same sex and never with people of the opposite sex	0.3	0	0.2

Those reporting homosexual (same sex) intercourse only (0.2%) or both homosexual and heterosexual intercourse (1.1%) account for a very small percentage of the Irish study population. This differs from the pattern of those reporting homosexual and bisexual experiences in other national studies (table 3.7).

**Table 3.7 Comparison of sexual experience across international studies**

<b>Data collection year Age range</b>	<b>Ireland (ICCP) 2003 18-45</b>		<b>Australia (ASHR) 2001 16-59</b>		<b>UK (Natsal) 2000 16-44</b>	
	Men n=1,333 %	Women n=1,938 %	Men n=9,728 %	Women n=9,578 %	Men n=4,762 %	Women n=6,399 %
No sexual intercourse	7.2	6.2	3.3	3.1	7.2	5.3
Opposite sex experiences only	91.6	92.7	90.7	88.3	87.4	89.8
Same sex only	0.2	0.04	0.6	0.1	5.4	4.9
Both opposite and same	1.0	1.0	5.4	8.4		

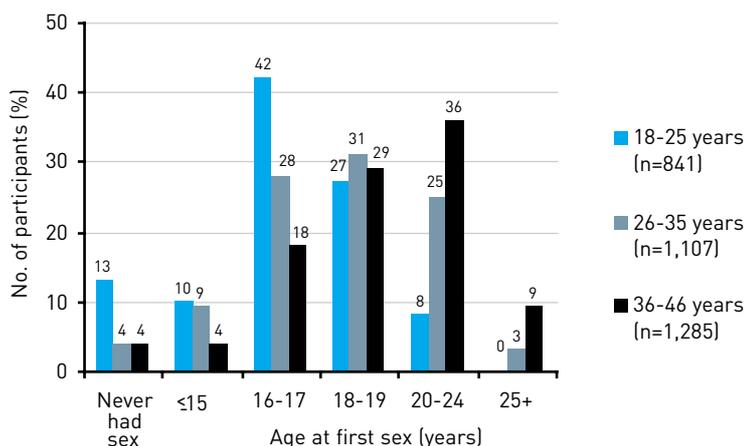
In the Australian ASHR study, participants were less likely to report having had exclusively heterosexual experiences, i.e. a smaller percentage of men (90.7%) and women (88.3%) reported only having sex with persons of the opposite sex (Smith et al. 2003). In 2000, the British study 'National Survey of Sexual Attitudes and Lifestyles' (Natsal) found that 5.4% of men and 4.9% women reported having ever had a homosexual partnership (Johnson, Mercer, Erens, Copas, McManus, Wellings, Fenton et al. 2001). The definitions used to ascertain sexual experiences and intercourse differ somewhat across these surveys. This may contribute to the difference in reporting rates of homosexual experiences. It may also be the case that potential respondents of the present study who are homosexual declined participation, since the focus of the study, as explained in the telephone introduction, was 'pregnancy and contraception'.

The Irish sample of the International Social Survey Project (ISSP) (1994) found that 2.9% of men and 3.2% of women reported ever having had homosexual sex (cf. Layte et al. 2003). This finding was lower than those who reported having had homosexual sex in the past year (2.9% and 3.8%) and may be due to a higher non-response for the lifetime questions. The European Values Survey (Halman 2001) is a large-scale survey of 'basic values' and associated attitudes. The most recent of three of these surveys was conducted in 1999/2000 and included Ireland (n=1,009). As the same questions were asked in over 33 countries across Europe at the same time period, this survey provides important information for cross-European comparisons (Layte et al. 2003). This survey included questions on homosexuality and explored attitudes towards particular groups of people. The latest study (1999/2000) indicated that Ireland was more conservative on issues of sexuality and more negative in attitudes towards specific groups. For example, almost one-third (27%) of those interviewed said that they would not like to have a homosexual as a neighbour. When asked to rate how justifiable certain forms of behaviour are on a scale of one to ten (one=never justified), 70% of the Irish sample rated homosexuality at five or less (on the less justified end of the scale). The Irish score on homosexuality was lower than other Western European countries, with the exception of Portugal and Northern Ireland. These findings may provide some insight into the lower reporting levels of homosexual behaviour by Irish participants: interviewees may be reluctant to declare themselves homosexual. These social attitudes may also contribute to a lower number of Irish men and women engaging in homosexual sex.

Participants who had experienced sexual intercourse with same sex partners only were excluded from the remainder of the 'Sex and Contraception' section, since this section focused on contraception in relation to pregnancy. Those who had experienced sexual intercourse with a person of the opposite sex were asked at what age they had first had sexual intercourse (with someone of the opposite sex).

Age at first sexual intercourse differed by age cohort, with younger participants (18-25 year olds) more likely to have had first sex before eighteen years of age and older participants (36-45 year olds) more likely to first have sex at ages 20-24 years. Figure 3.3 illustrates the age at first sexual intercourse by age cohort. It is important to take into account that 13% of the 18-25 year olds reported never having sex, compared with 4% of the 26-35 year olds and 4% of the 36-45 year olds. Nonetheless, since all participants in the study were more than eighteen years old, the finding that twice as many of the youngest participants (18-25 year olds) compared with the oldest participants (36-45 years old) had first sexual intercourse before the age of eighteen (52% vs. 22%) is robust.

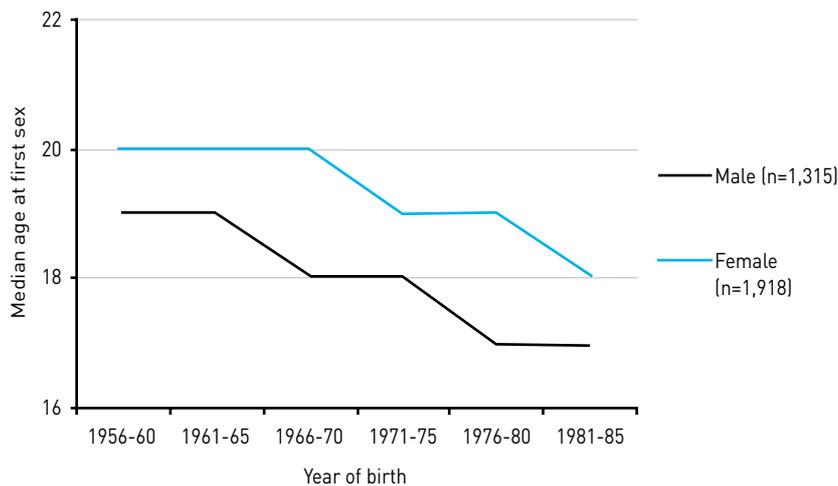
Figure 3.3 Age of first heterosexual sexual intercourse by age cohort



When analysing age of first sex across a population in which some members have not yet experienced the event, a bias can occur whereby age of first sex is estimated as lower than it actually is since those who have not yet experienced the event may have a higher age of first sex than those already having experienced it. Thus, a 'hazard rate' statistic was calculated, which took into consideration those who had not yet had sex. A hazard ratio of 1.0 indicates no difference between groups.

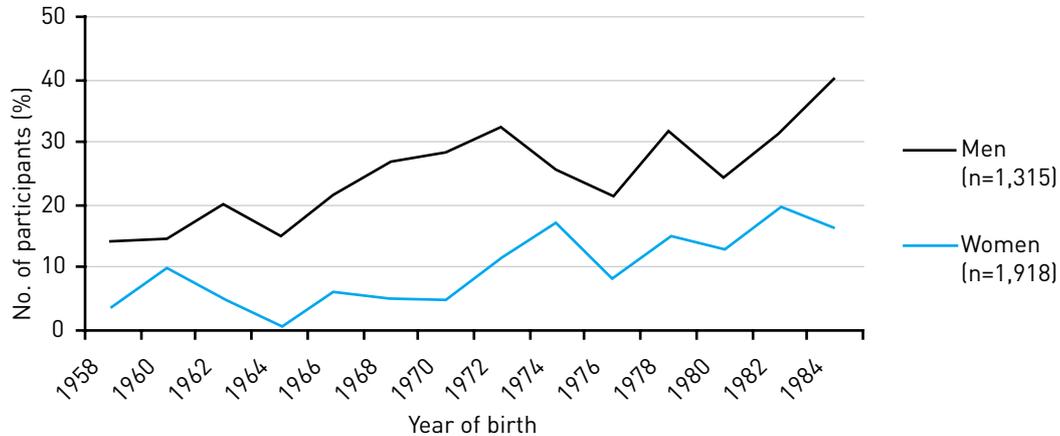
Women reported significantly older age at first intercourse than men (median nineteen vs. eighteen years) (hazard ratio 0.81,  $p < 0.001$ ). Cox regression indicated an association between year of birth and age at first sex, with older participants experiencing first sexual intercourse at a later age (hazard ratio 1.03,  $p < 0.001$ ).

**Figure 3.4 Median age of first sex based on hazard rate calculation, by gender and current age**



Median age of first sex for men decreased across age cohorts from nineteen years of age (year of birth 1956-60) to seventeen years of age (year of birth 1981-85). Similarly, the decline in median age of first sex for women was from twenty years age (year of birth 1956-60) to eighteen years of age (year of birth 1981-85) (figure 3.4). This is further supported by the increased percentage of younger participants (i.e. later year of birth) reporting first sex before age seventeen (the legal age for sexual intercourse) (figure 3.5).

Figure 3.5 Percentage of respondents reporting first sex before age 17 years



Cox regression indicated a significant interaction of year of birth (hazard ratio 1.03,  $p < 0.001$ ), gender (hazard ratio 0.82,  $p < 0.001$ ) and educational level (hazard ratio 0.86,  $p < 0.001$ ) in relation to age of first sex. Thus, predictors of lower age of first sex were male gender, later year of birth (younger age) and lower educational level.

When compared to other national studies, the median age of first sex for the Irish population occurs at least one year later in life. The Australian ASHR study reported a median age at first sex of eighteen years for women and seventeen years for men (Rissel, Richters, Grulich, de Visser, Smith 2003). In 2000, the British Natsal study found a median age at first intercourse of seventeen years across a number of age cohorts (20-24, 25-29, 30-34, 35-39 and 40-44), (Wellings, Nanchahal, Macdowall, McManus, Erens, Mercer, Johnson et al. 2001). In Britain, the number of women reporting first intercourse before the age of sixteen had increased up to, but not after, the mid 1990s (Wellings et al. 2001). They also found that while early age at first sex was not the most significant indicator of teenage pregnancy, it was significantly associated with pregnancy under age eighteen years. Clearly, age at first sexual intercourse is an important consideration when addressing the issue of crisis pregnancy. The results of this study do not point to an alarmingly early age at first sex, but do indicate a decrease in age at first sex in recent decades, similar to that experienced in other countries. Previous area-specific Irish studies have also indicated a lower age at first sexual intercourse (MacHale and Newell 1997). However, as this is the first national quantitative measure of age at first sex in Ireland, it is an important marker in tracking any future changes in this important life milestone.

### 3.3.2 Contraceptive use in the last year

- The most common methods of contraception and precautions used in the last year to avoid pregnancy were condoms (55%) and the contraceptive pill (38%).
- Most participants (80%) said that they had always used a method of contraception or precaution when having sex in the last year.
- Those who first had sex at a younger age were less likely to have always used contraception in the last year (e.g. 70% of those who had first had sex at fifteen years of age or younger compared with 85% who first had sex aged 20-24).

- Younger (18-25 year old) participants were less likely to report always (74%) using, and more likely to report mostly (19%) using, contraception. A concern relating to contraceptive use among 18-25 year olds is that they do not consistently use contraception every time they have sex.
- The two main explanations for non-use of contraception during the last year by those who did not want to become pregnant were that sex was not planned/they were not prepared (48%) and/or they were drinking alcohol or taking drugs (21%). These reasons were significantly more likely to be reported by younger age cohorts.

Recent contraceptive practices of the sample were sought. The study focused, as is typical in such studies, on the last year and last occasion of heterosexual sex. Collection of data relating to experiences over the last year provides an opportunity to gain an overview of levels and choices of contraceptive use across the population. The last occasion of sexual intercourse imparts a greater level of understanding relating to a specific event, which can be subsequently analysed across a number of precise variables, including use and non-use of contraception, specific contraceptive choices or reasons for non-use and relationship status at the time of intercourse. The last occasion of sexual intercourse is detailed in section 3.3.3.

Of those participants who had experienced heterosexual intercourse, 92% had had heterosexual sex in the last year. They were asked about contraceptive use over that period. Younger participants (18-25 years) were significantly less likely to report that they had not used any contraceptive method at any time in the last year (4%) compared with those in the older age cohorts (12% of 26-35 year olds and 16% of 36-45 year olds) ( $p < 0.001$ ). This may be related to the pregnancy intentions and relationship status of those in the older age categories. Overall, 11% of participants reported using no method of contraception in the last year. Much has changed since the late 1980s when Greene et al. (1989) reported, in a study of Irish pregnant women, that 19% of married and 64% of unmarried women had never used contraception.

The most common methods of contraception and precaution used in the last year to avoid pregnancy were condoms (55%) and the contraceptive pill (38%). A minority of participants used sterilisation (7%), safe period/rhythm method (6%) and withdrawal (6%). Since participants were asked to list all methods used, percentages stated are a percentage of the total population using the method in the last year.

Most early research assessed only married women, as the law up to 1985 limited the sale of contraception to married couples. Therefore, it is difficult to compare contraceptive usage patterns in Ireland over time (Mason 2003). Wilson-Davies' (1974) survey of 754 married women (randomly selected from the electoral register) found that natural methods were the most used method of contraception (55%), followed by oral contraception (15.6%) and withdrawal (10.2%) (cf. Mason 2003). O' Neill (1985) reported that of 198 postpartum women, 39% were using an oral contraceptive, 30% natural methods, 19% condoms and 27% had never used a method (cf. Mason 2003). By 1996, Wiley and Merriman reported that 22.3% of women from an unrestricted national sample reported using condoms, 22% used oral contraceptives and 14.2% natural methods (safe period/rhythm method).

Table 3.8 provides an overview of age differences in contraceptive use for all participants who reported experiencing sexual intercourse in the last year. Significant age cohort differences are shown. More 18-25 year olds (78%) had used condoms in the last year than 26-35 year olds (54%) or 36-45 year olds (36%). Younger age groups were also more likely to have used the contraceptive pill, with 55% of 18-25 year olds, 42% of 26-35 year olds and 18% of 36-45 year olds having used it in the last year. However, the 18-25 year olds were less likely to use the safe period or withdrawal methods than their older counterparts (3% vs. 8% and 4% vs. 6% respectively). As would be expected, 36-45 year olds were more likely to have been sterilised than the younger groups.

**Table 3.8 Contraception and other precautions used in the last year to avoid pregnancy**

	<b>18-25 years n=681 %+</b>	<b>26-35 years n=1,024 %+</b>	<b>36-45 years n=1,192 %+</b>	<b>Total n=2,897 %+</b>	
No method used (at any time)	4	12	16	11	***
Contraceptive pill	55	42	18	38	***
Condom	78	54	36	55	***
Coil/ IUD/ Mirena	3	4	10	5	***
Cap/ diaphragm	<1	<1	1	1	**
Spermicides (Gels/sprays /pessaries)	1	<1	<1	1	
Persona	0	<1	1	<1	*
Emergency contraceptive pill	5	2	<1	2	***
Safe period/ rhythm method (excl. Persona)	3	5	8	6	**
Withdrawal	4	6	6	6	
Injections/implanted capsules/patches/ring	4	3	2	3	
Sterilisation (participant or partner)	0	4	18	7	***
Abstinence	2	2	3	2	
Other method	0	<1	1	<1	*

+ Participants could select more than one response, thus column totals may be greater than 100%.

\* indicates significant age group differences [ $p < 0.05$ ]

\*\* indicates significant age group differences [ $p < 0.01$ ]

\*\*\* indicates significant age group differences [ $p < 0.001$ ]

These findings illustrate differing patterns of contraceptive methods across ages, with a higher proportion of younger people using condoms as a contraceptive method. This may be related to issues such as an awareness of the need to use condoms to protect against STIs and HIV, the nature of their relationships (i.e. short-term/casual), pregnancy intentions, and access and cost issues (much greater access to condoms compared to other methods). A French national study conducted in 1991 reported that younger people were more likely to use condoms as a method of contraception. The study postulated that this may be related to the single-risk prevention campaigns about AIDS conducted in France during the 1990s (cf. Richters, Grulich, de Visser, Smith and Rissel 2003). ASHR (2003) also found that the use of condoms was significantly related to age, with older women reporting lower usage (Richters et al. 2003).

The likely association between age and relationship status, which may have influenced the above age-cohort differences in contraceptive choices, is analysed further with regard to contraceptive use with most recent partner (section 3.3.3). Data in relation to most recent partner contains accurate categorisations with regard to relationship status and contraceptive method; the data can be assessed for one specific incident of sexual intercourse across the population, whereas relationship status may have changed over the course of the last year.

Study participants were asked to think about the last year and to outline frequency of use of contraceptive methods when having sex. Contraceptive methods were explained further to include withdrawal, the safe period and vasectomy or tubal ligation. Using one of these methods on all occasions would be considered as always using contraception. Those participants who stated that they had had a hysterectomy or had medically confirmed infertility were excluded from this question. Similarly, participants who said that they did not use contraception because they were pregnant, trying to become pregnant or that pregnancy would be a positive outcome were excluded from this analysis of frequency of contraceptive use.

Most (80%, 95% CI 77.5-82.0) said that they had always used a method of contraception or precaution when having sex in the last year. Level of contraceptive use was significantly related to gender, with 75% of men reporting always using contraception and a further 17% reporting mostly using contraception; 85% of women reported always using contraception and 9% reported mostly using contraception ( $p < 0.001$ ).

Additionally, there were significant differences across age groups ( $p < 0.001$ ), as reported in table 3.9. Younger (18-25 year old) participants were less likely to report always using contraception than older participants. While few 18-25 year olds reported never (1%) having used contraception in the last year, only three-quarters (74%) reported always using it, with more of this age group (19%) indicating that they mostly used contraception in the last year. This discrepancy suggests that the main contraceptive issue relating to 18-25 year olds is that they do not consistently use contraception every time they have sex.

**Table 3.9 Frequency of contraceptive use when having heterosexual sex in the last year by age group**

	<b>18-25 years</b> <b>n=652</b> <b>%</b>	<b>26-35 years</b> <b>n=811</b> <b>%</b>	<b>36-45 years</b> <b>n=1,045</b> <b>%</b>	<b>Total</b> <b>n=2,508</b> <b>%</b>
Always	74	81	84	80
Mostly	19	13	6	13
Sometimes	3	3	3	3
Rarely	3	<1	1	1
Never	1	3	6	3
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Significant differences were observed between frequency of contraceptive use in the last year and age at first sexual intercourse, with those who first had sex at a younger age less likely to have always used contraception in the last year. In total, 70% of those who had first had sex at fifteen years of age or under and 76% of those who first had sex at age sixteen or seventeen had always used contraception in the last year. In contrast 83% who first had sex aged eighteen or nineteen, 85% who first had sex aged 20-24 and 80% who first had sex aged 25 years or over had always used contraception in the last year ( $p < 0.005$ ).

There were also significant educational level differences ( $p < 0.005$ ). Three-quarters (75%) of participants with pre-Leaving Certificate education reported always using contraception in the last year, with 8% reporting never using contraception. More participants with Leaving Certificate (81%) and post-Leaving Certificate (82%) education reported always using contraception, with 2% of Leaving- and post-Leaving-Certificate level education reporting never using contraception in the last year. Similar to other studies, educational disadvantage seems to be a common denominator when addressing non-use of contraception and unintended pregnancy (Wellings et al. 2001, Richardson 2000, Wiley and Merriman 1996). These findings highlight the importance of targeting certain groups of people (men, early school leavers and young people aged 18-25 years) who appear to be at a higher risk of not using contraception on every occasion, even when they do not want to become or have a partner become pregnant.

As described above, a number of variables were significantly related to frequency of contraceptive use. This question was further analysed using logistic regression, to determine how these variables influenced each other in determining likelihood of always using contraception in the last year. Control variables were age, gender, education and relationship status. (While relationship status refers to current status, and not necessarily status throughout the last year, it was considered important to include this variable in regression analysis because of the possible influence of relationship on patterns of contraceptive use.) The odds of always using contraception over the last year were not statistically different by age (OR 0.99, 95% CI 0.97-1.01,  $p = 0.17$ ). Men were significantly less likely to report always using contraception than women (OR 0.57, 95% CI 0.43-0.75,  $p < 0.001$ ). Leaving and post-Leaving-Certificate level participants were pooled, since there was no difference between groups. This group was significantly more

likely to always use contraception than pre-Leaving level participants (OR 1.67, 95% CI 1.16-2.40,  $p < 0.01$ ). Relationship-status Wald-test analyses indicated two distinct categories in relation to always using contraception: participants who were married, living together or in a steady relationship were over twice as likely to have always used contraception in the last year than those in a casual or no relationship (OR 2.30, 95% CI 1.62-3.26,  $p < 0.001$ ).

The close association between education and social class resulted in exclusion of social class from the above regression. A further logistic regression was completed to investigate the association between social class, age, gender and relationship status. This confirmed the above findings in relation to age, gender and relationship status but found no significant social class influence on always using contraception during the last year.

A risk area in relation to contraceptive use, which has been suggested previously, concerns the number of participants who do not consistently use contraception, but who do not want to become pregnant. Findings indicate that being male, having lower educational levels (pre-Leaving Certificate) and being in a casual or in no relationship are factors associated with not consistently using contraception on every occasion of sexual intercourse.

Perhaps one of the most interesting questions asked by policy makers and researchers is 'Why is it that people who do not want to become pregnant or have a baby do not use contraception?' (Crisis Pregnancy Agency 2004). While the question seems straightforward, ascertaining an answer is a complex and difficult process. Consideration was given to how to assess this issue while drafting the study interview schedule. A qualitative question regarding non-use of contraception was included in pilot interviews. This allowed for the compilation of a reliable list of fixed-response categories for this study. Research undertaken to explain the issue of non-use of contraception is often qualitative and based on small sample sizes. This study thus provides, for the first time, important quantitative evidence allowing policy makers the opportunity to pinpoint, from a range of issues, the reasons reported by a majority of randomly selected Irish people.

Those who stated that they did not always use contraception when having sex in the last year (i.e. used mostly, sometimes, rarely or never) were asked to briefly explain why they did not always use a method. Responses were assigned to the fixed-response categories, as in table 3.8. Participants could specify a number of reasons, so percentages are of total participants who did not always use contraception.

The most common reason given was that sex was not planned or they were not prepared. This was mentioned by almost half (48%) of these participants. The second most common reason was drinking alcohol or taking drugs (21%). While these two issues have been discussed in previous research (Mahon et al. 1998, MacHale and Newell 1997, Hyde 1996), this study highlights, using a nationally representative sample, unexpected or unplanned sexual intercourse and use of alcohol or drugs as the two main explanations for the non-use of contraception by those who do not want to become pregnant.

There were some significant differences in reasons given for not always using contraception across age groups (table 3.10). For example, 58% of participants aged 18-25 years gave the reason that sex was not planned or they were not prepared, compared with 49% of 26-35 year olds and 29% of 36-45 year olds ( $p < 0.005$ ). Similarly, more 18-25

year olds (33%) than 26-35 years olds (17%) or 36-45 year olds (8%) said that they had not always used contraception because of drinking alcohol or taking drugs ( $p < 0.005$ ).

**Table 3.10 Reasons for not always using contraception in the last year**

	<b>18-25 years n=142 %+</b>	<b>26-35 years n=132 %+</b>	<b>36-45 years n=155 %+</b>	<b>Total n=429 %+</b>	
Unlikely to conceive because of menopause	0	1	18	5	***
Unlikely to conceive because possibly infertile – not medically confirmed	0	3	8	3	**
Don't like contraception/ methods are unsatisfactory	3	6	8	5	
Partner doesn't like or won't use contraception	0	1	2	1	
Not my responsibility	3	0	1	1	
I/my partner forget(s) to take the contraceptive pill	5	5	1	4	
Difficult to discuss contraception with partner	0	0	2	1	
Can't get contraception/ contraceptive services	3	1	4	2	
Against beliefs/religion to use contraception	0	4	5	3	
Drinking alcohol/ taking drugs	33	17	8	21	**
Sex not planned/ not prepared	58	49	29	48	**
Didn't/don't care if pregnancy happens	<1	<1	5	1	***
Other reason	11	14	19	14	
Refused/no response	2	3	5	3	

+ Participants could select more than one response, thus column totals may be greater than 100%.

\* indicates significant age group differences ( $p < 0.05$ )

\*\* indicates significant age group differences ( $p < 0.01$ )

\*\*\* indicates significant age group differences ( $p < 0.001$ )

Previous research has shown that alcohol plays a major role in sexual behaviour and this is particularly true of early first sexual intercourse (MacHale and Newell 1997, Strunin and Hingson 1992). Bajos et al. (2003) suggest that family-planning providers need to ensure that a contraceptive method suitable to the individual's sexual lifestyle and social situation is prescribed. However, the findings of this study show that many young people will not encounter a medical practitioner for contraceptive advice if they choose to use condoms. The issue of alcohol use adds to the complexity of the issue and requires much consideration. Attention needs to focus on preparing people (particularly younger people) for having sex with a greater awareness of the issues related to accessing and using contraception, even when sex may not be anticipated. Clearly, reducing the

negative impact of alcohol and drugs on contraceptive and safe-sex practices needs a stronger, clearer policy focus across all sectors providing education, information and services relating to sexual health and contraception. Increasing contraceptive use among people who do not want to become pregnant/have a partner become pregnant calls for a cross-agency strategy and response.

The unplanned or unexpected aspect of having sex may be an issue of lesser concern for the older age groups, as they are more likely to have entered marriage or a long-term relationship. For those in the older (36-45 years) age group, different issues emerged as a cause for concern. For example, a number of participants reported that non-use of contraception was related to the belief that they were unlikely to conceive because of the menopause. Further analysis of participants giving this reason (n=36) by age found that 93% were at the higher end of the age range (41-45 years), 3% in the range 36-45 years, with a further 4% aged 31-35 years. Very few women aged 45 years and younger are likely to be post-menopausal. Additionally, more participants in the older age group felt that they might be infertile (although this was not medically confirmed). These issues may point to a need for more education and information specifically related to and targeted at older age cohorts who are still at risk of becoming pregnant.

Participants whose response did not fall into one of the predetermined categories in table 3.10 were classified in the 'other reason' category, and were asked to explain further their reason for not using a method to avoid pregnancy. Almost half of these indicated a casual attitude towards contraceptive use in their response, for example "couldn't be bothered", "took a chance" or "no reason". All those who specified that they did not use contraception because they were trying to become pregnant were removed from this analysis. However, it is possible that some of these casual attitudes towards contraception may be a result of more positive (or at least not negative) attitudes towards pregnancy as an outcome. Hyde (1996) has identified a number of thought-processes that may explain these attitudes. Hyde identified three approaches towards life and contraception: 'fertility denial', 'intermittent or occasional risk-takers' and 'destiny dependence'. Taking a very bleak perspective of this 'casual attitude toward contraception', it may need to be acknowledged that for a small minority of sexually active people, non-use of contraception is not a concern or issue of any significance. Our findings suggest that further in-depth research is warranted in this area. A second group of participants within the 'other reason' category indicated casual use of the safe period and withdrawal. This group of participants said that they did not use any method to avoid pregnancy but indicated a casual use of these methods. Their attitude was exemplified by comments such as, '[I] am very careful' or "[I] felt it was [a] safe time of [the] month". Finally, a small number of participants indicated that they did not use a method because they had recently given birth or were breastfeeding.

### 3.3.3 Contraceptive use with most recent partner

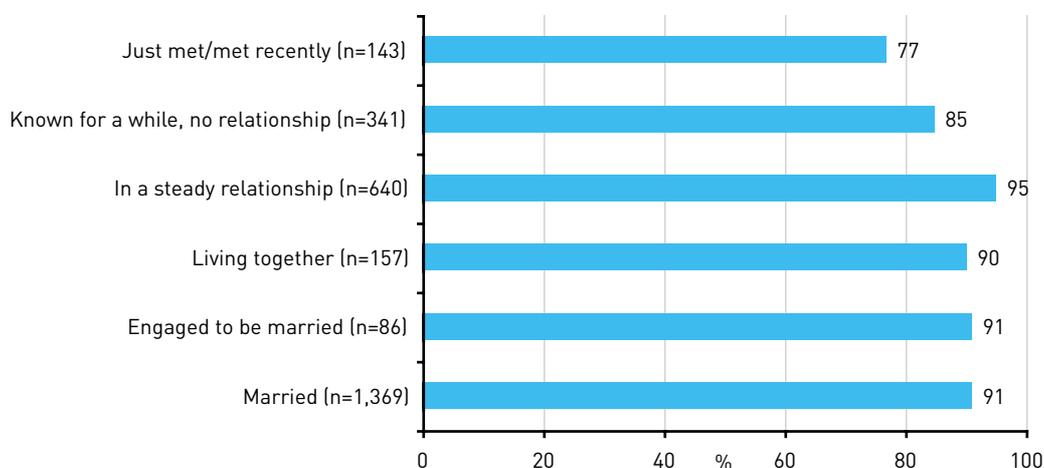
- 10% of those at risk of unplanned pregnancy did not use any method of contraception on the most recent occasion of sexual intercourse.
- Correlates of non-use of contraception on the most recent occasion of sexual intercourse were older age, lower educational level, lower social class and casual relationship status.
- Of those who used contraception on the most recent occasion of sexual intercourse, most used the condom (53%) or the contraceptive pill (34%).

- On the most recent occasion of sexual intercourse, the most common reasons cited for non-use of contraception among those at risk of unplanned pregnancy were that sex was not planned/they were not prepared (31%) and/or because they had been drinking or taking drugs (15%).

Research questions asking about general behaviour over a period of time (e.g. one year, as in the previous section) are useful to provide general patterns. More useful, specific information can be obtained by focusing on a specific occasion. Thus, participants who had previously had heterosexual sexual intercourse (n=3,134) were questioned about their contraceptive use on the most recent occasion of sexual intercourse (whether this was recently or some time ago). Participants whose most recent sexual experience was with someone of the same sex (n=8) were not included in this section, since the main focus concerned factors relating to contraceptive use to avoid pregnancy.

Those surveyed were asked to describe their relationship with the person they had sexual intercourse with most recently, based on the descriptions in figure 3.6. They were then asked whether any contraception or precaution had been used (by themselves or their partner) on that most recent occasion. Those who stated that they had not used contraception on the most recent occasion of sexual intercourse because they (or their partner) were pregnant or trying to become pregnant (9%), or were medically confirmed as infertile or had had a hysterectomy (1%) were excluded from further analysis of most recent partner. Of those remaining, most (90%) said that contraception or precautions were used on their most recent occasion of sexual intercourse. However, 10% who were also at risk of pregnancy and who did not specify that they wanted to become pregnant did not use any method of contraception or take precautions. This reflects an estimate by the authors of the 1990 Natsal study, that 10% of sexually active people in Britain were not protected against unplanned pregnancy (cf. Richters et al. 2003). In Australia, the ASHR study found that approximately 5% of women at risk of unplanned pregnancy did not use contraception (Richters et al. 2003).

**Figure 3.6 Percentage using contraception or other precautions by relationship type for last experience of heterosexual sexual intercourse (n=2,736)**



There was a significant difference in use and non-use of contraception by relationship type on the most recent occasion of intercourse (figure 3.6) ( $p < 0.001$ ), with those in longer-term relationships more likely to have used contraception. This study highlights the importance of the type of relationship to whether or not contraception is used. Participants whose most recent occasion of sexual intercourse was with someone they had just met for the first time or who they had met recently were least likely to have used contraception or taken precautions against pregnancy (77%); those in a steady relationship were most likely to have used contraception (95%). This finding points to a significant relationship between non-use of contraception and brief or new relationships. While the consequences of non-use of contraception, such as crisis pregnancy, have the potential to cause crisis and distress to the lives of those involved, a negative outcome is more likely to be exacerbated if the two people concerned are not in a steady or committed relationship. The fact that contraception was less likely to be used if the relationship was new or brief may indicate that issues concerning self-efficacy exist and/or that difficulties with negotiating condom or contraceptive use may be exacerbated in these types of relationships. However, no participant from any relationship type reported that the reason for not using contraception or taking precautions was due to difficulties in discussing contraception with a partner.

Analysis of use of contraception on most recent occasion of sexual intercourse highlighted significant age group differences. In the 18-25 year old category, 93% had used contraception, compared with 91% of the 26-35 year olds and 87% of the 36-45 year olds ( $p < 0.05$ ). This small but significant age difference may be explained by relationship status differences across age groups. There is an interesting inverse pattern of frequency of contraceptive use for overall sexual experiences, where younger groups were less likely to consistently use contraception in the last year yet were more likely to have taken contraceptive precautions on the most recent occasion of sexual intercourse. These findings highlight the importance of investigating levels of contraceptive use across different time periods.

There were also significant educational level differences: 83% of those with pre-Leaving Certificate education, 93% of those with Leaving Certificate and 92% of those with post-Leaving Certificate education had used contraception on their most recent occasion of sexual intercourse ( $p < 0.001$ ). Further significant differences were observed between social classes, with 93% and 92% of social classes I and II respectively using contraception on their most recent sexual intercourse, 87%-90% of social classes III to IV using contraception and 78% of those in social class VI stating that they used contraception on their most recent occasion of sexual intercourse ( $p < 0.005$ ).

Thus, a number of variables were indicated as being individually related to use of contraception on the most recent experience of sexual intercourse. The extent to which gender, age, education and relationship status interact was further assessed through logistic regression. There was no gender difference (OR 1.18, 95% CI 0.82-1.68,  $p=0.37$ ) when controlling for age, education and relationship status. There were age differences, with the likelihood of having used contraception increasing with year of birth (OR 1.05, 95% CI 1.02-1.07,  $p<0.001$ ) (i.e. likelihood decreasing with age). Education was also identified as a major predictor: a Wald test showed no differences between Leaving and post-Leaving Certificate level education, so these categories were pooled. The resulting group of Leaving and post-Leaving Certificate level participants was significantly more likely to report contraceptive use at last sex than pre-Leaving-Certificate level participants (OR 2.08, 95% CI 1.37-3.16,  $p=0.001$ ). Analysis of relationship status at time of most recent sexual intercourse found no differences between those who had just met, who had met recently or who had known each other for a while but were not in a steady relationship. These categories were subsequently pooled (group A). Similarly, no differences were found across those in a steady relationship, living together, engaged or married, and these were also pooled (group B). The final model established that those in a formal relationship of some description (group B) were three times more likely to have used contraception on the most recent occasion of intercourse than those in a casual/no relationship (group A) (OR 3.46, 95% CI 2.24-5.36,  $p<0.001$ ), when controlling for age, gender and educational level.

The close relationship between education and social class precluded social class from the above regression. The variable social class was then investigated through logistic regression to attain a more precise understanding of the relationship between social class and other demographic variables in determining contraceptive use at most recent sexual intercourse. Initial Wald tests detected no differences between social classes I and II, and these were pooled. Furthermore, social classes III-VI were pooled, following Wald test confirmation of no differences between these groups. The final model, controlling for age, gender, social class and relationship status at time of intercourse confirmed no significant gender differences (OR 1.28, 95% CI 0.87-1.86,  $p=0.204$ ). Participants from social classes I and II were significantly more likely (OR 1.93, 95% CI 1.30-2.87,  $p=0.001$ ) than social class III-VI participants to have used contraception on their most recent sexual intercourse. Significant year of birth (OR 1.05, 95% CI 1.03-1.08,  $p<0.001$ ) and relationship differences (group A vs. group B) (OR 3.30, 95% CI 2.12-5.14,  $p<0.001$ ), as reported above, were confirmed. These findings highlight particular risk groups and indicate areas to target with policy initiatives, for example, those from older age groups, with low levels of education, from lower social classes and in casual relationships.

Those who stated that they had used contraception or precautions were asked which form they had used. Participants could indicate that they used more than one method in combination, thus percentages are percentages of the total population. Of those who used contraception on the most recent occasion of sexual intercourse, most used the condom (53%) or contraceptive pill (34%). There were interesting differences in contraceptive use across age groups (table 3.11).

**Table 3.11 Contraception and precautions used (as a percentage of those reporting contraceptive use) on most recent occasion of sexual intercourse**

	<b>18-25 years</b> <b>n=664</b> <b>%+</b>	<b>26-35 years</b> <b>n=842</b> <b>%+</b>	<b>36-45 years</b> <b>n=1,016</b> <b>%+</b>	<b>Total</b> <b>n=2,522</b> <b>%+</b>	
Contraceptive pill	44	40	18	34	***
Condom	71	51	37	53	***
Coil/ IUD/ Mirena	2	4	11	6	***
Cap/ diaphragm	0	0	1	<1	**
Spermicides (Gels/sprays/pessaries)	<1	<1	0	<1	
Persona	0	0	1	<1	*
Emergency contraceptive pill	1	<1	0	<1	
Safe period/ rhythm method (excl. Persona)	<1	4	5	3	***
Withdrawal	1	2	3	2	**
Injections/implanted capsules/patches/ring	2	4	3	3	
Sterilisation (participant or partner)	<1	4	25	10	***

+ Participants could select more than one response, thus column totals may be greater than 100%.

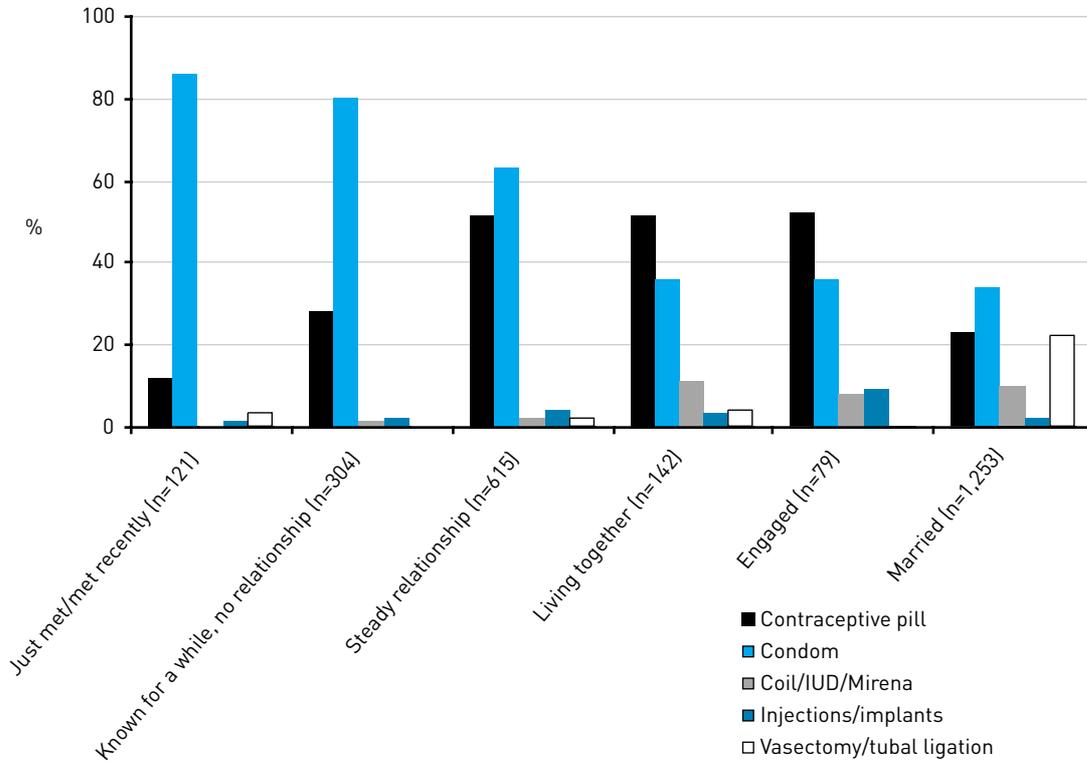
\* indicates significant age group differences ( $p < 0.05$ )

\*\* indicates significant age group differences ( $p < 0.01$ )

\*\*\* indicates significant age group differences ( $p < 0.001$ )

There were significant differences in contraceptive or precaution used on most recent occasion of intercourse between relationship types (based on reported relationship type at time of most recent sexual intercourse). Figure 3.7 illustrates these differences across relationship type for the most common forms of contraception.

**Figure 3.7 Use of common forms of contraception at most recent occasion of sexual intercourse by relationship type**



There were significant relationship differences in use of the contraceptive pill, with participants who had just met or recently met their most recent sexual partner less likely (10% and 13% respectively) to have used the contraceptive pill than those who were in a steady relationship (51%), living together (51%) or engaged (52%) ( $p < 0.001$ ). Interestingly, only 23% of those using contraception who were married used the contraceptive pill.

There were also significant differences in condom use. 86% of those who had just met, 86% of those who had met recently and 80% of those who had known each other for a while used condoms on the most recent occasion of intercourse. These figures contrast with the figures for those in more stable relationships: 36% of those living together, 36% of engaged participants and 34% of married participants ( $p < 0.001$ ) used condoms at last intercourse. More participants who were married (10%), engaged (8%) or living together (11%) used the coil/IUD/Mirena than those who were in a steady relationship (2%) or had known each other but did not have a relationship (1%), with none of those who had met recently or just met having used the coil/IUD/Mirena on their most recent occasion ( $p < 0.001$ ). Significantly more married participants (22%) specified vasectomy or tubal ligation than participants in any other relationship type ( $p < 0.001$ ).

While safe period and withdrawal methods were not included in figure 3.7 due to small numbers, it is interesting to note that significant differences existed in their use, with 6% of married participants who used contraception or precautions on their most recent occasion using the safe period, compared with 3% of participants who were living together and less than 1% of participants in all other relationship types ( $p < 0.001$ ). Similarly, 4% of married participants used withdrawal, compared with 2% of those who had known each other for a while but did not have a steady relationship and less than 1% of all other relationship types ( $p < 0.005$ ).

The two most common forms of contraception were clearly the condom (53%) and the contraceptive pill (34%). The differences across variables described above were further analysed for these two most common contraceptives. Those participants who had not used contraception on the last occasion of sexual intercourse were excluded from analyses in an attempt to better understand reasons for contraceptive choices.

Logistic regression analysis considered the influence of gender, age, education and relationship status on use of the contraceptive pill at most recent sexual intercourse. Following Wald test analyses, relationship status at last intercourse was re-categorised into four groups: just met/met recently, known for a while but no steady relationship, steady relationship/living together/engaged, and married. Using the category 'just met/met recently' as a baseline, those who knew each other but did not have a steady relationship were three times more likely (OR 2.88, 95% CI 1.37-6.06,  $p < 0.01$ ), those in a steady relationship/living together/engaged were seven times more likely (OR 7.23, 95% CI 3.72-14.05,  $p < 0.001$ ) and married participants over three times more likely (OR 3.27, 95% CI 1.55-6.92,  $p < 0.005$ ) to have used the contraceptive pill than those who just met/met recently. The odds of having used the contraceptive pill increased significantly (OR 1.04, 95% CI 1.02-1.06,  $p < 0.001$ ) for every increase in year of birth (i.e. likelihood of use decreased with increasing age). Men were significantly less likely to report use of contraceptive pill on the most recent occasion of intercourse (OR 0.67, 95% CI 0.54-0.84,  $p < 0.001$ ) and there were no educational level differences (OR 1.10, 95% CI 0.79-1.51,  $p = 0.575$ ). Therefore, of those who used contraception on the most recent occasion of intercourse, the contraceptive pill was most favoured by younger women and those in a steady relationship/living together/engaged, followed by married couples and those who knew each other but did not have a steady relationship.

Condom use was then analysed using logistic regression to determine the association between age, gender, education and relationship status. Wald test analyses revealed no differences between those who had just met, met recently and had known each other for a while but did not have a steady relationship, and these groups were pooled (group A – casual). A second distinct group consisted of those who were in a steady relationship but not living together (group B – 'steady'). There were no differences between those living together, engaged and married, and these were also pooled (group C – 'cohabiting'). Using the cohabiting group (group C) as a baseline, there were significant differences across other relationship groups, with those in a steady relationship significantly more likely to have used a condom (OR 2.18, 95% CI 1.60-2.98,  $p < 0.001$ ) and those in a casual relationship (group A) over five times more likely (OR 5.52, 95% CI 3.94-7.73,  $p < 0.001$ ) to have used a condom on the last occasion than the living together/engaged/married group (group C). Pre-Leaving Certificate level participants were significantly less likely to have used a condom than Leaving or post-Leaving Certificate level participants (OR 1.45,

95% CI 1.10-1.92,  $p=0.01$ ). Likelihood of using a condom at last intercourse increased with every increase in year of birth (OR 1.04, 95% CI 1.02-1.06,  $p<0.001$ ) and was greater for men than women (OR 1.72, 95% CI 1.39-2.12,  $p<0.001$ ). This final model indicates that likelihood of having used a condom at most recent intercourse increased with younger age, higher educational level, casual relationship status and male gender. In some respects, this is a positive finding in that those in casual relationships were most likely to use condoms. This may reflect the impact of international safe-sex and AIDS-awareness campaigns.

Of those who had used contraception on the most recent occasion, there were some significant educational level differences in type of contraceptive used, with fewer (28%) pre- Leaving Certificate participants using the contraceptive pill than Leaving and post- Leaving Certificate participants (38% and 35% respectively) ( $p<0.05$ ). Additionally, fewer (42%) pre- Leaving than Leaving (60%) or post- Leaving Certificate (54%) participants used condoms on the most recent occasion ( $p<0.001$ ). Those with lower educational levels were more likely to specify that they had contraceptive protection through tubal ligation or vasectomy at last intercourse, with 17% of pre- Leaving, 6% of Leaving and 9% of post- Leaving Certificate level participants using this method ( $p<0.001$ ).

Those participants who had not used any method of contraception or precaution on the most recent occasion of sexual intercourse, but who were (or whose partner was) not pregnant or trying to become pregnant, not medically confirmed as infertile or had not had a hysterectomy were asked why they had not used any method ( $n=225$ ). Their responses were assigned to categories, as in table 3.12. Participants could specify a number of reasons, so percentages are of the total.

As was seen in relation to contraceptive use over the last year, the most common reason for not using a method to avoid pregnancy during most recent sexual intercourse, given by 31% of participants, was that sex was not planned or they were not prepared. A further 15% said that they had not used contraception because they had been drinking or taking drugs and 9% felt they were unlikely to conceive because of the menopause. (Note, however, that all of these participants were aged less than 46 years and unlikely to be post-menopausal/have a post-menopausal partner.)

Table 3.12 Reasons for not using contraception at most recent sexual intercourse

	18-25 years n=37 %+	26-35 years n=65 %+	36-45 years n=123 %+	Total n=225 %+	
Unlikely to conceive because of menopause	0	0	21	9	***
Unlikely to conceive because possibly infertile – not medically confirmed	0	3	9	5	
Don't like contraception/ methods are unsatisfactory	0	6	8	5	
Partner doesn't like or won't use contraception	0	0	2	1	
Not my responsibility	0	0	1	<1	
I/my partner forgot to take the contraceptive pill	0	1	1	1	
Difficult to discuss contraception with partner	0	0	0	0	
Can't get contraception/ contraceptive services	2	1	4	3	
Against beliefs/religion to use contraception	5	2	9	6	
Drinking alcohol/taking drugs	29	16	7	15	
Sex not planned/not prepared	46	40	17	31	*
Didn't/don't care if pregnancy happens	0	4	4	3	
Other reason	14	22	23	20	
Refused/no response	4	8	5	6	

+ Participants could select more than one response, thus column totals may be greater than 100%.

\* indicates significant age group differences ( $p < 0.05$ )

\*\* indicates significant age group differences ( $p < 0.01$ )

\*\*\* indicates significant age group differences ( $p < 0.001$ )

Those participants who gave a response not allocated to the predetermined response categories were classified as 'other'. Within this category, almost half indicated a casual attitude towards contraception, for example, "didn't think about it", "not bothered" or "no reason". While those who were not using contraception because they were trying to become pregnant were removed from this analysis, it is possible that some of these casual attitudes towards contraception may be a result of more positive (or at least not negative) attitudes towards pregnancy as an outcome. As was discussed in relation to non-use of contraception over the last year (section 3.3.2), Hyde (1996) identified a number of thought processes that may explain these attitudes, named 'fertility denial', 'intermittent/ occasional risk takers' or 'destiny dependent' approaches towards life and contraception. Again, a second group of participants within the other category indicated casual use of the safe period and withdrawal. This group of participants said that they

did not use any method to avoid pregnancy on the most recent occasion but indicated a casual use of these methods, for example, “[I] am very careful” or “[I] felt it was safe”. A small number of participants, again, indicated breastfeeding as their reason for not using contraception at last intercourse.

ASHR (2003) also asked respondents to give a reason for non-use of contraception. Interviewers used predetermined response categories. Interestingly, ‘spontaneous sex/sex not planned’ and ‘alcohol/drug taking’ were not listed as response options. This makes for little comparative value between the two surveys in relation to this question. However, the most common reasons for non-use as reported in the ASHR study were side-effects/contra-indications (23%), leaving it to chance (20.2%) and forgetting/not caring (18.9%) (Richters et al. 2003). Non-use of contraception or precautions was not assessed in the British Natsal survey.

There were no significant gender differences in reasons for not using contraception. Analysis of reasons for not using contraception in terms of relationship status at the time of sexual intercourse highlighted a small number of interesting and significant differences. Firstly, those who stated that they did not use contraception because of alcohol or drug use were more likely to be in a casual relationship: 37% of those who had just met for the first time, 51% of those who had met recently and 26% of those who knew each other but did not have a relationship stated that they did not use a method to avoid pregnancy because of drinking alcohol or taking drugs. Fewer of those in a steady relationship (13%) gave the reason as drinking alcohol or taking drugs, with no participants who were married, engaged or living together giving this reason ( $p < 0.005$ ). There were also interesting variations in those who said that they did not use contraception because sex was not planned or they were not prepared. Fewer married (13%) and engaged (16%) participants gave this reason than those who had just met for the first time (44%), met recently (59%), knew each other but did not have a steady relationship (36%) and those who were in a steady relationship (53%) ( $p < 0.05$ ).

One significant educational level variation in reasons for not using a method to avoid pregnancy was observed. A greater percentage (11%) of participants with pre-Leaving Certificate education specified that they did not like contraception or that contraceptive methods were unsatisfactory, compared with 2% of Leaving and 1% of post-Leaving Certificate level participants specifying this reason ( $p < 0.005$ ). The only significant difference between lower and higher social classes was that more participants from lower social classes than from higher classes (26% vs. 6%) indicated drinking alcohol or taking drugs as a reason that they did not use contraception ( $p < 0.005$ ).

### 3.3.4 Emergency contraception ('morning-after pill')

- Knowledge of the existence of the emergency contraceptive pill (ECP) was high (96%). However, specific knowledge relating to correct usage was lacking (38% identified the correct time-period for use; 44% underestimated the time limit).
- Of those who had heard of the ECP, 29% of women had used it previously, and 24% of men reported that a partner had used it.
- 31% of those who had heard of the ECP thought it would be difficult to obtain. They suggested major barriers to accessing the ECP were locality/accessibility (66%) and attitudes of professionals (29%).

In total, 96% (95% CI 94.8-97.3) of participants had heard of the emergency contraceptive pill (ECP), with 97% of women and 95% of men having heard of it. This reflects the findings of some international studies (Larsson, Eurenus, Westerling and Tyden 2004, Kosunen, Vikat, Rimpela, Rimpela and Huhtala 1999, Graham et al. 1996, Smith et al. 1996).

Of those who had heard of the ECP, 29% (95% CI 25.4-31.8) of women had used it previously, and 24% (95% CI 21.2-27.6) of men reported that a partner had used it. This compares to 19.2% of respondents in ASHR (2003) and 3.3% who reported ever using it in an Irish (North Eastern Health Board) needs assessment study (age range 18-45 years) (Mason 2003).

Significantly more of the younger age groups had used the ECP, with 34% of 18-25 year olds, 30% of 26-35 year olds, and 14% of 36-45 year olds having used (or partner having used) the ECP ( $p < 0.001$ ). Other research has also found that usage and knowledge of the ECP is significantly related to age (Larsson et al. 2003, Smith et al. 2003, Perslev, Rorbye, Boesen, Norgaard and Nilas 2002, Rowlands, Devalia, Lawrenson, Logie and Ineichen 2000, Smith et al. 1996). Additionally, significantly fewer (21%) participants with pre-Leaving certificate education had ever used the ECP, compared with Leaving certificate (25%) and post-Leaving certificate (31%) level participants ( $p < 0.005$ ).

Logistic regression further clarified these relationships. There were no differences between pre-Leaving and Leaving Certificate educational level in relation to previous use of the ECP, so these groups were pooled. Controlling for age, gender and education, post-Leaving Certificate level participants were 50% more likely (OR 1.50, 95% CI 1.17-1.91,  $p = 0.001$ ) to have used the ECP than pre-Leaving and Leaving Certificate level. Likelihood of use increased by 57% with each decade increase in year of birth (OR 1.57, 95% CI 1.39-1.77,  $p < 0.001$ ). No differences in use of the ECP for men (reporting partner use) and women were found (OR 0.81, 95% CI 0.64-1.03,  $p = 0.09$ ).

Participants who had heard of the ECP were asked how long after unprotected sexual intercourse they thought it could be used. Five response options were suggested: up to twelve hours, up to 24 hours, up to 72 hours, up to five days or over five days. In total, 38% of those who had heard of it knew that the ECP could be taken up to 72 hours after unprotected sex. There were significant gender differences in knowledge, with 26% of men and 51% of women correctly identifying the 72-hour limit ( $p < 0.001$ ). Similarly, there were significant differences across age groups, with 45% of 18-25 year olds, 43% of 26-35 year olds, and 28% of 36-45 year olds correctly identifying the time limit ( $p < 0.001$ ). Participants with lower education levels were significantly less likely to correctly identify the time limit, with 31% of pre-Leaving, 38% of Leaving and 44% of post-Leaving

certificate level participants identifying the 72-hour limit ( $p < 0.001$ ). Those participants from higher social classes (41%) were also more likely to identify the correct time limits than participants from lower social classes (34%) ( $p < 0.05$ ).

Interestingly, of the participants who had heard of the ECP, 15% thought it could only be used up to twelve hours after unprotected sex, 29% thought it could only be used up to 24 hours, 1% up to five days and 17% said that they did not know. These results have implications for uptake of the ECP, since 44% of participants underestimated the time limit. In an unprotected sexual situation, these individuals might assume that the time limit for using the ECP has passed when, in fact, it could still be effective. The term 'morning-after pill' may inadvertently indicate that the time limit for effective use is much shorter than 72 hours. While the optimum time to take the ECP is within 24 hours (Irish Family Planning Association 2004), the recommended time limit is 72 hours. Gender, education, age and social class were significantly related to knowledge regarding ECP usage. Participants with lower levels of education (also reported by Perslev et al. 2002) and those from the lower social classes were less likely to identify the correct time period for ECP usage. Although actual knowledge of the existence of the ECP was high, specific knowledge relating to its efficacy periods was lacking. This has also been reported in many other studies (Aneblom, Larsson, Odland and Tyden 2002, Perslev et al. 2002, Haggstrom-Nordin and Tyden 2001, Virjo, Kirkkola, Isokoski and Mattila 1999, Smith et al. 1996).

An information gap clearly exists in relation to specific knowledge concerning the ECP, which may act as a barrier to usage (62% either do not know or are inaccurate in their estimation of the timeframe for use of ECP). Emergency contraception has a potentially important role in the prevention of unintended pregnancy, particularly since many of the situations in which contraception has not been used relate to lack of advance planning or alcohol/drug use (15% used ECP because no contraception had been available and a further 19% because contraception had not been used). Thus, knowledge concerning contraceptive choices after the event is very important. A strategy is required to bridge the knowledge gaps of the general population. Health service providers may need to explore the possibility of moving towards a model of contraceptive counselling that would involve exploring issues relating to the ECP and its usage. Larsson et al. (2003) found that women who had visited a clinic for contraceptive counselling had a better general knowledge about ECP than those who had not requested counselling. Perslev et al. (2002) conclude that information campaigns need to target women with lower educational levels, those in stable relationships and women not using contraception. This recommendation may also apply to the findings of this study. Issues such as cost, ease of access, personal beliefs and accurate risk assessment after an incident of unprotected sexual intercourse are just some of the other factors which impact on actual usage (Tyden, Aneblom, von Essen, Haggstrom-Nordin, Larsson and Odland 2002, Sorensen, Pedersen, Nyrborg 2000).

Those who had heard of the ECP were then asked how difficult they thought it would be for someone to obtain it. Half (50%) thought it would not be at all difficult, with 45% of men and 56% of women thinking that it would be not at all difficult to obtain (table 3.13).

**Table 3.13 Participant rating of perceived difficulty in obtaining the emergency contraceptive pill**

	<b>Women n=1,910 %</b>	<b>Men n=1,293 %</b>	<b>Total n=3,203 %</b>
Very difficult	4	4	4
Quite difficult	8	10	9
Somewhat difficult	18	18	18
Not at all difficult	56	45	50
Don't know	14	23	19

Those who felt it would be somewhat, quite or very difficult (n=972) to obtain the emergency contraceptive pill were asked to explain further (table 3.14). Participants could give more than one reason, thus responses are of the total participants answering the question. Interviewers coded responses to the three broad categories in table 3.14, or specified more detailed responses in the 'Other' category. The major barrier to accessing the ECP was thought to be locality/accessibility, mentioned by 66% of those who perceived difficulties in accessing it. Some (29%) identified attitudes of professionals, with a number of participants (16%) specifying other reasons. The barriers to accessing the emergency contraceptive pill noted within the 'other' category were lack of knowledge or awareness of the emergency contraceptive pill and its purpose, young age, and embarrassment.

**Table 3.14 Reasons given by participants who thought it was difficult to obtain the emergency contraceptive pill**

	<b>Total n=972 %</b>
Expense/cost	7
Locality/accessibility	66
Attitudes of professionals	29
Other	16

Analysis of participant comments highlighted particular issues relating to locality and, particularly, to accessibility. The most common of these was the difficulty created by having to visit a medical practitioner, such as a GP, to get a prescription for the ECP. Difficulties were intensified due to limited availability of GP appointments and problems with accessing a GP on weekends and public holidays. Those living in rural areas found these problems particularly acute. Similarly, poor access to a pharmacy was noted in participant comments, particularly in relation to weekend or evening access and pharmacy opening hours. A number of participants commented that they thought it was difficult to get the ECP because it was available by prescription, rather than over-the-counter at a pharmacy.

In some European countries (including Britain, Sweden and Denmark), the ECP is currently available over-the-counter at most pharmacies as a contraceptive product. The situation in Ireland is more complex. The ECP was not formally available in Ireland until late 2001, when the Irish Medicines Board reclassified Levonelle (ECP) from an abortifacient to a contraceptive. Until this point, medical practitioners usually prescribed a double dosage of an oral contraceptive as an ECP. Currently, the ECP can only be acquired by prescription from a medical practitioner. In the absence of over-the-counter availability of ECP, advance provision may alleviate access difficulties and thus reduce unintended and crisis pregnancy (Blanchard, Bungay, Furedi and Sanders 2003, Glasier and Baird 1998). The World Health Organisation's guidelines on ECP service delivery state that "repeated use poses no health risks and should never be cited as a reason for denying women access to treatment" (cf. Abuabara, Becker, Ellertson, Blanchard, Schiavon and Garcia 2004: 339). This statement is supported by several other studies that conclude that repeated use of the ECP is safe and that use of ECP does not result in abandonment of other forms of contraception (Gold, Wolford, Smith and Parker 2004, Camp, Wilkerson and Raine 2003, Shelton 2002, Grimes, Raymond and Scott Jones 2001, Ellertson, Ambardekar, Hedley, Coyaji, Trussell and Blanchard 2001, Rowlands et al. 2000, Glasier and Baird 1998). Larsson et al. (2003) conducted a population-based survey one year after deregulation of ECP in Sweden and found that two-thirds of the women surveyed highly appreciated this new means of over-the-counter access. Other studies have found that deregulation of ECP does not in itself result in over-use of emergency contraception (Larsson et al. 2003, Camp et al. 2003).

Attitudes and beliefs of professionals can act as a barrier to women obtaining the ECP. The present study found this to be considered a barrier by 29% of those who perceived difficulties in obtaining the ECP. Some concerns of professionals relating to emergency contraception in Ireland are of a legal nature (Mason 2003). Internationally, researchers have documented professional concerns regarding the impact of emergency contraception on sexual behaviour and planned contraception (Bissell and Anderson 2003, Barrett and Harper 2000, Brown and Boulton 1999, Ziebland 1999, Gold, Schein and Coupey 1997). Simonds and Ellertson (2004) state that:

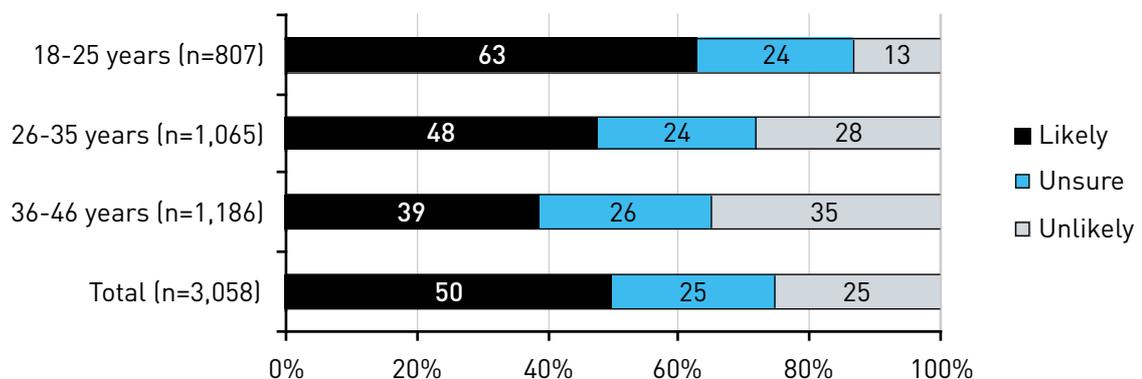
Understanding the cultural and political significance of ECPs involves consideration of the evolution of current circumstances in which people use and distribute the method (Simonds and Ellertson 2004: 1285).

They conclude, from their qualitative study of family planning clients and health care workers, that sexual behaviour, contraceptive habits and abortion can be used by both health professionals and clients as indicators of a woman's "moral worth" and that such thinking needs to be challenged and dismantled. Using media coverage of the British Pregnancy Advisory Service's (BPAS) decision to launch an emergency contraception advance-provision service, Blanchard et al. (2003) illustrated examples of this moral debate regarding emergency contraception practices. They cite newspaper coverage of the new BPAS service that argued (despite current research findings, which indicate the contrary) that such an advance ECP service would encourage stockpiling of ECPs, would pose health risks, and would encourage promiscuity among teenagers. While Bissel and Anderson's (2003) study reported positive attitudes from professionals and clients regarding supplying ECPs over-the-counter in pharmacies in the UK, they also noted that both users and pharmacists had concerns about these schemes. These concerns

related to potential misuse (i.e. over-use), the risk of contracting STIs through ECP as a contraceptive choice and to possible changes in patterns of contraceptive behaviour.

Finally, all of those who had heard of the ECP were asked how likely they would be to take (or to advise a partner to take) it if they thought there was a possibility of an unwanted pregnancy shortly after having unprotected sex. Of all those who felt the question was applicable to them (n=3,058), 50% thought it was quite likely or very likely that they would take the emergency contraceptive pill (or advise their partner to take it), with 25% unsure and 25% thinking it quite or very unlikely. There was a significant gender difference, with 43% of men thinking it was quite or very likely they would advise their partner to take the emergency contraceptive pill if there was a possibility of an unwanted pregnancy; 56% of women thought they would use it (p<0.001). Additionally, there were significant age differences (p<0.001), with 63% of 18-25 year olds quite likely or very likely to take the emergency contraceptive pill, compared with 48% of 26-35 year olds, and 39% of 36-45 year olds (figure 3.8). Reasons for not expecting to use the ECP were not pursued. However, these may include moral concern (for those who view the ECP as an abortifacient), health concerns or uncertainty about acceptability of an unplanned pregnancy in particular situations (e.g. with a long-term partner).

**Figure 3.8 Likelihood of using emergency contraceptive pill if there was a possibility of an unwanted pregnancy after unprotected sex, by age group**



Participants who had had heterosexual sexual intercourse in the last year were asked about their use of the ECP in the year. In total, 50 participants (or their partner) (2% of participants who had experienced heterosexual intercourse) had used the emergency contraceptive pill in the last year. More participants in the younger age groups had used the ECP, with 5% of 18-25 year olds, 2% of 26-35 year olds and <1% of 36-45 year olds using it in the last year (p<0.001). Most (60%) had used it once in the last year, with 17% using it twice, 10% using it three times and 13% more than three times. One person used the ECP on 10 occasions in the last year.

Apart from non-use of contraception (no contraception used: 19%; no contraception available at the time: 15%), many respondents reported condom failure (25%) or forgetting to take the contraceptive pill (8%) as the main reason for using the ECP (on the most recent occasion) (table 3.15). It is interesting that over a quarter of participants chose not to (or, at least, did not choose to) use contraceptives (8% did not want to use condoms and 19% did not use (as distinct from did not have) contraceptives)).

**Table 3.15 Main reason for using emergency contraceptive pill (on most recent occasion in the last year)**

	<b>Total n=46 %</b>
Condom failure	25
Missed contraceptive pill/ forgot to take pill	8
Possibility of contraceptive pill failure	9
Rhythm/ safe period	4
I/partner didn't want to use a condom	8
No contraception available at the time	15
No contraceptive used	19
Other	11

Other studies have also found condom failure to be a common reason cited by women needing emergency contraception (Camp et al. 2003, Blanchard, Haskell, Ferden, Johnstone, Spears et al. 2002). Hyde (1996) found that 17% (n=9) of study participants reported that their pregnancy was the result of contraceptive failure or misuse; of these nine participants, seven had been using condoms. Falk, Falk, Hanson and Milsom (2001) found that 32% of the young women in their study (aged 15-25 years) reported using emergency contraception because a condom had ruptured. Taking account of the high levels of contraceptive failure and misuse reported in other studies and the findings of this study, it is clear that people need clear and practical information on product use, side effects and suitability of particular contraceptives for different lifestyles. A co-ordinated and concerted approach is required. A model of contraceptive counselling is a possible option to deal with the apparent deficits in information regarding contraception in Ireland. As Smith and Bury (2000) reported, over 73% of women interviewed said that they felt it was appropriate for a practice nurse or GP to inquire if they needed contraceptive advice.

### 3.3.5 Contraceptive services

- More men (14%) than women (9%) reported never having obtained contraceptive supplies or sought advice. Women were more likely than men to have used a health professional route (e.g. GP, family planning clinic) (79% vs. 37%) and less likely to have used a commercial route (e.g. chemist, vending machine) (48% vs. 73%).
- More older men and women (37% and 82%, respectively) had used a health professional route to contraceptive advice or supplies than younger men and women (16% and 71%, respectively). Younger participants were more likely to have used commercial routes than the older groups (men: 78% vs. 64%; women: 51% vs. 41%).
- 95% did not find it difficult to get contraception. Those who reported difficulty in obtaining contraception explained that accessibility and embarrassment were barriers.

Participants were questioned about their use of contraceptive services. Participants who had only experienced sexual intercourse with someone of the same sex were excluded from all questions relating to contraceptive services because their decisions about contraceptive use do not relate to pregnancy. Thus the following analyses relate to participants who had experienced heterosexual sex at some time in their life and those who had not yet had sex (n=3,312). Table 3.16 on the next page shows the sources of contraceptive supplies or advice participants had ever used, by gender and age cohort. Since participants were asked to list all sources ever used, percentages stated are percentages the total population that had ever used each source.

There were a number of interesting and significant gender differences in sources of contraceptive supplies or advice, with more men (14%) than women (9%) never having obtained supplies or sought advice ( $p < 0.001$ ). Women were most likely to have sought supplies or advice from their own GP (70%), a chemist shop/pharmacy (44%) or a family planning clinic (26%). Men were more likely to have used a commercial route to contraceptive supplies, including a chemist shop (59%), vending machine (39%) or over the counter (24%). Durex (2002) reported that the most popular place to buy condoms in Britain was a chemist and 11% of participants had reported that they relied on vending machines to purchase their condoms.

Women were more likely than men to have sought contraceptive supplies or advice. This may be related, in part, to the finding that men are significantly more likely to take a 'commercial' approach: obtaining contraceptives from, for example, a pharmacy, petrol station, supermarket or vending machine. Thus they 'by-pass' health professional advice. Women need to attend a medical practitioner to have a wide range of contraceptive products prescribed; 79% of women in this study had used a health professional route to contraceptive supplies and/or advice compared to 25% of men. Importantly, this finding points to a number of difficulties that may be encountered in trying to bridge an information or skills gap experienced by men. Women, in many cases, need to visit a medical practitioner for contraceptive products; this in itself provides an opportunity to explore contraceptive needs and options. Men may not be provided with this opportunity, unless the health professional in another health visit adopts a proactive approach towards the issues of contraception and family planning. Other studies found that embarrassment can be an inhibitor or a barrier to seeking contraceptive advice, and this can be particularly true for younger people (Dempsey et al. 2001, IFPA 2002).

Interesting age differences in sources used to obtain contraceptive supplies or advice were observed. More older women and men had used their own GP for supplies or advice than younger groups, with significant age-group differences for men and women. The findings highlight the importance of the role of the GP in terms of contraceptive service provision, particularly for women and for the older age groups. Younger men and women were more likely to have used a vending machine, obtained contraception over-the-counter or been supplied by a sexual partner, family or friends. Sources of contraceptive advice and supplies were categorised into health professional, commercial and personal contact routes, highlighting obvious gender and age-group differences. Significantly more men and women in the older age groups had used a health professional route to contraceptive advice or supplies. Alternatively, more younger men and women had used a commercial route or a personal contact route than older groups. These findings indicate clear patterns in routes to contraceptive advice or supplies, which could be used to target age and gender groups.

**Table 3.16 Sources of contraceptive supplies or advice ever used, by gender and age group (n=3,312)**

	Women					Men				
	18-25 %	26-35 %	36-45 %	Total %		18-25 %	26-35 %	36-45 %	Total %	
<b>No. of participants</b>	<b>469</b>	<b>682</b>	<b>809</b>	<b>1,960</b>		<b>386</b>	<b>447</b>	<b>519</b>	<b>1,352</b>	
<b>Never obtained supplies or sought advice +++</b>	12	6	9	9	*	14	11	18	14	
<b>Health professional route +++</b>	71	84	82	79	***	16	23	37	25	***
Own GP +++	63	74	73	70	**	11	19	30	20	***
Another doctor at a GP's surgery +++	5	10	8	8	*	1	2	4	2	**
Family Planning/Well Woman Clinic +++	20	28	28	26	*	3	6	10	6	**
Well Man Clinic ++	0	1	<1	1		3	1	4	2	
Emergency Dept. of a hospital +	2	1	1	1		<1	0	1	<1	
<b>Commercial route +++</b>	<b>51</b>	<b>52</b>	<b>41</b>	<b>48</b>	<b>**</b>	<b>78</b>	<b>78</b>	<b>64</b>	<b>73</b>	<b>***</b>
Chemist shop/ pharmacy +++	46	48	39	44	*	55	68	55	59	**
Over the counter (petrol station/super-market/etc.) +++	11	12	7	10	*	26	30	20	24	***
Vending machine +++	16	11	3	10	***	50	41	26	39	***
Through the post	1	<1	<1	<1		1	0	2	1	
<b>Personal contact route +</b>	<b>27</b>	<b>22</b>	<b>11</b>	<b>20</b>	<b>***</b>	<b>23</b>	<b>17</b>	<b>9</b>	<b>16</b>	<b>***</b>
Supplied by sexual partner/family/friend +	27	22	11	20	***	23	17	9	16	***
<b>Any other service</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>		<b>3</b>	<b>&lt;1</b>	<b>1</b>	<b>2</b>	<b>*</b>

\* indicates significant differences across age groups ( $p < 0.05$ )  
 \*\* indicates significant differences across age groups ( $p < 0.01$ )  
 \*\*\* indicates significant differences across age groups ( $p < 0.001$ )  
 + indicates significant differences across gender ( $p < 0.05$ )  
 ++ indicates significant differences across gender ( $p < 0.01$ )  
 +++ indicates significant differences across gender ( $p < 0.001$ )

These results support an earlier finding that younger people were more likely to report using condoms in the last year. They indicate that more young people are choosing to access supplies and/or advice via a commercial route, rather than a health professional route. From a policy perspective, making contraceptives easier to access needs to be balanced by a substantial effort to ensure correct and consistent usage of contraception, given the number of technical difficulties being experienced by users.

Further analysis of sources of contraceptive advice or supplies found that significantly more participants with pre-Leaving Certificate education (16%) had never obtained supplies or sought advice than those with Leaving Certificate (11%) or post-Leaving Certificate level (9%) ( $p < 0.005$ ). There were also a small number of significant differences between lower and higher social classes. Significantly more participants from higher classes (19%) had used a family planning or Well Woman clinic than those from lower classes (13%) ( $p < 0.001$ ). One-fifth (21%) of those from lower classes had obtained contraception over-the-counter, compared with 15% of those from higher classes ( $p < 0.01$ ). 29% of participants from lower classes, and 21% of those from higher classes had used vending machines ( $p < 0.005$ ). Cost may be a factor that impacts on a person's service use when they need contraceptive supplies/advice. Medical-card holders (those with free healthcare entitlements) are not covered financially to attend specialist voluntary services free and are thus limited to attending their named GP for free contraceptive services. Participants were asked which would be their preferred source of contraceptive supplies or advice if all were available easily and locally (table 3.17).

Overall, around a third of participants (34%) indicated that they would prefer to obtain contraceptive advice or supplies from a chemist shop/pharmacy, with their own GP being the second most popular source (31%). There were differences between men and women regarding their preferred source of contraceptive supplies or advice. Almost half of all women (48%) would prefer to get contraceptive supplies or advice from their own GP, with a further 24% preferring a chemist shop/pharmacy and 12% preferring a family planning or Well Woman clinic. These findings suggest that the pharmacy/chemist needs to be considered when implementing education and information programmes. Only 14% of men chose their own GP and 2% a family planning or Well Woman clinic as their preferred source. More men than women preferred to access contraception from a chemist/pharmacy (43% vs. 24%), vending machines (16% vs. 1%) and over-the-counter (6% vs. 2%).

**Table 3.17 Preferred source of contraceptive supplies or advice if all were available easily and locally**

	<b>Men n=1,302 %</b>	<b>Women n=1,912 %</b>	<b>Total n=3,214 %</b>
<b>No preference</b>	<b>15</b>	<b>8</b>	<b>12</b>
<b>Health professional route</b>	<b>17</b>	<b>61</b>	<b>39</b>
Own GP	14	48	31
Another doctor at a GP's surgery	<1	1	<1
Family planning/Well Woman Clinic	2	12	7
Well Man Clinic	1	<1	1
Emergency Department of a hospital	0	0	0
<b>Commercial route</b>	<b>66</b>	<b>27</b>	<b>46</b>
Chemist shop/pharmacy	43	24	34
Over the counter (petrol station/supermarket/etc.)	6	2	4
Vending machine	16	1	8
Through the post	<1	<1	<1
<b>Personal contact route</b>	<b>2</b>	<b>4</b>	<b>3</b>
Supplied by sexual partner/family/ friends	2	4	3
<b>Any other service</b>	<b>&lt;1</b>	<b>&lt;1</b>	<b>&lt;1</b>
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>

There were some notable differences across age groups, with older groups more likely to prefer their own GP as the source of contraceptive supplies or advice: 24% of 18-25 year olds preferred their own GP, compared with 31% of 26-35 year olds and 39% of 36-45 year olds. However, more participants in the 18-25 year old category (15%) preferred vending machines, compared with 6% of 26-35 year olds and 4% of 36-45 year olds. There was one notable difference across household locations, with more participants who lived in a city (12%) preferring a family planning or Well Woman clinic compared with those living in a rural area (4%), village (5%) or town (4%). This may reflect a lack of availability or experience of family planning or Well Woman clinics among participants not living in a city, since significantly more of those living in a city (25%) had previously used a family planning or Well Woman clinic than those living in a rural area (11%), village (11%) or town (13%) ( $p < 0.001$ ). Furthermore, 16% of participants living in rural areas had never obtained supplies or sought advice, compared with 11% of those living in a village, 9% living in town and 10% in a city ( $p < 0.05$ ). Compared to Natsal (2000), a relatively small proportion of women stated that they had used or would prefer to use a family planning/Well Woman clinic. This may reflect the limited availability of such services to women outside the main cities in Ireland.

Participants were then asked how difficult they found it to get contraception. Those participants who had never tried to obtain contraception and those who responded 'don't know' (10%) were excluded. Of the remainder ( $n=3,005$ ), most (95%) found it not at all

difficult to get contraception, 4% found it somewhat difficult, 1% quite difficult and <1% very difficult. There was no significant difference in perceived difficulty of access to contraception between men and women, with the majority of men (94%) and women (96%) saying that it was not at all difficult to get contraception.

Those participants who found it very, quite, or somewhat difficult (n=127) to get contraception were asked to explain (table 3.18). Participants could give more than one reason to explain why they found it difficult to access contraception, so percentages are of total participants who answered the question. As was seen with emergency contraception, the issues that caused most difficulty in accessing contraception were locality/accessibility (45%), embarrassment (25%) and expense (17%). Some participants indicated that the perceived attitude of professionals (10%) and confidentiality (8%) were also issues of difficulty when accessing contraception. Dempsey et al. (2001) reported that cost is an issue of concern to most young people when accessing contraceptive services. The IFPA (2002) recommend free access to sexual health services in order to increase uptake of services and contraception.

**Table 3.18 Reasons given by participants who thought it was difficult to obtain contraception**

	<b>Male n=63 %</b>	<b>Female n=64 %</b>	<b>Total n=127 %</b>	
Expense	10	25	17	
Accessibility	58	29	45	**
Embarrassment	30	19	25	
Confidentiality/ privacy	6	10	8	
Attitude of professionals	2	22	10	***

\* indicates significant differences across age groups ( $p < 0.05$ )

\*\* indicates significant differences across age groups ( $p < 0.01$ )

\*\*\* indicates significant differences across age groups ( $p < 0.001$ )

Of participants who had ever sought contraception, only 3% reported that they had been refused a method of contraception. The majority of those who had been refused contraception (90%) were female. These women (n=100) reported having been refused the contraceptive pill (58%), coil/IUD/Mirena (12%), injections/implants (11%), emergency contraception (9%), condoms (3%), vasectomy/sterilisation (3%), and the cap/diaphragm (2%). A small number of men (n=10) were refused contraception and most of these (58%) were refused condoms.

Most explained that they were refused contraception because the doctor/nurse did not approve of the method (37%) or for medical reasons (34%). Other reasons for refusal included being too young (under age) (9%) or that the pharmacist did not stock the contraceptive requested or did not approve (5%).

A small percentage (10%) reported that the attitude of professionals was an issue that caused difficulty. This negative attitude towards a particular contraceptive method was also reported as the main reason for refusal of that method (37%). Mason's (2003) study of contraceptive services in the North Western Health Board area found that nearly a quarter of GPs surveyed had personal objections to at least one method of contraception. The most common methods objected to were emergency contraception, IUDs and Mirenas. Female doctors were more likely to have objections than male doctors. Mahon et al.'s (1998) findings also suggest that some GPs may refuse to provide contraception because of age or a personal moral attitude towards sex outside marriage.

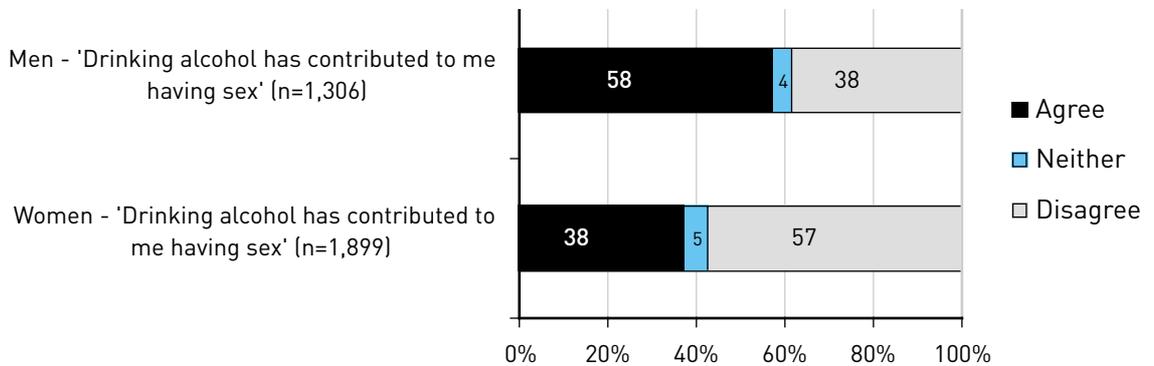
Data from this study convey very positive findings in relation to access to contraception: (95% of respondents felt it was not at all difficult to get contraception). This positive view of contraceptive access contrasts with earlier findings from Wiley and Merriman (1996). These authors assessed the provision of family-planning advice across two dimensions: accessibility and adequacy. Only 51% of their respondents thought that family-planning advice was accessible, with 13% of women surveyed rating family-planning information as inadequate. Ease of access measures an important dimension of contraceptive service provision, but needs to be viewed in the wider quality context to include other factors such as satisfaction.

### 3.3.6 *Role of alcohol*

- 58% of men and 38% of women agreed that drinking alcohol had contributed to them having sex.
- Almost half (45%) of men and 26% of women agreed that drinking alcohol had contributed to them having sex without using contraception. Correlates of agreement were male gender, lower educational level, lower social class and currently being in a casual relationship or in no relationship.

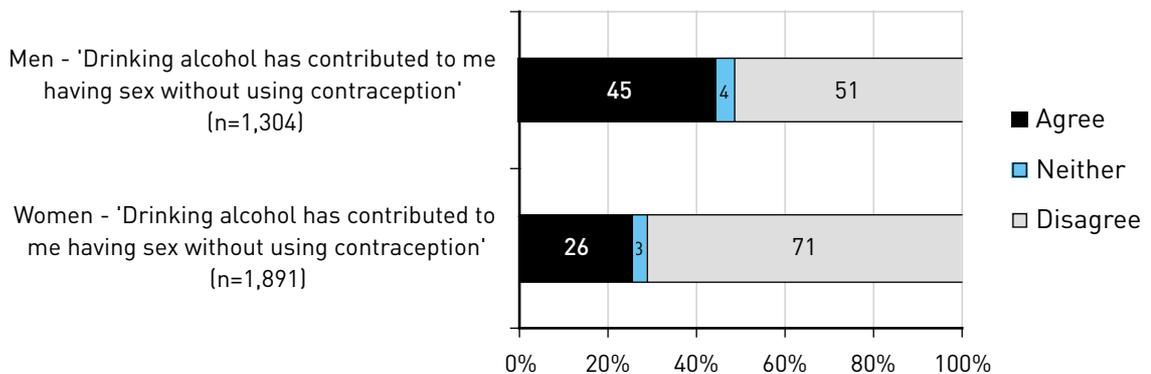
Alcohol has been considered as a possible risk factor for unprotected sex in many previous studies. Two statements regarding the role of alcohol in decisions to have sex and decisions to have unprotected sex were included in the 'Attitudes' section of the interview schedule. In total, 48% (95% CI 45.9-50.5) of all participants agreed that drinking alcohol had contributed to them having sex, with a further 4% (95% CI 3.2-6.0) neither agreeing nor disagreeing. There were significant gender differences, with 58% (95% CI 54.7-61.4) of men and 38% (95% CI 35.4-41.5) of women agreeing or strongly agreeing that drinking alcohol had contributed to them having sex ( $p < 0.001$ ) (figure 3.9). There were no significant differences across age groups, household location or educational level. However, there were significant differences across current relationship status, with 44% of married or cohabiting participants agreeing that alcohol had contributed to them having sex, compared with 47% of those in a steady relationship, 60% of those in a casual relationship and 54% of those not in a relationship ( $p < 0.005$ ).

Figure 3.9 Role of alcohol in decision to have sex



Additionally, 36% [95% CI 33.3-38.5] of all participants agreed that drinking alcohol had contributed to them having sex without using contraception, and a further 3% [95% CI 2.0-5.8] neither agreed nor disagreed. Again there were significant gender differences, with almost half (45%, 95% CI 41.8-48.9) of men and 26% [95% CI 23.3-29.6] of women agreeing or strongly agreeing that drinking alcohol had contributed to them having sex without using contraception ( $p < 0.001$ ) (figure 3.10). No significant differences across age categories or household location were observed.

Figure 3.10 Role of alcohol in experiences of sex without using contraception



There were significant differences in agreement that alcohol had contributed to sex without contraception across educational level, with participants with lower educational attainment more likely to agree that alcohol had contributed to them having sex without using contraception ( $p < 0.001$ ). 46% with pre-Leaving Certificate education agreed with the statement, compared with 32% of Leaving Certificate level and 33% of Post-Leaving Certificate level participants. There were, again, significant differences in relationship status, with 32% of married, 33% of cohabiting and 35% of participants in a steady relationship agreeing that drinking alcohol had contributed to them having sex without using contraception, compared with 48% of those in a casual relationship and 40% not in a relationship ( $p < 0.05$ ). Non-manual classes were slightly less likely to agree (34%) than manual classes (41%) ( $p < 0.05$ ).

Logistic regression was carried out to investigate the association of gender, year of birth and educational level in determining agreement with the statement that alcohol had contributed to having sex without using contraception. The model confirmed no relationship for year of birth (OR 1.00, 95% CI 0.99-1.01,  $p=0.723$ ), that men were over twice as likely as women to agree with the statement (OR 2.21, 95% CI 1.81-2.71,  $p<0.001$ ), and that those with Leaving or post-Leaving Certificate education were significantly less likely to agree with the statement than those with pre-Leaving Certificate education (OR 0.57, 95% CI 0.45-0.73,  $p<0.001$ ).

An additional regression investigated social class with gender, year of birth and relationship status. Adjusted Wald tests confirmed no differences between social classes I-III, thus these were pooled to a single non-manual category. There were no differences between manual (IV-VI) classes and these were also pooled. Non-manual classes were significantly less likely to report that alcohol had contributed to sex without contraception than manual classes (OR 0.79, 95% CI 0.65-0.97,  $p<0.05$ ). Again, taking the married/cohabiting group as a baseline, findings confirmed that those in a steady relationship (OR 1.51, 95% CI 1.03-2.23,  $p<0.05$ ) and in a casual/no relationship (OR 1.80, 95% CI 1.38-2.34,  $p<0.001$ ) were more likely than those who were married/cohabiting to agree with the statement. Gender differences were additionally confirmed, with men approximately twice as likely as women to agree (OR 0.46, 95% CI 0.37-0.56,  $P<0.001$ ), with no differences across year of birth (OR 0.99, 95% CI 0.97-1.00,  $p=0.161$ ).

Of concern from a policy perspective is the finding that 45% of men and 26% of women felt that drinking alcohol had contributed to them having had sex without using contraception. Additionally, in relation to these findings concerning the role of alcohol, it has been noted previously that 21% of participants who stated that they did not always use contraception in the last year when they had sex (excluding those who were pregnant, trying to become pregnant, sterilised or medically confirmed infertile) gave the reason that they had been drinking alcohol or taking drugs. Similarly, 15% of those who had not used contraception on the most recent occasion of sexual intercourse said they had not used contraception because they had been drinking alcohol or taking drugs. As would be expected, these percentages are lower than for those agreeing with the statement 'Drinking alcohol has contributed to me having sex without using contraception' (36% agreement) because this statement refers to alcohol ever having contributed to unprotected sex.

Addressing the non-use of contraception more generally is a difficult issue, but the contributory role of alcohol adds to the complexity of achieving behaviour change. While international research findings regarding the role of alcohol and contraceptive behaviour are contradictory (see introduction), this study has found a strong relationship between alcohol use and non-use of contraception.

### 3.4 Learning about sex

- Most participants (80%) agreed that it is mainly the responsibility of parents to educate their children about sexual matters.
- 82% of parents of 12-18 year olds had spoken to their children about sexual matters. Of the remainder, 43% indicated that they plan to talk to them about sexual matters in the future, with 23% stating that someone else had already provided sex education to their children.
- While most parents (75%) felt confident as sex educators of their own children, they would also welcome support to carry out this role. Suggested supports were leaflets/booklets (84%), parent meetings in the school/community (67%) and classes/training (65%).

As part of the wider consideration of contraception and related sexual issues, public attitudes to the education of children are important. A fundamental issue concerns responsibility for sex and relationship education. Most participants (80%, 95% CI 77.1-81.8) agreed with the statement 'it is mainly the responsibility of parents to educate their children about sexual matters'. There were significant age-group differences, with 70% of 18-25 year olds, 80% of 26-35 year olds and 89% of 36-45 year olds agreeing that it is mainly the responsibility of parents ( $p < 0.001$ ). Participants with pre-Leaving Certificate education were more likely to agree that sex education was mainly the responsibility of parents (85% agreement) than participants with Leaving (78%) or post-Leaving (78%) Certificate education ( $p < 0.05$ ). There were no significant differences between manual and non-manual social classes in their attitude to education about sexual matters from parents. There was a significant difference between parents and those without children, with 89% of parents agreeing that it was the parents' responsibility (and 71% of those without children) ( $p < 0.001$ ).

These findings place the focus of responsibility for sex education on parents. So how do parents feel about their ability to provide this information and education to their children? In order to gather further information regarding attitudes and behaviours towards educating children about sexual matters, participants with children aged twelve to eighteen years ( $n=765$ ) were asked further questions about their own experiences. Of this group, 82% (95% CI 77.8-85.8) had spoken (or their partner had spoken) to their children about sexual matters. Those who had not spoken to their child/children about sexual matters were asked why not (table 3.19). Participants could give a number of responses so percentages are of the total.

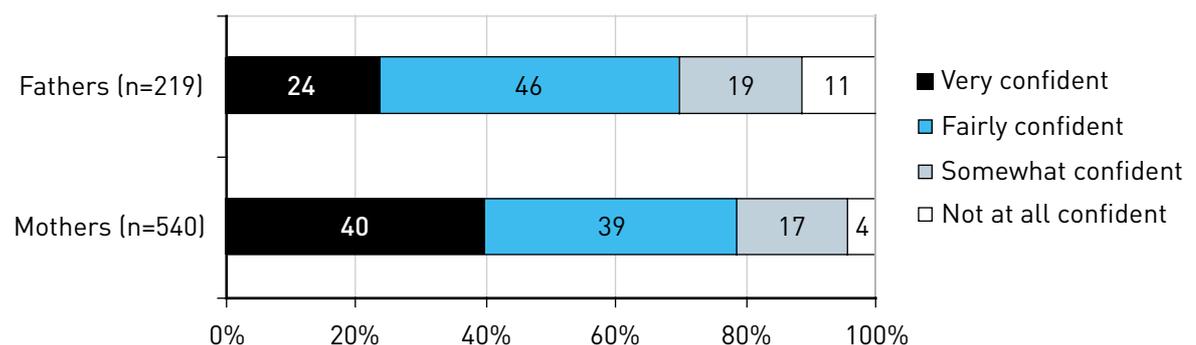
**Table 3.19 Reasons why parents have not spoken to child about sexual matters**

	<b>Total n=126 %</b>
Someone else already told them	23
Not yet, will in the future	43
It's the school's responsibility	22
Not sure how to talk about it/ embarrassed	12
Child won't listen/ feels uncomfortable	5
Don't think they should be told	1
Don't want to encourage sexual behaviour	1
Other	15

Almost half of this group (43%) responded that they planned to talk to them about sexual matters in the future, with 23% giving the reason that someone else had already told them and 22% saying that it was the school's responsibility. Those participants in the 'Other' category were asked to explain further. Two main themes emerging were that children seemed to know about sexual matters already or that the issue had not yet arisen with them.

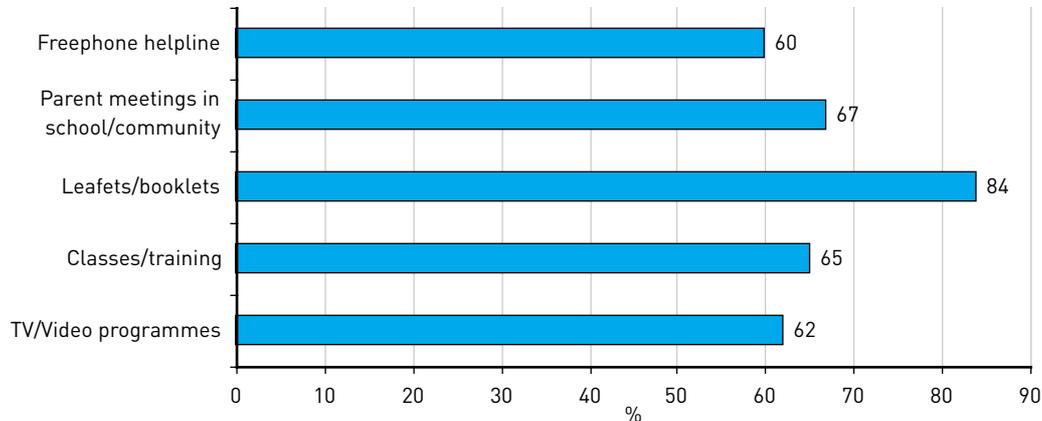
Parents of children aged twelve to eighteen years were then asked how confident they were in their ability to talk to their child/children about sexual matters. Most felt either fairly (42%) or very (33%) confident. There was a significant difference between mothers and fathers ( $p < 0.005$ ) in how able they felt to talk to their child / children about sexual matters (figure 3.11), with mothers feeling more confident.

**Figure 3.11 Parents' ratings of their ability to talk to their children about sexual matters**



The group of participants with children aged twelve to eighteen years were then asked if there was anything they thought would help parents to talk to their child/children about sexual matters (from a list of suggestions) (figure 3.12).

**Figure 3.12 Parental agreement that specific support resources would help parents to talk to their children about sexual matters (n=737)**



The most popular suggestions for support resources were leaflets/booklets (84%), parent meetings in the school/community (67%) and classes/training (65%). These findings suggest that while parents feel confident as sex educators of their own children, they would also welcome support to carry out this role. Studies have shown that parents can influence their children's sexual behaviour and contraceptive use through education (Dittus et al. 1999, Pistella and Bonati 1998).

### 3.5 Knowledge, attitudes and beliefs

#### 3.5.1 Attitudes to using contraception

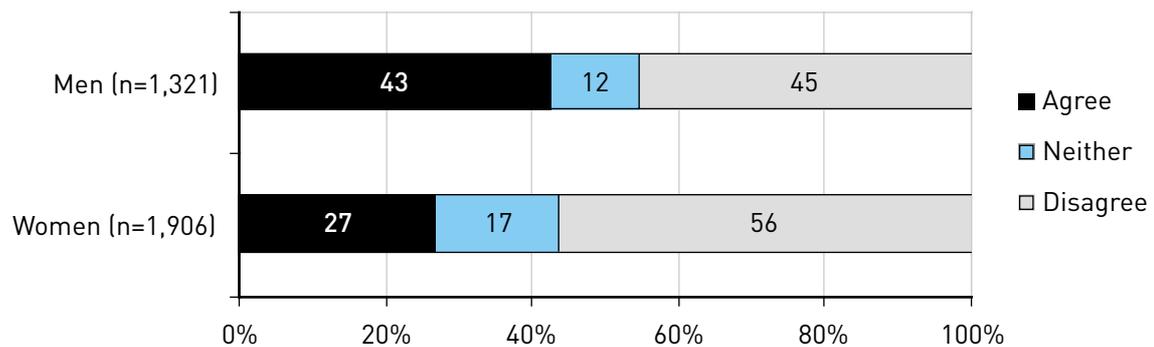
- 43% of men and 27% of women agreed that condoms reduce sexual pleasure.
- Half of participants (50%) agreed that the contraceptive pill has dangerous side effects, with older participants more likely to agree.
- Two-thirds (67%) of participants believed that taking a break from the contraceptive pill is a good idea, with older age groups more likely to agree.
- More women (38%) than men (23%) agreed that using the contraceptive pill (or their partner using it) did not appeal to them, with older participants more likely to agree.

Attitudes to contraception may be key precursors to choices concerning contraceptive use. The study aimed to assess attitudes that may serve as barriers to using two major forms of contraception: condoms and the contraceptive pill. Attitudes assessed were identified from previous research. Participants were asked their views on four statements relating to contraception. Since there were significant gender differences across all statements, results are displayed by gender. No social class differences were found across any of these statements.

In total, 35% (95% CI 32.4-37.7) of participants agreed that condoms reduce sexual pleasure. There was a significant gender difference, with 43% (95% CI 39.3-47.1) of men and 27% (95% CI 24.1-29.8) of women agreeing with the statement ( $p < 0.001$ ) (figure 3.13). There was also a significant difference across age groups, with 28% of 18-25 year olds agreeing, compared with 39% of 26-35 year olds and 37% of 36-45 year olds ( $p < 0.005$ ). Comparison of those who had used ( $n=1,495$ ) and had not used ( $n=1,349$ ) condoms in the last year established that those who had not used condoms were

significantly more likely to agree (41%) and less likely to disagree (44%) that condoms reduced sexual pleasure than those who had used condoms (32% agreement, 57% disagreement) ( $p < 0.001$ ). Thus, it is possible that a negative attitude towards using condoms influences behaviour in relation to actual condom use.

**Figure 3.13 Agreement with statement 'Condoms reduce sexual pleasure'**

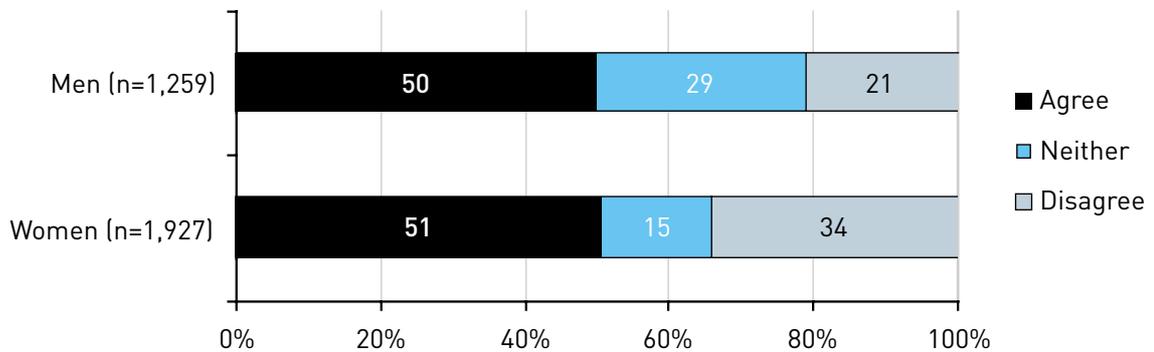


Over one-third of participants agreed that 'condoms reduce sexual pleasure'. Men were more likely than women to agree with this statement. A number of other studies support this finding (Mahon et al. 1998, Abraham et al. 1992). An awareness campaign that acknowledges this attitude but also presents the advantages of condom use, i.e. condoms prevent the spread of HIV/AIDS, prevent infection and prevent unwanted pregnancy, is needed. While a substantial number of participants agreed with the statement about condoms reducing sexual pleasure, only a very small minority (6% in the last year and on the most recent occasion of sexual intercourse reported that the reason for non-use of contraception was that they 'don't like contraception', 'methods are unsatisfactory' or 'partner doesn't like or won't use contraception'. However, UK research in this area has indicated that attitudes towards condoms do predict condom use (Sheeran et al. 1999).

Half (50%, 95% CI 47.4-53.0) of all participants agreed that the contraceptive pill has dangerous side effects, with significant gender difference ( $p < 0.001$ ) (figure 3.14). There was a significant difference across age categories, with older participants more likely to agree with the statement ( $p < 0.001$ ). Over a third (36%) of 18-25 year olds agreed with the statement, compared with 52% of 26-35 year olds and 62% of 36-45 year olds.

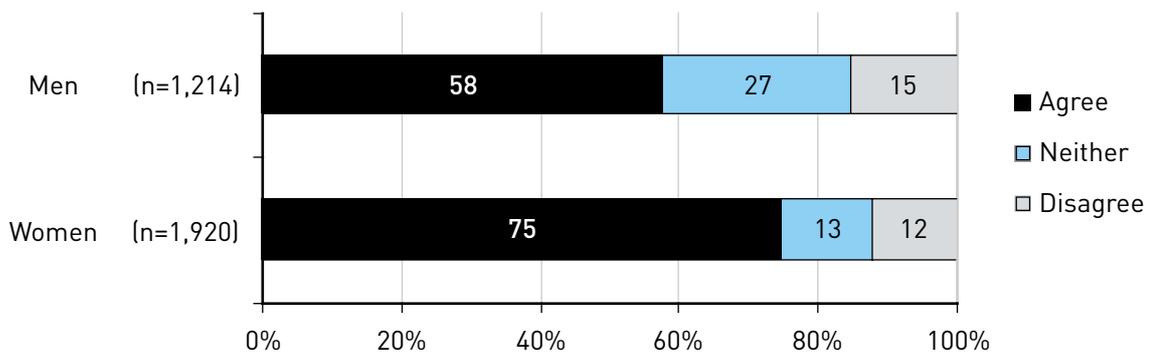
Significant differences were observed between those who had (or their partner had) used and those who had not used the contraceptive pill in the last year ( $p < 0.001$ ). Over half of those not using the contraceptive pill in the last year (57%) agreed that it has dangerous side effects, compared with 39% of those who had (or their partner had) used it in the last year. These findings support those identified in previous research showing that women often hold negative views regarding the contraceptive pill and tend to overestimate the risks associated with using it (Hansen and Skjeldestad 2003, Edwards et al. 2000, Tessler and Peipert 1997). However, the findings in relation to those using and not using the contraceptive pill, and also in relation to age differences, may to some extent reflect medical advice given to older women about risks and may also reflect their awareness of 'first generation' versions of the contraceptive pill, which had a higher side-effect profile than preparations used in more recent years.

Figure 3.14 Agreement with statement 'The contraceptive pill has dangerous side-effects'



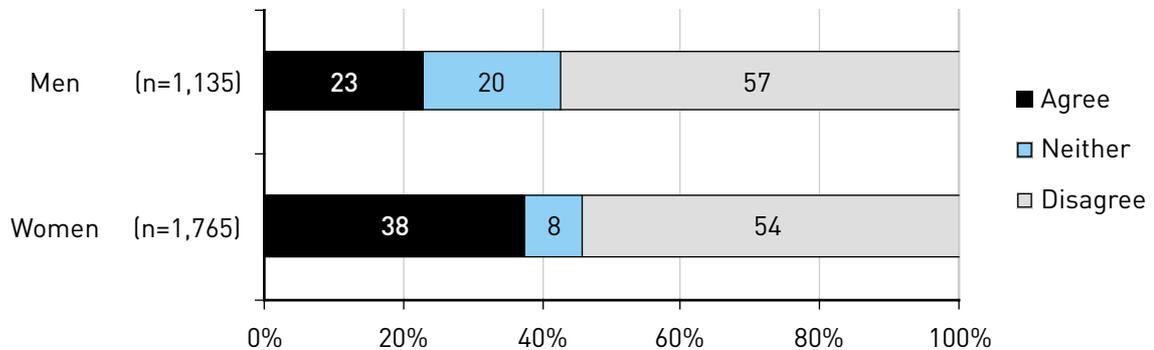
Two-thirds (67%, 95% CI 63.6-69.4) of participants agreed that taking a break from the contraceptive pill is a good idea, with more women (75%) than men (58%) agreeing ( $p < 0.001$ ) (figure 3.15). However, 27% of men said that they neither agreed nor disagreed with the statement, compared with 13% of women. Significant age differences were observed, with older groups more likely to agree ( $p < 0.001$ ). Nearly half (49%) of 18-25 year olds agreed, compared with 70% of 26-35 year olds and 80% of 36-45 year olds. Significantly more of those not using (or their partner not using) the contraceptive pill in the last year (72%) agreed that taking a break from long-term use was a good idea, compared with those using the contraceptive pill in the last year (64% agreement) ( $p < 0.005$ ).

Figure 3.15 Agreement with statement 'Taking a break from the long-term use of the contraceptive pill is a good idea'



Nearly one-third (31%, 95% CI 28.2-33.4) of participants felt that using the contraceptive pill (or their partner using it) did not appeal to them, with more women (38%) agreeing with the statement than men (23%), and more men (20%) neither agreeing nor disagreeing with the statement than women (8%) ( $p < 0.001$ ) (figure 3.16). There was a significant difference across age groups ( $p < 0.001$ ), with 21% of 18-25 year olds agreeing with the statement, 32% of 26-35 year olds agreeing and 39% of 36-45 year olds agreeing. Thus the contraceptive pill is less appealing as an option for older groups.

**Figure 3.16 Agreement with statement ‘(My partner) taking the contraceptive pill doesn’t appeal to me’**



Additionally, there were significant differences across relationship status, with 40% of married participants agreeing that using the contraceptive pill (or their partner using it) did not appeal to them, compared with 28% of cohabiting, 24% of those in a steady relationship, 24% of those in a casual relationship and 23% of those not in a relationship. No significant differences in attitude were found for those who felt that pregnancy would be a positive outcome, a negative outcome or neither positive or negative. Interestingly, 12% of those who had used the contraceptive pill in the last year agreed that it did not appeal to them, compared with 43% of those who had not used the contraceptive pill in the last year ( $p < 0.001$ ). There were significant differences across educational levels ( $p < 0.001$ ), with 38% of the pre-Leaving Certificate group agreeing with the statement, compared with 27% of Leaving Certificate level and 30% of post-Leaving Certificate level.

Overall, while condom use was associated with reduced pleasure for a third of the sample, a third also reported that the contraceptive pill was not appealing as a contraceptive option. There were also concerns over possible health effects of contraceptive pill use. These findings suggest that different contraceptive options will be more or less appealing to different individuals. No one contraceptive option appears to be acceptable for most people.

Older age groups (age 36-45 years) were more likely to agree that taking a break from the contraceptive pill is a good idea (80%), that the contraceptive pill has dangerous side effects (62%), that condoms reduce sexual pleasure (37%) and that taking the contraceptive pill did not appeal to them (39%). These findings, in conjunction with the findings that older people were less likely to use any method of contraception in the last year (including condoms and the contraceptive pill) suggest that older age groups have particular problems with the most common and accessible forms of contraception.

### 3.5.2 Social context of contraceptive use

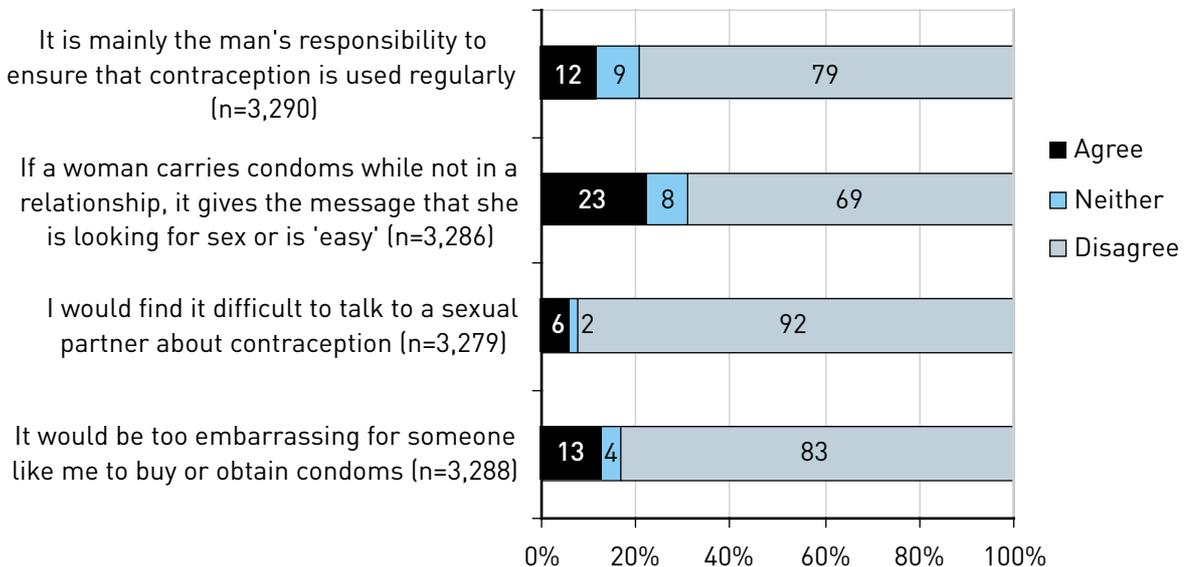
- Most participants (79%) disagreed that it is mainly the man’s responsibility to ensure that contraception is used regularly, with more men (19%) than women (7%) agreeing.
- Nearly one-quarter (23%) of participants agreed that if a woman carries condoms while not in a relationship, it gives the message that she is looking for sex or is “easy”.

- Very few participants (6%) agreed that they would find it difficult to talk to a sexual partner about contraception, with the majority (92%) disagreeing.
- Most participants (83%) disagreed with the statement that 'it would be too embarrassing for someone like me to buy or obtain condoms'.

A very important aspect of contraceptive practice is how it is planned for and negotiated between sexual partners. A set of statements concerning responsibility for and implications of planning and negotiating contraceptive use were evaluated. First, the issue of responsibility for contraceptive use was considered. Most participants (79%, 95% CI 76.1-81.3) disagreed with the statement 'It is mainly the man's responsibility to ensure that contraception is used regularly' (figure 3.17). There were significant gender differences ( $p < 0.001$ ), with 19% of men agreeing with the statement compared with 7% of women, and 69% of men and 88% of women disagreeing with the statement. While there were no significant age differences, significant differences were observed across educational levels ( $p < 0.001$ ), with pre-Leaving Certificate level less likely to disagree with the statement (71% disagreement), than Leaving Certificate level (80% disagreement) or Post-Leaving Certificate (83%). Similarly, while those in the highest social class showed high levels of disagreement (85%), and those in social classes II-V showed only slightly lower levels of disagreement (ranging between 75% and 80%), only 69% of participants in social class VI disagreed ( $p < 0.001$ ). Collapsing social classes into a higher and lower class categorisation again produced significant differences, with 82% disagreement among higher classes and 76% disagreement among lower classes ( $p < 0.0005$ ).

Possible implications of perceived contraceptive planning for new sexual encounters were considered. An important consideration for individuals is the social context of pro-contraceptive behaviour. Nearly one-quarter (23%, 95% CI 20.7-25.2) of participants agreed that if a woman carries condoms while not in a relationship, it gives the message that she is looking for sex or is "easy" (figure 3.17). There were no significant gender or age differences, or differences between those having used and not used condoms in the last year. However, there were significant differences across educational level, with 30% of pre-Leaving Certificate level participants agreeing with the statement, compared with 23% of Leaving Certificate level and 19% of post-Leaving Certificate level participants ( $p < 0.005$ ). There were also significant differences across relationship status, with 21% of married, 19% of cohabiting and 21% of those in a steady relationship agreeing with the statement; 39% of those in a casual relationship and 25% of those not in a relationship agreed ( $p < 0.005$ ). This group, who had only recently met a partner or who were in a casual relationship, were least likely to report using contraception at the most recent experience of sexual intercourse. This suggests that those most likely to encounter new partners and to start up new relationships are also those whose views could be seen as most judgemental of proactive sexual protection practices. This finding differs considerably from a British survey, where a large majority of participants (84%) reported that they believed that women who carry condoms are sensible and responsible; only 5% believed that women carrying condoms were promiscuous and 4% believed they were 'experienced' (Durex 2002).

**Figure 3.17 Agreement with statements relating to responsibility and efficacy in contraceptive use**



The issue of embarrassment or difficulty in obtaining contraceptives or in negotiating contraception was also examined. Very few participants (6%, 95% CI 4.7-7.8) agreed that they would find it difficult to talk to a sexual partner about contraception, with the majority (92%) disagreeing, and the remainder neither agreeing nor disagreeing (figure 3.17). No significant differences across gender or age group were observed. Significant differences existed across educational level, with 13% of pre-Leaving Certificate level participants in agreement with the statement, compared with 4% and 3% of Leaving and post-Leaving Certificate level respectively ( $p < 0.001$ ). While few participants who were married, cohabiting or in a steady relationship agreed with the statement (4%, 2% and 3% respectively), those in a casual relationship or not in a relationship showed higher levels of agreement (7% and 10% respectively) ( $p < 0.001$ ). There were also significant social class differences, with only 1% agreement among the highest social class (social class I) and 5%-6% agreement among social classes II-IV, compared with 9% and 16% agreement among social classes V and VI respectively ( $p < 0.001$ ). Analysis of a simple lower and higher social class categorisation again highlighted significant differences, with 8% agreement in lower social classes and 4% agreement in higher classes ( $p < 0.005$ ).

While the majority of participants said they would not find it difficult to talk to a sexual partner about contraception, the following participants were significantly more likely to expect this to be difficult:

- those with lower levels of educational attainment
- those in a casual relationship or not in a relationship
- those in lower social classes (classes V-VI).

Again, these results need to be considered in conjunction with the earlier finding that participants with lower levels of education and in lower social classes were more likely to report not having used contraception during their most recent experience of sexual intercourse. Educational initiatives need to be more cognisant of educational level/social class as a factor influencing the ability to negotiate in sexual situations. Feeling

confident about being able to talk to a sexual partner about contraception is an important issue to consider when trying to improve contraceptive use. Confidence did not differ by gender. This is a particularly important and positive finding. Relationship power has previously been found to be an important factor in whether or not contraception is used (Pulerwitz et al. 2002).

Most participants (83%, 95% CI 80.5-84.5) also disagreed with the statement that 'it would be too embarrassing for someone like me to buy or obtain condoms' (figure 3.17), with no significant differences across gender or age. There were, again, significant differences across educational level, with those participants with pre-Leaving Certificate level education less likely to disagree with the statement (75% disagreement), than Leaving (86% disagreement) or post-Leaving Certificate (85% disagreement) educational level ( $p < 0.001$ ). Additionally, there were significant differences across social classes. Disagreement was highest (87%) in social class I, with similar levels of disagreement among social classes II-V (ranging between 81% and 85%) but only 70% disagreement in social class VI ( $p < 0.05$ ). There was a trend ( $p = 0.06$ : non-significant) towards higher agreement (13%) among those who had not used condoms in the last year, compared with 10% agreement among participants who had used condoms in the last year, suggesting that this attitude towards obtaining condoms may affect actual condom usage to some extent.

### 3.5.3 Knowledge of fertility

- 54% of participants correctly identified the most fertile time in the female menstrual cycle (about half way between menstrual periods), with women and older participants more likely to respond correctly.
- A substantial proportion of female participants (35%) could not identify when they were most likely to become pregnant during the menstrual cycle.

Knowledge is clearly a fundamental precursor to effective contraceptive practices. This can be difficult to assess extensively and in a non-threatening manner in public surveys. One important knowledge item concerning female fertility was included in the study. This item was included in a 1993 study of Irish women (Wiley and Merriman 1996) and, as such, can provide a comparison of knowledge levels over time. All participants in the present study were asked at what time of the month they thought a woman is most likely to become pregnant. In total, 54% correctly identified the most fertile time as about half way between menstrual periods, with significant gender differences between correct and incorrect responses ( $p < 0.001$ ) (table 3.20).

**Table 3.20 Knowledge about time (during menstrual cycle) when a woman is most likely to become pregnant**

<b>A woman is most likely to become pregnant:</b>	<b>Men n=1,352 %</b>	<b>Women n=1,955 %</b>	<b>Total n=3,307 %</b>
During her period	4	1	2
Just before her period	12	11	11
Just after her period	17	14	16
* About half way between periods	42	65	54
Don't know/ Not sure	25	9	17

\* *Most accurate answer*

Knowledge of fertility times among women was investigated further. Significant differences in women's knowledge were observed across age groups, with 57% of 18-25 year olds correctly identifying the most fertile time, compared with 67% of 26-35 year olds and 71% of 36-45 year olds ( $p < 0.001$ ). Similarly, there were significant educational level differences in women's knowledge, with 56% of pre-Leaving Certificate level participants correctly identifying the most fertile time, 59% of Leaving Certificate level participants and 75% of post-Leaving Certificate level participants identifying the correct time ( $p < 0.001$ ). Additionally, 72% of participants from higher social classes and 58% from lower social classes identified the most fertile time ( $p < 0.001$ ).

A substantial proportion of female participants could not identify when they were most at risk of becoming pregnant during the menstrual cycle. This is particularly worrying in light of the number of older persons who say that they practise the 'safe-period' method and those who indicate a casual approach towards using this method. Wiley and Merriman (1996), in their 1993 survey, found that between one-third and one-quarter of women across different age groups did not know that a woman is most likely to get pregnant in the middle of her cycle. As a result they recommended:

In particular, it would seem essential to ensure that sex education programmes aimed at post pubescent girls specifically address all issues arising with regard to the risk of becoming pregnant (Wiley and Merriman 1996: 42).

Ten years later, this study has found that knowledge concerning fertility (specifically when it is most likely for a woman to become pregnant during her cycle) has worsened. Table 3.21 outlines the comparisons by age categories across the studies. There is a higher level of inaccuracy in the 2003 sample compared with 1993. Provision of this basic biological information may need to receive a stronger focus in sex education initiatives. As with the findings of Wiley and Merriman (1996), this study found a relationship between educational attainment and perceived likelihood of pregnancy. Only 45% of pre-Leaving Certificate level participants could correctly identify the fertile time, compared to 62% of post-Leaving Certificate Level participants. Only 48% of participants from the lower social classes could identify the most fertile time in a woman's menstrual cycle.

**Table 3.21 Knowledge concerning fertility (time during menstrual cycle a woman is most likely to become pregnant)**

Age (years)	Wiley & Merriman (1996) [sample 1993 – women] n=2,988 % incorrect/don't know	ICCP (2004) [sample 2003 – women] n=1,955 % incorrect/don't know	Age (years)
18-24	33.0	43.4	18-25
25-29	18.2	32.7	26-35
30-34	21.7		
35-39	17.4		
40-44	21.1	28.6	36-45
<b>Total</b>	<b>23.1</b>	<b>34.6</b>	<b>Total</b>

These findings provide the basis for targeting information programmes to those whose current levels of information are lowest and least adequate. Given the extent of the knowledge deficit, it may be necessary to launch a broad campaign to educate the Irish public about such a basic factor concerning contraception and pregnancy.

### 3.6 Crisis pregnancy

#### 3.6.1 Crisis pregnancy services

- Almost half of participants (47%) indicated that the preferred way to find out information about crisis pregnancy services was face-to-face or one-to-one. Over a quarter of participants (28%) felt that telephone/helpline was the preferred source of information.

In terms of making information on crisis pregnancy both available and accessible, it is important to consider public preferences for receiving information given the range of possible technologies now available. Participants were asked about their preferences. Almost half (47%) of participants indicated that the preferred way to find out information about crisis pregnancy services was face-to-face or one-to-one. Face-to-face/one-to-one information-giving was preferred more by women (51%) than by men (43%). Over a quarter (28%) of participants felt that telephone/helpline was the preferred source of information. More men (14%) than women (9%) indicated that the Internet was the preferred method of sourcing information on crisis pregnancy. Other paper or electronic media were preferred by a very small percentage of the population (table 3.22).

**Table 3.22 Preferred ways of finding information on crisis pregnancy services**

	<b>Men n=1,326 %</b>	<b>Women n=1,914 %</b>	<b>Total n=3,240 %</b>
Face-to-face/one-to-one	43	51	47
Telephone/Helpline	26	30	28
E-mailing	3	3	3
Dedicated website/internet	14	9	11
Leaflet	4	3	4
Teletext	1	1	1
Text messaging	1	1	1
Other	<1	<1	<1
Don't Know	9	4	6
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>

Since the number of participants in most of these categories was small, the three major categories of preference (face-to-face/one-to-one, telephone/helpline and website/internet) were further analysed by age group, social class and household location (n=2,486). These demographic variables can be used to target this information more accurately to specific groups. There were significant age-group differences ( $p < 0.005$ ), with older participants preferring face-to-face routes (18-25 year olds: 49%; 26-35 year olds: 53%; 36-45 year olds: 60%). Younger participants preferred the website/internet option (18-25 year olds: 16%; 26-35 year olds: 14%; 36-45 year olds: 9%), and there was little difference across the telephone/helpline route (18-25 year olds: 35%; 26-35 year olds: 33%; 36-45 year olds: 30%).

An interesting social class difference was observed: 18% of social class I, 16% of social class II and 11/12% of social classes III-V preferred the website/internet route for information on crisis pregnancy services, compared with 7% of social class VI. A further higher/lower social class analysis showed significant variation in preferences across higher and lower social classes ( $p < 0.05$ ). Again, more participants from higher social classes preferred the internet/website route (15% vs. 10%), with slight differences in preference for telephone/helpline (higher classes: 31%; lower classes: 34%) and for face-to-face (higher classes: 54%; lower classes: 56%). There were no significant differences across household location.

Research carried out in 2002 by Lansdowne Market Research, on behalf of the CPA, found that 69% of respondents, if looking for information on crisis pregnancy services, preferred to receive this information by face-to-face or one-to-one counselling. This was followed by 47% indicating that a telephone helpline was the most appealing medium.

### 3.6.2 Crisis pregnancy information - "Positive Options" campaign

- A minority of all participants (23%) had seen or heard advertising for the Positive Options campaign. However, a larger percentage (36%) of the agency's target group (18-30-year-old women) had seen or heard advertising or promotions for Positive Options.
- Half of participants (52%) thought that counselling or advice for women with a crisis pregnancy would be available if they contacted the Positive Options service, followed by 40% reporting the most accurate response (a list of crisis pregnancy agencies).

When a crisis pregnancy occurs many decisions have to be made. A range of support services exists to support women (and their partners or families) in considering their options and reaching a decision about how to manage their situation. Despite this, many people report lack of access to information or support at crucial times during the pregnancy. One of the aims in establishing the Crisis Pregnancy Agency (CPA) in Ireland was to facilitate those experiencing a crisis pregnancy by making available information on pregnancy counselling agencies. The CPA has done this by developing a media campaign called 'Positive Options'. The 'Positive Options' campaign offers a list of crisis pregnancy agencies that provide support for women with a crisis pregnancy. This list is available through a free text-messaging service.

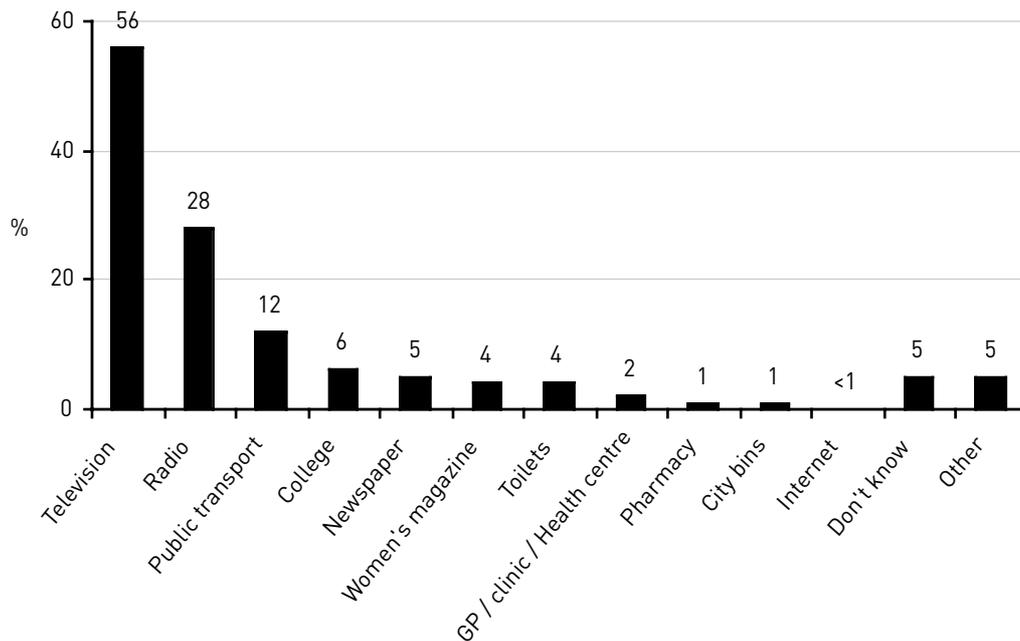
Information was collected on the CPA 'Positive Options' advertising campaign. Of all participants answering the question (n=3,305), one-quarter (23%, 95% CI 21.2-25.6) had heard or seen advertisements or promotions for 'Positive Options'. Women were more likely than men to have seen or heard advertising for 'Positive Options' (29% women vs. 18% men) ( $p < 0.001$ ). More 18-25 year olds (29%) had seen or heard advertising or promotions than 26-35 year olds (22%) and 36-45 year olds (20%) ( $p < 0.005$ ). Significant differences were observed between educational levels, with more participants with post-Leaving Certificate (28%) or Leaving Certificate (24%) education having seen or heard advertising or promotions than pre-Leaving Certificate (16%) level ( $p < 0.001$ ).

Regression analysis further clarified the association between gender, age and education. Using pre-Leaving Certificate level as a baseline, this group was significantly less likely than Leaving (OR 1.41, 95% CI 1.01-1.98,  $p < 0.05$ ) or post-Leaving level participants (OR 1.83, 95% CI 1.28-2.60,  $p = 0.001$ ) to have seen or heard advertising for 'Positive Options'. Younger participants were more likely to have seen or heard advertising, with a significant increase in likelihood for every increase in year of birth (i.e. decrease in age) (OR 1.02, 95% CI 1.01-1.04,  $p = 0.001$ ). Men were approximately half as likely as women to have seen or heard advertising (OR 0.54, 95% CI 0.42-0.71,  $p < 0.001$ ).

A minority of all participants (23%) had seen or heard advertising for the Positive Options campaign. However, the target group for the Positive Options advertising campaign was 18-30 year old women. A larger percentage of this target group (36%) had seen or heard advertising or promotions for Positive Options. Alternatively, 19% of men in the target age group of 18-30 years reported campaign awareness.

Figure 3.18 shows the location of advertising and promotions seen or heard (percentages are of total participants reporting having seen or heard advertising or promotions: n=811). Over half (56%) of those who had seen advertisements or promotions saw them on television. There were no significant differences between the target group and other participants in the location of advertising and promotions seen or heard.

**Figure 3.18 Location of advertising and promotions for 'Positive Options' seen by participants (n=811)**



Participants who had heard of 'Positive Options' (n=811) were asked what information or services they would expect to be available from the 'Positive Options' service. Participants could specify a number of options, so percentages are of total participants who were asked the question. Many of those who had heard about 'Positive Options' believed that services would be directly available from the CPA; half (52%) thought that counselling or advice for women with a crisis pregnancy would be available, with 57% of the target group of 18-30-year-old women expecting this to be available (table 3.23). The next most frequent response was the list of crisis pregnancy agencies (40% overall; 41% of the female, 18-30-year-old group). This is the response most accurately reflecting the role of the CPA as described by the Positive Options campaign. A clear discrepancy exists between what people think the Positive Options campaign provides and what it actually offers.

These findings point to a number of issues, which need to be addressed in relation to the Positive Options campaign:

- A minority of the population had heard or seen the campaign.
- Television seems to be the most effective of the advertising media used.
- While 'Positive Options' offers a route to a range of counselling services by providing information, many participants who have heard or seen the campaign assume that Positive Options is itself a counselling service.
- Face-to-face was cited as the most appealing way to receive information on crisis pregnancy services, with text messaging appealing least.

**Table 3.23 Information and services participants expected to be available from the 'Positive Options' service**

	<b>Women 18-30 (target group) n=276 %</b>	<b>Men 18-30 n=114 %</b>	<b>Total n=811 %</b>
<b>Contacts</b>			
List of crisis pregnancy agencies that provide support for women with crisis pregnancy*	41	40	40
<b>Information</b>			
Information on pregnancy tests	9	9	11
Information on general pregnancy health services	15	15	17
Information on a specific pregnancy agency	13	10	12
Adoption information	16	7	14
Abortion information	21	9	19
Fostering information	6	7	8
Information on parenting/keeping infant	12	10	12
Post-abortion medical information	9	3	8
<b>Counselling</b>			
Counselling or advice for women with a crisis pregnancy	57	47	52
Post-abortion counselling	9	3	8
<b>Don't know</b>	<b>7</b>	<b>12</b>	<b>12</b>
<b>Other</b>	<b>19</b>	<b>9</b>	<b>16</b>

\* These services are provided by Positive Options

Two similar small-scale surveys were conducted with women aged 18-30 years (the CPA target group) by Lansdowne Market Research in May/June 2003 (n=389) and October/November 2003 (n=378). Between these time periods, awareness of advertisements or promotions for crisis pregnancy services increased from 60% to 70%. When asked if they could recall seeing or hearing any advertising specifically for Positive Options, 34% of those surveyed in mid-2003 said yes. This increased substantially to 65% by late 2003. (This larger survey sampled the population between these time points – from October 2003 to January 2004- with 36% of the target group having heard about the campaign.) The late 2003 Lansdowne Market Research findings showed that the majority of respondents recalled seeing this advertising on TV. Both Lansdowne Market Research surveys asked respondents to indicate what they would expect to be available from the Positive Options service. Without being prompted or being given a list of options, half the respondents from both surveys reported that they expected that counselling or advice for women with a crisis pregnancy would be available. A larger percentage of respondents

in late 2003, (52%) stated the correct response (i.e. that the service provided a contact list, rather than providing services themselves) compared with 34% of respondents in mid-2003 (findings based on a spontaneous response to an open question).

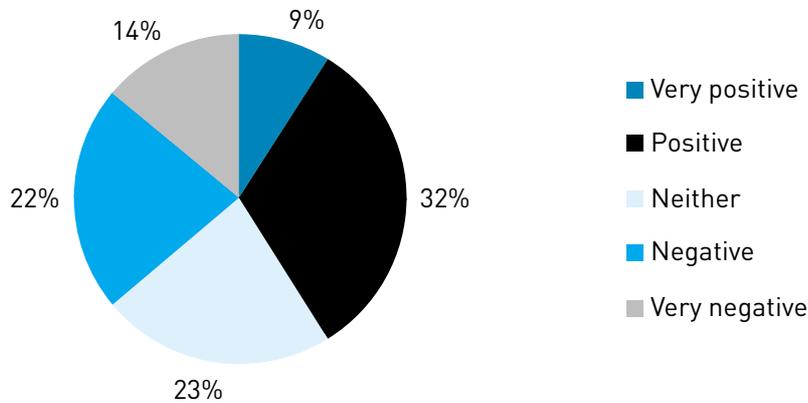
In-service evaluation is needed to determine whether misunderstandings concerning the nature of the service offered are problematic. It may be the case that a single contact point (such as Positive Options), which can clearly ascertain the type of service the person requires and then refer them to appropriate services in appropriate geographic locations, is quite acceptable. An information service to guide potential counselling-service users may be an efficient use of resources where many services already exist and where access, not service availability, is the challenge. On the other hand, a substantial number of women will make a first service contact at a time of considerable distress and confusion. In other parallel areas, such as services for childhood abuse (the National Counselling Service), a freephone system for enquiries and making appointments is offered. This halfway system of one-to-one contact, but without providing telephone counselling, has been found, in service evaluation, to be highly valued by service users (Leigh, Rundle, McGee and Garavan 2003).

### 3.6.3 *Current attitudes to pregnancy*

- 41% felt it would be positive or very positive if they or their partner became pregnant now, despite being unplanned.
- Most of those at risk of pregnancy (70%) stated that the most likely outcome of an unplanned pregnancy would be parenthood, with 2% stating adoption and 4% abortion.

General attitudes to becoming (or having a partner become) pregnant at the present time were assessed. Individual willingness to become pregnant or acceptance of a potential pregnancy may influence contraceptive choices. In total, 4% of participants (or their partner) were pregnant at the time of interview, with a further 4% trying to become pregnant. All other participants were then asked what their response would be (very positive to very negative) if they (or their partner) became pregnant now. Of those participants who answered the question and who felt it applied to them (n=2,788), 41% felt it would be positive or very positive if they or their partner became pregnant now (even though it was unplanned) (figure 3.19). Previous research has shown that not all unplanned pregnancies are crises or unwanted. This positive or benign attitude towards an unplanned pregnancy may also impact on choice of outcome in the event of an unplanned or unwanted pregnancy. There are no comparative international figures on this issue. Intuitively, the percentage who said they would view pregnancy as a positive outcome, despite it being unplanned, seems high. Ireland, despite falling fertility rates, still has the highest fertility rate in Europe. It may be that attitudes to pregnancy and parenthood here are more positive than elsewhere.

Figure 3.19 Rating of response to pregnancy if participant (or partner) became pregnant at this time (n=2,788)



Participants were then asked which outcome they thought would be the most likely if they were to experience an unplanned or unwanted pregnancy (even if it was unlikely that this would happen). Participants who were unable to conceive (those who were sterilised, infertile, etc.) were excluded from this question. Of the remaining participants who answered the question, most (70%) thought the most likely outcome would be parenthood; 2% thought adoption, and 4% thought abortion would be the most likely outcome. However, 24% were unsure or unable to say what the most likely outcome would be. There were significant differences across age groups ( $p < 0.001$ ) (figure 3.20).

Figure 3.20 Most likely outcome of an unplanned or unwanted pregnancy at this time

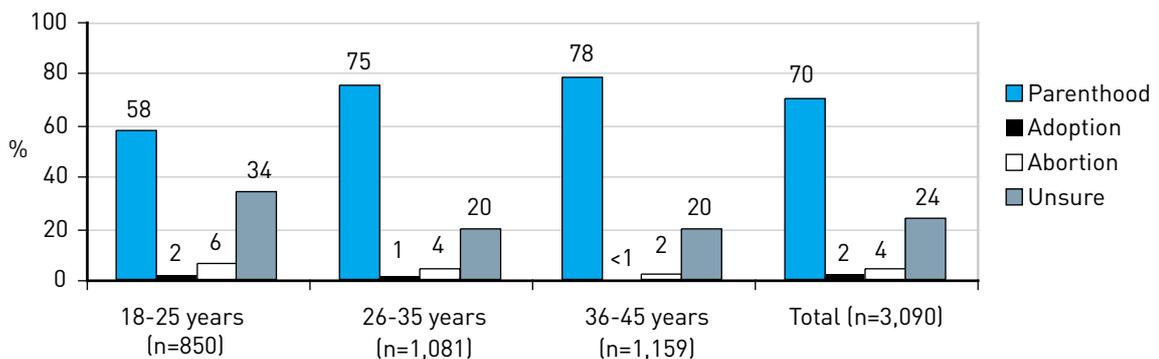


Figure 3.20 illustrates that significantly more participants in the 26-35-year-old category (75%) and in the 36-45 year-old category (78%) chose parenthood as the likely outcome of a crisis pregnancy, compared with 58% of 18-25 year olds. Alternatively, more (34%) 18-25 year olds were unsure of, or unable to state the likely outcome of a crisis pregnancy than 26-35 year olds (20%) or 36-45 year olds (20%). There were significant employment-status differences, with 72% of employed, 75% of unemployed and 80% of home duties participants choosing parenthood as the most likely outcome, compared with 48% of students choosing parenthood. Instead, 9% of students chose abortion as the most likely outcome, compared with 4% of employed, 2% of unemployed, and 3% of those on home duties ( $p < 0.001$ ).

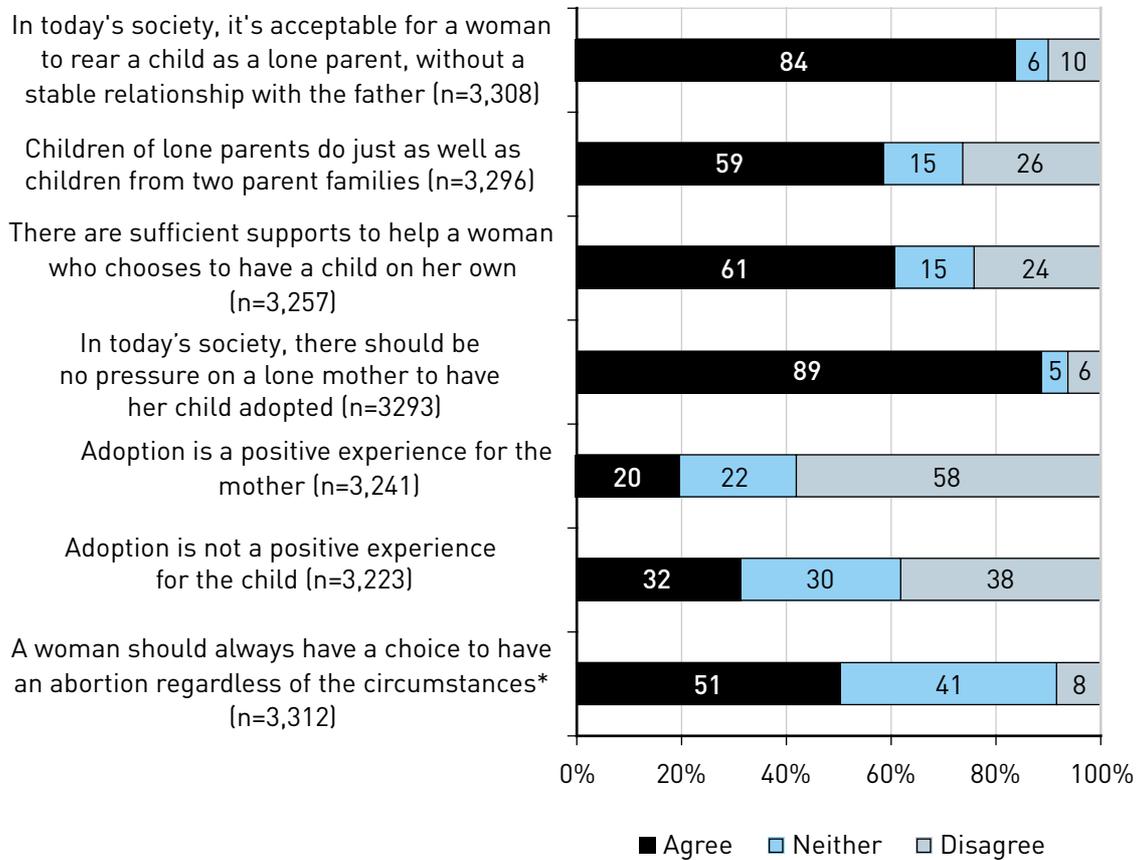
It is interesting that almost a quarter of participants (24%) were unsure about the outcome they would be most likely to choose; younger participants were more likely to say that they were unsure of a possible outcome (34%). As women in this age group (age 18-25 years) are those most likely to travel to Britain for an abortion, it may be reasonable to extrapolate that quite a proportion of those who are unsure may choose abortion in the event of an unplanned/unwanted pregnancy.

#### 3.6.4 Attitudes to outcomes of crisis pregnancy

- 84% of participants agreed that in today's society it is acceptable for a woman to rear a child as a lone parent, without a stable relationship with the father.
- Over half of participants (59%) agreed that children of lone parents do just as well as children of two-parent families, with 26% disagreeing.
- 61% agreed that there are sufficient supports to help a woman who chooses to have a child on her own.
- A large majority (89%) agreed that in today's society there should be no pressure on a lone mother to have her child adopted.
- 20% of participants agreed that adoption is a positive experience for the mother, with 58% disagreeing with the statement.
- One-third of participants (32%) agreed that adoption is not a positive experience for the child, with 38% disagreeing with the statement.
- Half of participants (51%) thought that a woman should always have a choice to have an abortion, regardless of the circumstances.
- Two-thirds of participants (68%) knew someone personally who had experienced a crisis pregnancy; 58% knew someone who had experienced a crisis pregnancy and kept the baby, 6% knew someone who had had the baby adopted and 24% knew someone who had had an abortion.

Public attitudes to aspects of crisis-pregnancy outcomes were assessed to evaluate the acceptability of alternative outcomes. Lone parenting, adoption and abortion are seen as the main options available to those with crisis pregnancy, and they are the focus of most pregnancy counselling activities. It is important to gauge current public opinion on each of these options in order to inform policy about the focus needed in the work of crisis pregnancy services. Furthermore, the impact of planned initiatives and/or other societal changes on these options can only be determined by comparison with a profile of contemporary attitudes. Thus, participants were asked their views on a list of statements relating to different outcomes of pregnancy (figure 3.21).

Figure 3.21 Attitudes to crisis pregnancy/lone parenting outcomes



\* For this question 'neither' refers to those who felt that abortion should only be available in certain circumstances (39%) and those who did not know/had no opinion (2%).

The majority (84%) of participants agreed that in today's society it is acceptable for a woman to rear a child as a lone parent, without a stable relationship with the father. There were small but significant gender differences, with more women (87%) than men (80%) agreeing with the statement (p<0.0005).

Most participants (59%) agreed with the statement 'Children of lone parents do just as well as children of two-parent families', with 26% disagreeing. Significantly more women (66%) than men (51%) agreed with the statement (p<0.0001). Additionally, there were significant differences across age groups, with 18-25 year olds more likely to agree (63%) than 26-35 year olds (60%) or 36-45 year olds (53%) (p<0.01).

The majority (61%) agreed that 'there are sufficient supports to help a woman who chooses to have a child on her own', with no gender differences. A large majority (89%) agreed that in today's society there should be no pressure on a lone mother to have her child adopted, with no gender differences in attitude.

Only 20% of participants agreed that adoption was a positive experience for the mother, with 58% disagreeing with the statement, and no gender differences observed. There were significant age differences, with older (36-45 year olds) and younger (16-25 year olds) age cohorts less likely to agree with the statement (17% in each cohort) than 26-35 year olds (24% agreement) (p<0.01). Significant differences across educational level were

observed, with 27% of pre-Leaving, 19% of Leaving and 17% of post-Leaving Certificate level participants in agreement with the statement ( $p < 0.0001$ ). While no significant differences across social classes I-VI were observed, there was a significant difference in a higher and lower social class divide, with 18% of higher and 23% of lower social classes agreeing that adoption is a positive experience for the mother. In terms of the experiences of adoption for the child, one-third (32%) of participants agreed that adoption is not a positive experience for the child, with 38% disagreeing with the statement.

Previous research has found that stigma and secrecy may be experienced by those faced with an unplanned or unwanted pregnancy, particularly if the pregnancy is outside of marriage (Mahon et al. 1998). Positive attitudes were reported across all aspects relating to lone parenthood, with 84% of participants agreeing that, 'in today's society, it is acceptable for a woman to rear a child alone without in a stable relationship with the father'. This positive attitude may reflect changing social norms, as one-third of all births in Ireland today are outside of marriage. Participants were less likely to agree that lone parents receive sufficient supports (61%). Although a majority felt that children from lone-parent families do just as well as children from two-parent families, a substantial minority (26%) disagreed. Attitudes towards adoption were viewed in a substantially less favourable light, with over half of participants (58%) disagreeing that adoption was a positive experience for the mother and 32% of participants agreeing that it was not a positive experience for the child. Again this attitude is paralleled by actual numbers of women choosing to have a child adopted. In 1955, 63.7% of all non-marital births resulted in adoption compared to only 1.4% in 2002 (An Bord Uchtála 2002).

Participants were next asked about their attitudes towards abortion. The questions were adapted from the Third Report of the Second Joint Committee on Women's Rights, which investigated 'Attitudes towards Moral Issues in Relation to Voting Behaviour in Recent Referenda' (Fine-Davis 1988). This reported on a study involving interviews with 600 members of the general public, aged 18 to 65 years (300 Dublin residents and 300 living in rural Ireland) in 1986. The sample population was based on stratified quotas by age, gender and urban/rural location and was subsequently weighted to match the general population in Ireland at the time. The replication of these questions in the present study provided an opportunity to measure any changes in attitudes to abortion across time. In the 1986 study, over one-third of participants (38%) indicated that they believed abortion was not permissible under any circumstances while 58% felt that it should be allowed under certain circumstances. Four percent did not express a view.

In the present study, the question was extended to include the option that a woman 'should always have a choice to have an abortion, regardless of the circumstances'. In the 2003 sample, 8% of participants felt that abortion was not permissible under any circumstances, while 39% felt that it should be allowed under certain circumstances. 51% felt women should always have a choice to have an abortion and 2% were unsure (figure 3.21). Thus, a notable change in attitudes towards abortion was observed over the seventeen-year period (1986-2003), with a substantially higher proportion of the population supporting a choice of abortion in some or all circumstances in the more recent survey (table 3.24). No significant gender differences in attitudes were found in either study. The present study was not in a position to identify factors that may have contributed to these attitude changes. Media attention and public debate concerning some high profile abortion court cases and an abortion referendum in 2002 are possible

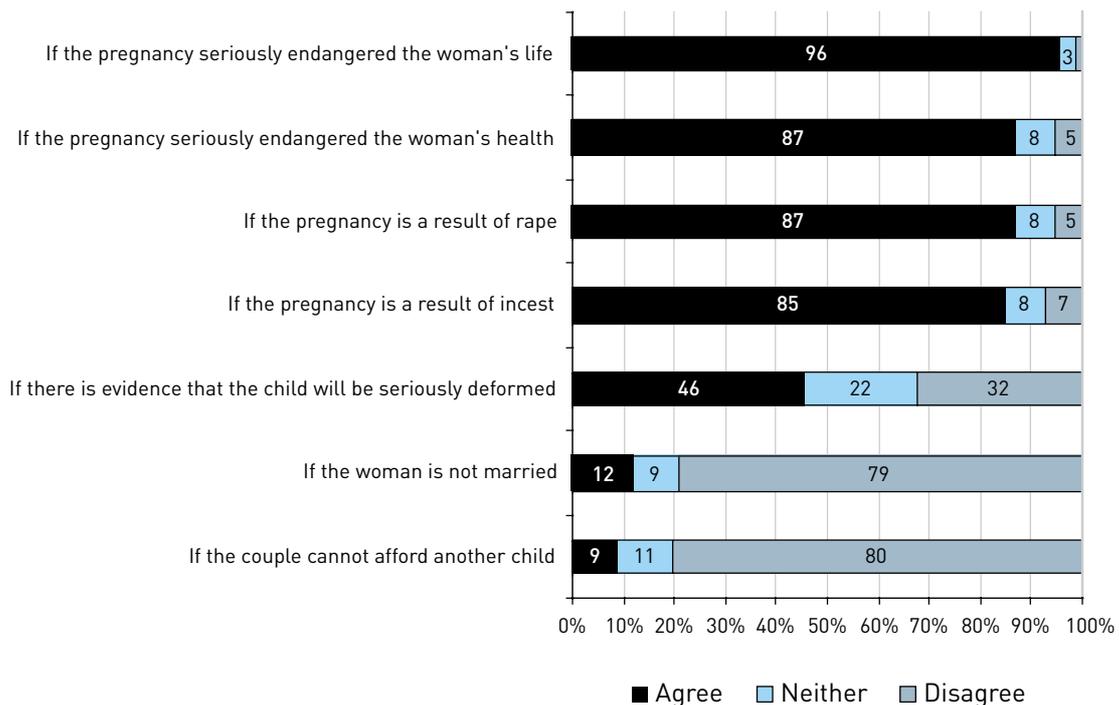
contributors to a change in attitude to abortion. (The 1986 survey was conducted three months after the previous abortion referendum.)

**Table 3.24 Public attitudes to abortion (1986 and 2003)**

	<b>1986 (Fine-Davis 1988) n=600 % agreement</b>	<b>2003 (ICCP Study 2004) n=3,312 % agreement</b>
Abortion not permissible in any circumstances	38	8
Abortion permissible under some circumstances	58	39
Abortion permissible in all circumstances	NA	51
No opinion/don't know	4	2

Since it was anticipated that many would hold qualified views concerning the acceptability of abortion, circumstances in which abortion would be considered more or less acceptable were queried (questions adapted from Fine-Davis 1988). Information on this issue can further inform the CPA's policy of reducing abortion as an outcome of crisis pregnancy and, as outlined previously, provide a baseline against which to assess attitudes and attitude change in the future. For those participants who thought that a woman should have a choice in certain circumstances, or who did not know, a list of possible circumstances were outlined. Participants were asked whether they agreed or disagreed that a woman should have a choice to have an abortion in each circumstance (figure 3.22).

**Figure 3.22 Participant views on circumstances in which a woman should have a choice to have an abortion\* (n=1,297)**



\* Sample excludes those who believe women should never (8%) or always (51%) have a choice.

The level of agreement reported across possible circumstances under which an abortion may be acceptable varied greatly across circumstance. The majority of these participants agreed that a woman should have a choice to have an abortion if the pregnancy seriously endangered her life (96%) or her health (87%). Additionally, most agreed that a woman should have a choice to have an abortion if the pregnancy was a result of rape (87%) or incest (85%). Less than half (46%) of participant's felt that a woman should have a choice if there was evidence that the child would be seriously deformed. Furthermore, the majority of participants disagreed that a woman should have a choice if she was not married (79%) or if the couple cannot afford another child (80%). There were no significant variations in attitude across gender or educational level for any of the statements. There were small but significant age differences across two items. Firstly, younger participants were more likely to favour abortion as a choice for rape victims (92% of 18-25 year olds vs. 87% of 26-35 year olds and 83% of 36-45 year olds ( $p < 0.05$ )). The reverse pattern was evident in the case of pregnancy where there is evidence that the baby will be seriously deformed. Here older participants were more likely to favour having the choice to have an abortion (fewer (42%) of 18-25 year olds agreed vs. 49% of 26-35 year olds and 48% of 36-45 year olds ( $p < 0.05$ )). It is interesting that the circumstances where abortion is seen as more acceptable as a choice may be those which are more salient as possibilities for those at opposite ends of the fertility cycle (i.e. rape for younger participants and having a seriously deformed child for older participants).

The findings relating to circumstances in which abortion was acceptable were compared with those reported by Fine-Davis (1988) from her 1986 study. Table 3.25 shows percentages agreeing that abortion is acceptable in various circumstances, as a proportion of all those interviewed for the study (not just the sub-group of those who agreed that abortion was permissible in some circumstances). This shows that the acceptability of abortion in various circumstances has increased substantially in the population over time. It is notable that, while attitudes towards abortion have become considerably more positive over time, the hierarchy of circumstances in which abortion may be permitted has remained similar.

**Table 3.25 Public attitudes to circumstances in which a woman should have a choice to have an abortion**

<b>Should a woman have a choice to have an abortion in this circumstance?*</b>	<b>1986 (Fine-Davis 1988) n=600 % agreement</b>	<b>2003 (ICCP Study 2004) n=3,312 % agreement</b>
If the pregnancy seriously endangered the woman's life	57	90
If the pregnancy seriously endangered the woman's health	48	86
If the pregnancy is the result of rape	51	86
If the pregnancy is the result of incest	52	86
If there is evidence that the child will be deformed	31	70
If the woman is not married	8	56
If the couple cannot afford another child	7	55

\* Replies are calculated from whole sample. Those saying abortion should never be permitted were counted as 'no' while those who said abortion should always be permitted were counted as 'yes' (asked in 2003 only).

A 2001 survey of 1,122 nationally representative members of the population aged over fifteen years in Ireland asked a somewhat different question in relation to acceptability of abortion (Irish Family Planning Association 2001). The survey asked whether, in any of a list of circumstances, abortion should be allowed in Ireland. The circumstances were: where the woman's life was physically at risk by continuation of pregnancy (52% agreed that it should be allowed), where suicide was a risk if the pregnancy continued (37%), where continuation of pregnancy would cause irreparable damage to the health of the women (41%), in the case of rape or incest (47%), where the foetus had a disorder which was incompatible with life (23%) and for reasons such as family size, economic and social circumstances and the welfare of other children (6%).

Attitudinal comparisons across pregnancy outcome options at this point in time indicate that lone parenthood is relatively acceptable. While there are no public surveys with which to gauge opinion, it is clear that this differs significantly from the perception of lone parenthood in the past. It is reasonable to surmise that there have been major changes in public opinion on this topic. On the other hand, adoption is seen as a much less positive option in this survey. Reasons for this should be explored further in a qualitative study. It is not clear, for instance, if this is a historical/cohort effect of the current generation, who have witnessed the negative consequences of the covert adoptions of many of their contemporaries, or if it is a more generic set of beliefs about adoption. Finally, abortion as a pregnancy outcome was considered as acceptable by half of this young sample of the Irish population, while most of the remainder would find it acceptable in some situations.

It is interesting to consider the influence of perceived levels of crisis pregnancy and crisis pregnancy outcomes on attitudes. This is an important question as it may be an indicator of social norms, i.e. the more people we know who behave in a particular way or belong to a particular social group, the more the behaviour of the group is accepted as the norm.

Personal awareness of crisis pregnancies and outcomes in other people was assessed by asking participants whether they knew anyone personally who had experienced them (table 3.26). Over two-thirds of participants (68%) knew someone personally who had experienced a crisis pregnancy, with 58% knowing someone who had experienced a crisis pregnancy and kept the baby, 6% someone who had had the baby adopted and 24% someone who had had an abortion.

**Table 3.26 Personal knowledge of crisis pregnancy and outcomes in others**

<b>Do you know anyone personally who has had:</b>	<b>18-25 years n=851 %</b>	<b>26-35 years n=1,127 %</b>	<b>36-45 years n=1,321 %</b>	<b>Total n=3,299</b>
a crisis pregnancy	72	67	65	68
a crisis pregnancy and kept the baby	64	55	54	58
a crisis pregnancy and had a baby adopted	4	5	9	6
a crisis pregnancy and had an abortion	18	27	25	24

In Britain, where abortion is available, the 2002 Durex report, 'Survey into Sexual Attitudes and Behaviour in Britain' found that 64% of survey participants knew someone who had had an unplanned pregnancy, a similar level to that seen in Ireland in relation to crisis pregnancy (68%). The Durex survey reported that 60% of participants knew someone who had had an abortion, a much higher level than that found in Ireland in the present study (24%) (Durex 2002).

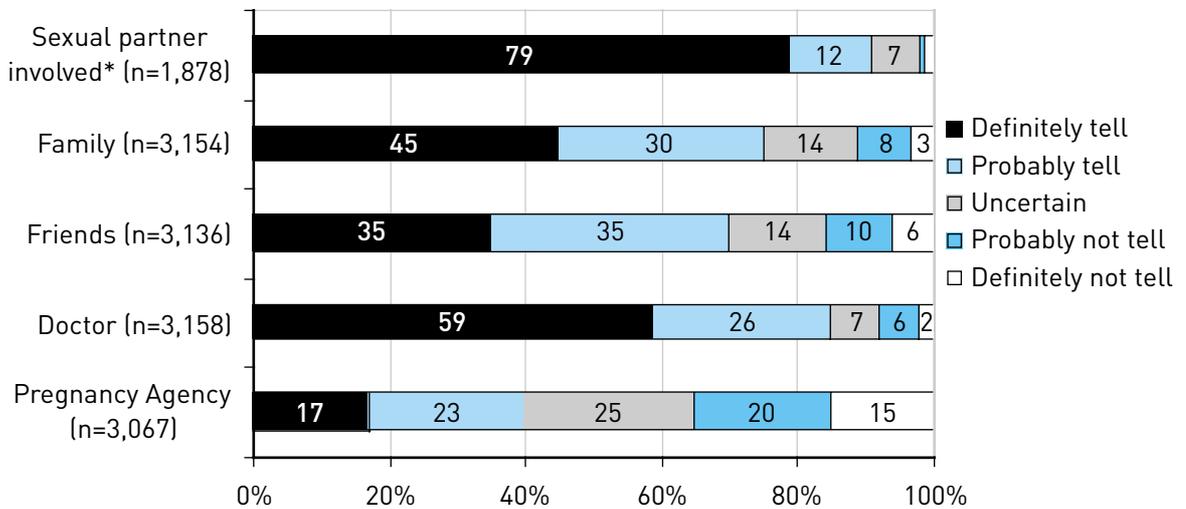
### 3.6.5 Disclosure of crisis pregnancy

- The majority of women (91%) said that they would definitely or probably tell the sexual partner involved if they experienced a crisis pregnancy.
- 75% reported that they would definitely or probably tell family about a crisis pregnancy. More women (73%) than men (66%) indicated that they would definitely or probably tell friends.
- More women (92%) than men (78%) would definitely or probably tell a doctor if they experienced a crisis pregnancy, and 43% of women and 37% of men would definitely or probably tell a crisis pregnancy agency.
- The majority of participants (66%) indicated that they would prefer to go to a GP for professional help if they were to experience a crisis pregnancy in the future.

A major challenge to effective decision making in crisis pregnancy is disclosure of the pregnancy to others. Willingness to disclose a crisis pregnancy was assessed.

Participants were asked how likely they would be to tell a list of selected persons if they were to experience a crisis pregnancy. Regarding telling the sexual partner involved, only women were questioned, as it is not a legitimate question for men. The majority of women (79%) said they would definitely tell the sexual partner involved, with a further 12% saying that they would probably tell them. There were significant gender differences in reporting whether they would tell friends about a crisis pregnancy, with significantly more women (73%) than men (66%) indicating that they would definitely or probably tell friends ( $p < 0.005$ ). Similarly, significantly more women (92%) than men (78%) would definitely or probably tell a doctor if they experienced a crisis pregnancy ( $p < 0.001$ ), and 43% of women and 37% of men would definitely or probably tell a crisis pregnancy agency ( $p < 0.05$ ). There were no gender differences in likelihood of disclosing to family, with 75% reporting that they would definitely or probably tell (figure 3.23).

Figure 3.23 Likelihood of disclosing a crisis pregnancy to others



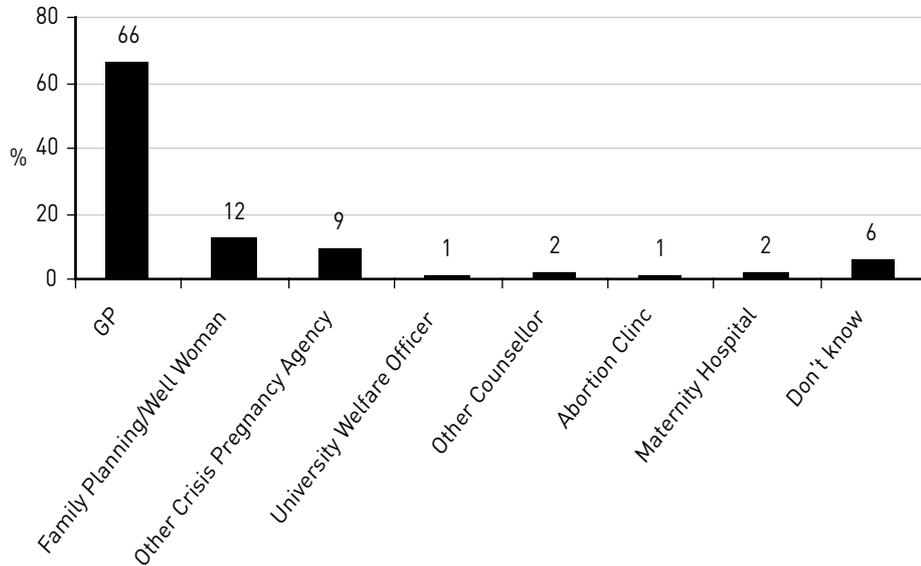
\* Women only

There were some interesting age-group differences in how likely participants would be to tell if they experienced a crisis pregnancy. More 18-25 year olds and 26-35 year olds (78% and 76% respectively) would definitely or probably tell their family than 36-45 year olds (72%) ( $p < 0.05$ ). Similar differences existed in telling friends, with 76% of 18-25 year olds, 70% of 26-35 year olds and 62% of 36-45 year olds stating that they would probably or definitely tell friends ( $p < 0.001$ ). Conversely, more participants in the 36-45-year-old group (89%) would probably or definitely tell a doctor than 26-35 year olds and 18-25 year olds (84% and 83% respectively) ( $p < 0.05$ ).

Consistent with other research findings, most participants indicated that they would definitely or probably tell significant others such as the sexual partner involved, family and friends. Interestingly, participants from the older age cohort (age 36-45 years) were less likely to indicate that they would tell their family than younger participants. These findings give us an important insight into crisis pregnancy in that we can now say that people who may experience a crisis pregnancy will talk to other people in their lives and that, importantly, most will talk to a health professional.

Participants were asked to choose from a list, their preference for obtaining professional help if they were to experience a crisis pregnancy in the future (figure 3.24).

Figure 3.24 Preference for type of professional help if faced with a crisis pregnancy (n=3,242)



The majority of participants (66%) indicated that they would prefer to visit a GP if they were to experience a crisis pregnancy. Given their universal availability, this is a preference that can be enabled relatively easily. It is also likely to indicate high levels of satisfaction concerning the discretion of GPs as confidants in the context of crisis pregnancies. This, along with the earlier findings that most women would definitely or probably tell a GP about a crisis pregnancy, that most women use GP services to obtain contraceptive supplies and that the preference for finding out about crisis pregnancy services was face-to-face/one-to-one, indicates that GPs are an extremely important resource for women in a crisis pregnancy.

The findings relating to preferences for professional help in a crisis pregnancy situation are similar to those reported by Lansdowne Market Research, in their study conducted on behalf of the CPA. In 2002, over half of those asked (57%) stated that they would consult a GP as a source of information if they or a friend needed help concerning a crisis pregnancy.

## 4. Results and Discussion II – Crisis Pregnancy

### 4.1 Overview of pregnancy experiences

- Over half of all participants (54%) had had sexual intercourse that had resulted in a pregnancy, with more women (61%) than men (46%) having had sex that resulted in a pregnancy.
- Of participants who had experienced pregnancy, younger participants were more likely than older participants to have experienced an abortion. Conversely, they were less likely to have experienced a live birth than older groups.
- Of participants who had experienced pregnancy, 28% of women and 23% of men had experienced a crisis pregnancy.
- 55% of 18-25-year-old men and women had experienced one or more crisis pregnancies, compared with 21% of women and 14% of men aged 36-45 years.
- Among participants who had experienced crisis pregnancy 14% of women (range 1-6 crisis pregnancies) and men (range 1-3) had experienced more than one crisis pregnancy.
- 83% of all pregnancies reported by women ended in live birth, 12% in miscarriage, 2% in abortion, 1% in stillbirth and <1% adoption. 2% were currently pregnant.
- 79% of pregnancies reported by men resulted in live birth, 14% in miscarriage, 3% in abortion, 1% stillbirth and <1% adoption, with 3% currently pregnant.
- 12% of all pregnancies experienced by women were experienced as a crisis. The percentage experienced as crises decreased with age (42% for 18-25 year olds vs. 7% for 36-45 year olds).
- 10% of all pregnancies experienced by men were crisis pregnancies, with 31% of 18-25 year olds, compared with 7% of 36-45 year olds reporting experience of a crisis pregnancy.
- The percentage of crisis pregnancies resulting in live births increased across age groups for both men and women. Abortion as an outcome of crisis pregnancy decreased with age for women, but not for men.

All participants who had previously had heterosexual sex (n=3,129) were asked if they had ever had sex that had resulted in a pregnancy (including any that resulted in miscarriage or abortion). Over half (54%) had had sexual intercourse that had resulted in a pregnancy, with more women (61%) than men (46%) having had sex that resulted in a pregnancy. The 1992 US National Health and Social Life Survey (NHSLs) found that 72% of women aged between 18 and 59 years had experienced a pregnancy (cf. Smith et al. 2003). ASHR (2003) reported that a similar number of women aged 16-59 (71%) had been pregnant at least once (Smith et al. 2003). These differences across studies may be related to the narrower age range in the present study, since a higher proportion of women have not reached the end of their reproductive life.

Table 4.1 displays a profile of lifetime pregnancy experiences and outcomes for all women and men. Results are displayed by age, since fertility levels for each age group may differ. As would be expected, the percentage experiencing a pregnancy, a live birth or a pregnancy loss (miscarriage or stillbirth) increased with age cohort.

**Table 4.1 Lifetime pregnancy experiences and outcomes for all participants who had experienced heterosexual sex, by gender and current age**

	Women				Men			
	18-25 yrs n=401 %	26-35 yrs n=664 %	36-45 yrs n=798 %	Total n=1863 %	18-25 yrs n=333 %	26-35 yrs n=431 %	36-45 yrs n=502 %	Total n=1266 %
Never pregnant	77	37	11	39	92	51	26	54
Live birth	18	59	88	58	4	42	71	40
Adoption	0	<1	1	<1	0	<1	<1	<1
Miscarriage	3	15	23	14	3	11	21	12
Stillbirth	0	1	2	1	0	1	1	1
Abortion	4	4	2	3	1	5	3	3
Currently pregnant	4	5	2	4	2	5	3	4
Other	0	<1	2	1	0	<1	0	<1

Those participants who had never experienced a pregnancy were then excluded from analyses. Table 4.2 provides an overview of pregnancy outcomes for all participants who had experienced pregnancy. Younger groups were more likely to have experienced an abortion and less likely to have experienced a live birth than older groups.

**Table 4.2 Lifetime pregnancy outcomes for participants who had experienced pregnancy, by gender and current age**

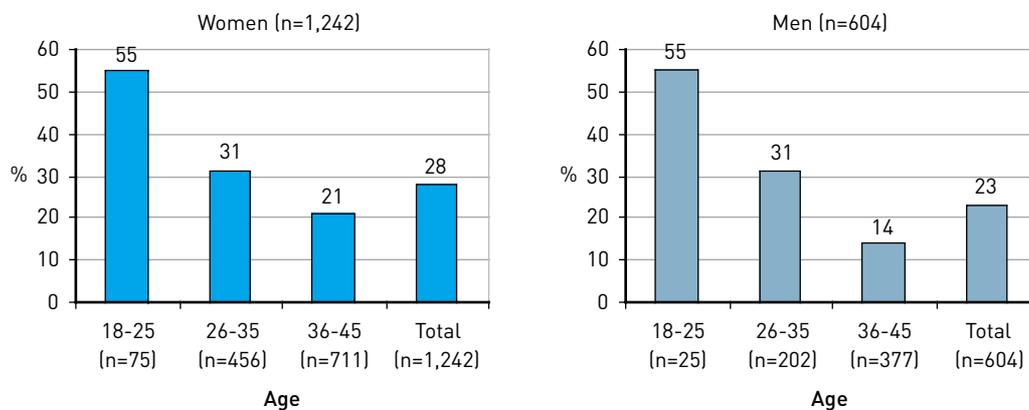
	Women				Men			
	18-25 yrs n=77 %	26-35 yrs n=458 %	36-45 yrs n=722 %	Total n=1,257 %	18-25 yrs n=25 %	26-35 yrs n=203 %	36-45 yrs n=378 %	Total n=606 %
Live birth	77	93	98	94	51	85	96	89
Adoption	0	<1	1	<1	0	<1	<1	<1
Miscarriage	14	23	25	23	40	22	28	26
Stillbirth	0	2	2	2	0	2	2	2
Abortion	15	6	2	5	10	9	4	7
Currently pregnant	16	8	2	6	24	11	4	8
Other	0	<1	2	1	0	<1	0	<1

Participants who had experienced pregnancy were asked whether they would describe any of their pregnancies as crisis pregnancies. It was explained that a crisis pregnancy is a pregnancy that represents a personal crisis or emotional trauma. It was also explained that crisis pregnancy can be pregnancy that began as a crisis, even if the crisis was subsequently resolved, or a pregnancy that develops into a crisis before the birth due to a change of circumstances. A history of crisis pregnancy experiences and outcomes was recorded. Those participants who stated that they had experienced a miscarriage or stillbirth as a crisis pregnancy were asked whether they felt it was a

crisis because of the miscarriage or stillbirth or prior to it. For the purposes of this study, only those participants who experienced pregnancy as a crisis prior to the miscarriage or stillbirth were included as crisis pregnancies.

Figure 4.1 illustrates the percentage of crisis pregnancy experienced by age group, for all those who had experienced pregnancy. There were significant age group differences for both genders, with younger women more likely to have experienced a pregnancy as a crisis than older women ( $p < 0.0001$ ). Younger men were also more likely to have experienced a pregnancy as a crisis than older groups ( $p < 0.0001$ ).

**Figure 4.1 Participants who had experienced one or more crisis pregnancies, as a percentage of all those experiencing pregnancy**



For both men and women who had previously experienced pregnancy, there were no significant educational-level differences in whether participants had experienced a crisis pregnancy. A significant social class difference was discovered, whereby more (44%) participants from the lowest social class (class VI) had experienced one or more crisis pregnancy than those in classes I-V (20%, 26%, 36%, 25% and 22% respectively) ( $p < 0.005$ ).

Further analysis was carried out to investigate age and educational differences in experiences of pregnancy outcomes for those who had experienced crisis pregnancy. Live birth and abortion outcomes were investigated (adoption was not considered, due to small participant numbers). Logistic regression considered the interaction of age and educational level. In relation to experiences of live birth among those who had experienced crisis pregnancy, no educational level differences were found among women or men. Year of birth differences were identified, with likelihood of having experienced a live birth decreasing with year of birth (i.e. increasing with age) for both women (OR 0.95, 95% CI 0.91-0.99,  $p < 0.05$ ) and men (OR 0.91, 95% CI 0.85-0.98,  $p < 0.05$ ). For abortion experiences among those who had experienced crisis pregnancy, there were no educational-level differences for both men and women in likelihood of having experienced abortion. A significant increase in likelihood of having experienced abortion with increase in year of birth (i.e. decrease in age) was found for women (OR 1.08, 95% CI 1.02-1.14,  $p = 0.01$ ), but not for men.

Of those who had experienced crisis pregnancy, 14% of both women (range 1-6 crisis pregnancies) and men (range 1-3) had experienced more than one crisis pregnancy. Since many participants had experienced more than one crisis pregnancy, pregnancy outcomes and crisis pregnancy outcomes in relation to total pregnancies are now considered.

Further analyses were carried out on outcomes of all pregnancies reported by women (weighted n=2,676) and by men (weighted n=1,821) (table 4.3). Of all pregnancies reported by women, 83% ended in live birth, 12% in miscarriage, 2% in abortion, 1% in stillbirth and <1% adoption, with 2% currently pregnant. In relation to pregnancies reported by men, 79% resulted in live birth, 14% in miscarriage and 3% in abortion.

**Table 4.3 Pregnancy outcomes of all pregnancies reported by participants, by current age**

	Women				Men			
	18-25 yrs n=140* %	26-35 yrs n=913 %	36-45 yrs n=1,623 %	Total n=2,676 %	18-25 yrs n=65 %	26-35 yrs n=594 %	36-45 yrs n=1,162 %	Total n=1,821 %
Live birth	68	80	87	83	58	77	81	79
Adoption	0	<1	<1	<1	0	<1	<1	<1
Miscarriage	10	14	11	12	24	13	14	14
Stillbirth	0	1	1	1	0	1	1	1
Abortion	11	2	<1	2	5	4	2	3
Currently pregnant	11	3	1	2	13	5	2	3
Other	0	<1	<1	<1	0	<1	0	<1
Total	100	100	100	100	100	100	100	100

\* n refers to weighted number of pregnancies

The abortion figures are significant, as it is particularly difficult to ascertain accurate estimates of prevalence of abortion in Ireland since abortions are performed in Britain or elsewhere. A US study found that a lower percentage (76%) of all conceptions resulted in a live birth with a much higher percentage in abortion (9.7%) than in this Irish study (cf. Smith et al. 2003). As in the present study, they found that younger women were more likely to report having an abortion. (Calculating the abortion rate per woman will yield a higher rate than the abortion rate calculated as a percentage of total pregnancies). ASHR (2003) reported an almost identical abortion rate to the US (as a percentage of all pregnancies) of 9.8%. The Natsal (1990) study reported figures somewhat differently: 12% of UK women had had an induced abortion (cf. Smith et al. 2003). These higher abortion rates found in the US, Britain and Australia most likely reflect, in part, the fact that abortion is available in these countries. Henshaw, Singh and Haas (1999), using a number of sources and national figures, estimated a worldwide abortion rate of about 35 per 1000 women (3.5%) aged 15-44. In countries where there are no restrictions on abortion, the rates range from 8.3% in Vietnam to 0.7% in Belgium and the Netherlands. Henshaw et al. (1999) concluded that moderate to high abortion rates reflected a country's lower rates of both contraceptive use and contraceptive effectiveness.

The ASHR (16-59 years) and Natsal (16-59 years) studies interviewed women of a much wider age profile than that used in our study. Other studies have found that age is an important determinant of an abortion outcome (younger participants are more likely to choose abortion than their older counterparts, and participants with higher education levels are more likely to choose abortion). This study found that younger women were more likely to choose abortion compared with older age groups (11% of all pregnancies to 18-25-year-old women ended in abortion compared with 2% for those aged 26-35 years and less than 1% for those aged 36-45 years). These findings suggest that the

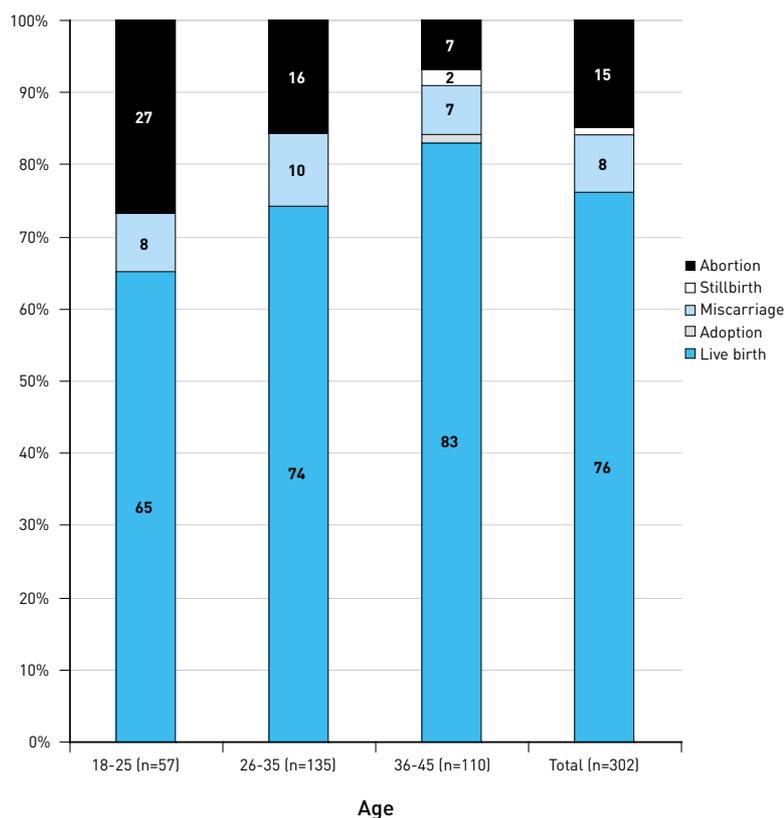
likelihood of abortion as a pregnancy outcome decreases with age. It is unclear from these figures whether this is an age or cohort effect. Since the lower percentages are for older women, it is unclear if this is influenced by age, or attitude to abortion, or both. Only in another decade will it be evident if those currently in the younger age groups are less likely to use abortion in a crisis pregnancy as they get older (suggesting an age effect) or as likely (suggesting an attitude which is more accepting of abortion as a crisis pregnancy outcome).

The age effect on abortion outcome is similarly evident in ASHR (2003) where 23.4% of pregnancies reported by those currently aged 20-29 years had ended in abortion compared with 9.4% for 40-49 year olds. However, US data indicate a more U-shaped pattern, with younger women (aged under twenty years) and older women (aged over 40 years) reporting the highest proportion of pregnancies terminated.

In total, 12% of all pregnancies experienced by women were experienced as a crisis. The percentage of pregnancies experienced as crises decreased with age, with 42% reported as a crisis by 18-25-year-old participants, 15% of pregnancies reported by 26-35 year olds and 7% of pregnancies reported by 36-45-year-old participants experienced as a crisis. Similarly, 10% of all pregnancies experienced by men were crisis pregnancies, with 31% of 18-25 year olds, 15% of 26-35 year olds and 7% of 36-45 year olds reporting experiencing a crisis pregnancy.

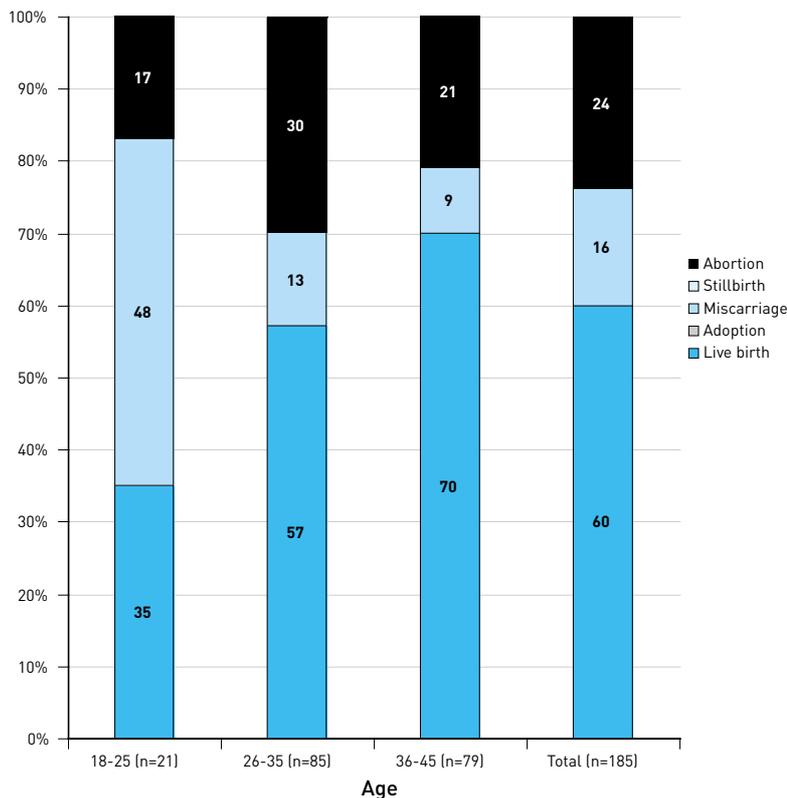
Outcomes of crisis pregnancies were then analysed. Those participants who reported that they were currently pregnant with a crisis pregnancy and those who reported 'other' outcomes were excluded, due to small numbers. Figures 4.2 and 4.3 illustrate outcomes of crisis pregnancies experienced by women and men respectively, by age at interview.

Figure 4.2 Outcomes of crisis pregnancies reported by women, by current age



An increase in proportions of live births as outcome of crisis pregnancy was seen across age groups for both men and women. Abortion as an outcome decreased with age for women, but not for men. However, caution is necessary in the interpretation of some results (e.g. 18-25 year olds), due to small participant numbers.

**Figure 4.3 Outcomes of crisis pregnancies reported by men, by current age**



Of all men and women who reported experience of one or more crisis pregnancy, 12% were living in another country at the time. These were excluded from further questions relating to crisis pregnancies, since the study focused on experiences of crisis pregnancies in the Republic of Ireland. Remaining participants were asked for consent to ask some more questions about their most recent experience of a crisis pregnancy. 1% of participants opted not to answer more in-depth questions about their experience. In total, 245 women and 90 men completed the crisis pregnancy section of the study.

## 4.2 Crisis pregnancy experiences

### 4.2.1 Crisis pregnancy outcomes

- 245 women and 90 men completed additional questions recounting their experience of their most recent crisis pregnancy.
- Of the women who reported on their experience of a crisis pregnancy, 75% gave birth, 15% had an abortion, 6% had a miscarriage, 1% a stillbirth and 3% were currently pregnant.
- 57% of crisis pregnancies reported by men resulted in birth, 24% in abortion, 17% in miscarriage and 2% were currently experiencing a crisis pregnancy.
- Most recent crisis pregnancy was experienced at a mean age of 23.4 years for women and 24.6 years for men.

- There were significant differences in pregnancy outcomes across age at crisis pregnancy: 22% of 18-25 year olds choosing abortion, compared with 7% of those under eighteen years of age, 7% of 26-35 year olds and 8% of 36-40 year olds.

The following analyses related to the 245 women and 90 men who completed the crisis pregnancy section of the survey, providing details of their (most recent) experience of crisis pregnancy. Of the women who experienced a crisis pregnancy (n=245), 75% gave birth, 15% had an abortion, 6% had a miscarriage, 1% a stillbirth and 3% were currently pregnant. For all analyses by pregnancy outcome, those participants who were currently pregnant were excluded because of small numbers and because the final outcome of the pregnancy was not yet known. Additionally, those who experienced a miscarriage or stillbirth were combined to make one category, due to small numbers, and this was further removed from pregnancy outcome analyses in those analyses relating to choosing an outcome. Those women who gave birth further specified the outcome after the birth. 57% of them raised the child with the birth father, 2% raised the child with a partner other than the birth father and 38% raised the child alone. 1% of women stated that another family member raised the child, 1% had the child adopted and <1% gave another reason (e.g. the child died shortly after birth).

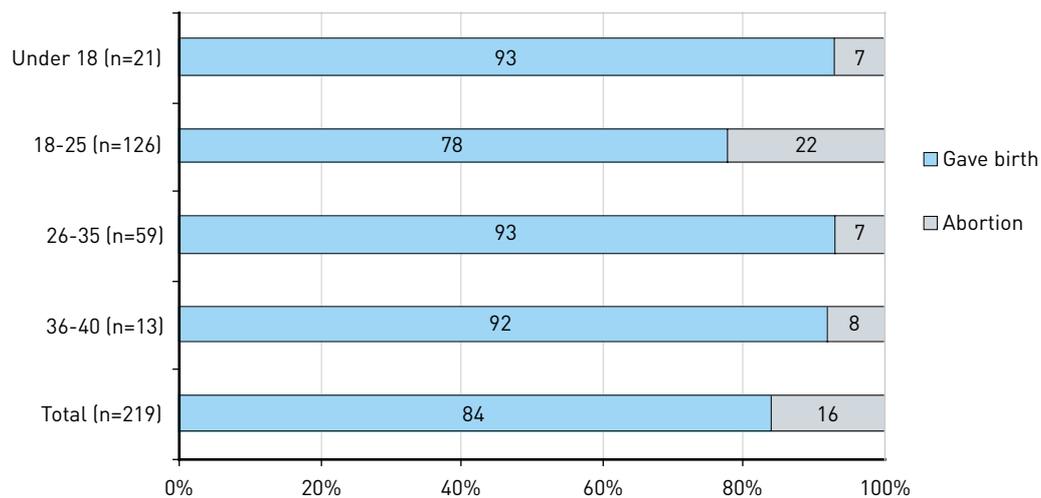
In relation to men's experiences of crisis pregnancy (n=90), 57% of pregnancies resulted in birth, 24% in abortion, 17% in miscarriage and 2% were currently experiencing a crisis pregnancy. Again, those currently experiencing a crisis pregnancy were excluded from pregnancy outcome analyses. Further breakdown of the pregnancies resulting in birth established that most (78%) had been raised by the participant and birth mother, 14% by the birth mother alone and 2% by another family member. A further 6% outlined other options.

The findings relating to those who chose to give birth are reflective of the findings of previous research that births outside of marriage are not to a homogenous group. Over half of these women (57%) reported that they raised the child with the birth father while over one-third raised the child alone. A tiny minority (1%) of women who chose to give birth (75%) reported that the child was adopted. This finding also reflects the annual figures compiled by the Adoption Board in Ireland, which show very few adoptions in recent years (see Introduction, section 1.5). Interestingly, men reported quite a different profile of pregnancy outcomes for their crisis pregnancy experiences than women. Fewer men reported that the pregnancy resulted in a live birth (57% vs. 75%) with abortion and miscarriage being more common outcomes for men (24% vs. 15% abortion and 17% vs. 6% miscarriage). Reasons for this discrepancy are uncertain. It may be that men are not always informed about a crisis pregnancy resulting in a live birth. This would proportionately increase percentages of other pregnancy outcomes known to them. The relative ordering of outcomes (i.e. more abortions than miscarriages) was the same for men and women.

Participants' most recent crisis pregnancy was experienced at a mean age of 23.4 years for women (95% CI 22.5-24.4) and 24.6 years for men (95% CI 23.0-26.2). There was little difference in women's mean age for each pregnancy outcome, with those who gave birth having a mean age of 23.5 (95% CI 22.4-24.6) years at the time, compared with 22.7 (95% CI 21.5-24.0) years for those having an abortion and 23.2 (95% CI 21.1-25.3) years for those having a miscarriage or stillbirth. Mean ages for men were 24.7 (95% CI 22.2-27.2) years for those experiencing a live birth, 25.2 (95% CI 23.3-27.2) years for those experiencing abortion and 23.3 (95% CI 19.8-26.9) years for those experiencing miscarriage.

Pregnancy outcomes of birth and abortion were further analysed by age at crisis pregnancy for women (figure 4.4). Miscarriage and stillbirth were not analysed, since the outcome is not one of choice. Interesting differences across age groups were observed, with 22% of 18-25 year olds choosing abortion, compared with 7% of those under eighteen years of age, 7% of 26-35 year olds and 8% of 36-40 year olds ( $p < 0.05$ ).

**Figure 4.4 Pregnancy outcome by age at crisis pregnancy for women**



There were no statistically significant differences in relation to giving birth or having an abortion across educational level, with pre-Leaving Certificate level participants more likely to give birth (91%) than Leaving Certificate (78%) or post-Leaving Certificate (81%) level participants.

A strong trend ( $p = 0.059$ ) was observed in relation to duration of time since crisis pregnancy occurred and outcome of pregnancy (birth or abortion). Of those crisis pregnancies occurring from 0-10 years ago ( $n = 123$ ), 80% resulted in birth and 20% in abortion. Most crisis pregnancies occurring 11-20 years ago ( $n = 68$ ) resulted in birth (89%), with 11% ending in abortion. The vast majority of crisis pregnancies occurring 21-30 years ago ( $n = 26$ ) resulted in birth (97%), with just 3% resulting in abortion.

If reducing the number of abortions is a goal for the CPA, then these findings highlight the need to target interventions at those in younger age groups (18-25 year olds). However, as discussed earlier, there may be cohort (i.e. generational) effects since abortion appears to be increasing over the last three decades as a choice in crisis pregnancy. While education was not found to be significantly related to pregnancy outcome, those with lower levels of education were more likely to give birth (87%) than those with post-Leaving Certificate education (74%). This finding may reflect that of Richardson (2000) in her study of young mothers. She concluded that there was a low level of educational attainment among the women, together with early school leaving. The majority of women in her study had left school before they became pregnant. This group of women (without Leaving Certificate/post-Leaving Certificate) are at a particular risk of poverty and social exclusion. The importance of preventative measures is evident, as pointed out by Richardson (2000):

It is recommended that every effort should be made to encourage young women to remain in education at least to completion of senior secondary level. (Richardson 2000: 3).

#### 4.2.2 Describing a crisis pregnancy

- When describing why the pregnancy was a crisis, women (41%) and men (39%) explained that it was not planned. Other common themes were being too young, being unmarried, having relationship difficulties or being in a relationship that was new or not steady.
- Older women (at time of crisis pregnancy) were more likely to report that the pregnancy was experienced as a crisis because they believed that their family was already complete.
- Younger participants were more likely to report actual or anticipated negative family reaction, not being married and being too young as reasons that it was experienced as a crisis.

Participants were asked to briefly explain why they would describe this pregnancy as a crisis pregnancy. Responses were recorded in a qualitative manner. Responses were analysed and assigned to categories, as in table 4.4. Many participants gave a number of reasons, so percentages are of total numbers of participants responding.

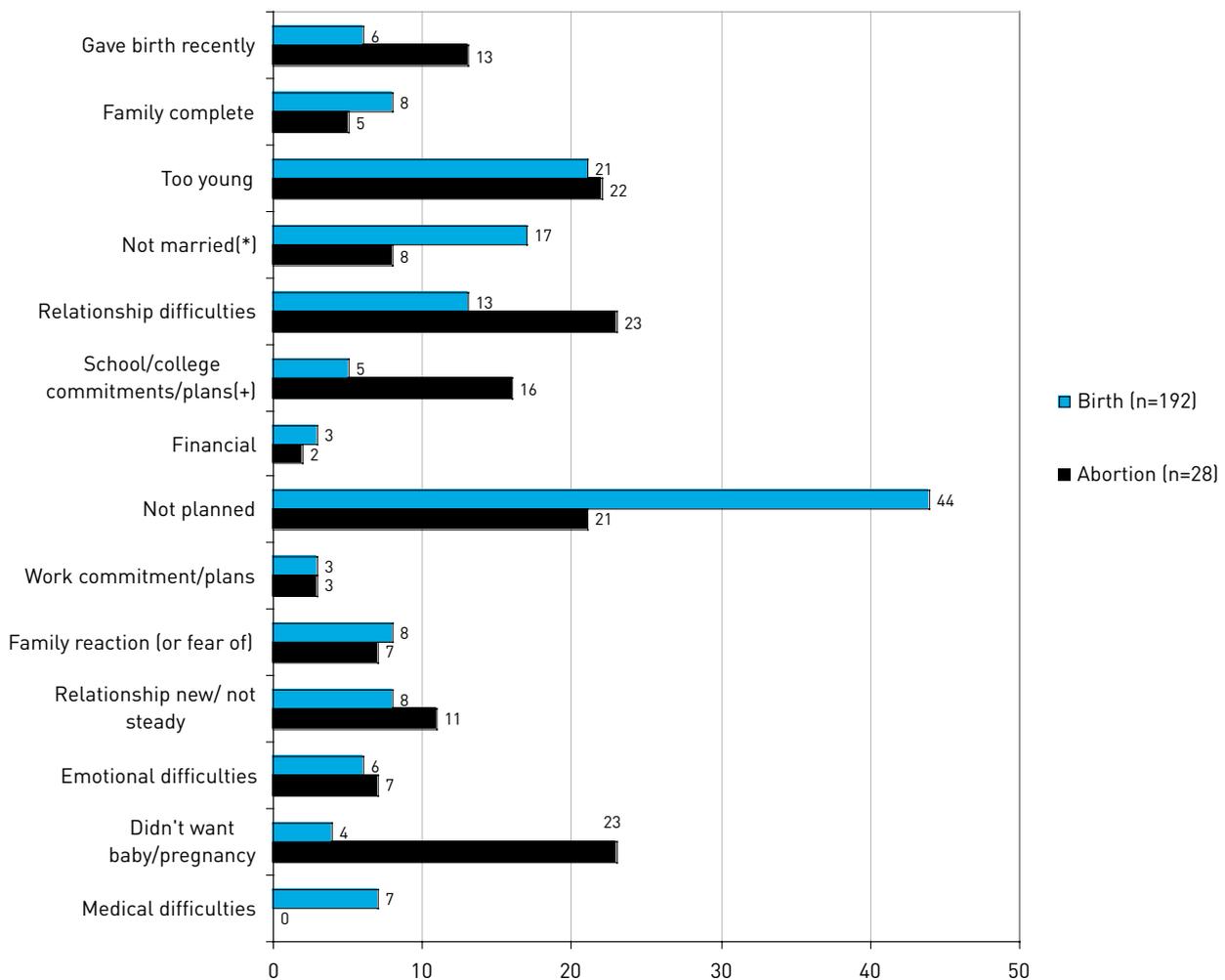
**Table 4.4 Reasons why participants described pregnancy as a crisis pregnancy**

	Women (n=245) %	Men (n=90) %
Very young or new baby/ gave birth recently	8	1
Existing children/family complete	7	5
Too young	20	22
Not married	16	10
Relationship difficulties	15	9
School/college commitments/plans	8	7
Financial reasons/ unemployment	5	14
Not planned	41	39
Work commitments/plans	3	2
Family reaction – actual or anticipated reaction	8	6
Relationship new/ not steady	8	13
Emotionally difficult experience	5	4
Did not want baby/pregnancy	6	3
Medical difficulties	6	6

When describing why they felt the pregnancy was a crisis, many women (41%) and men (39%) explained that it was not planned. Other common themes were being too young, being unmarried, having relationship difficulties or being in a relationship that was new or not steady (table 4.4). Reasons given by men as to why the pregnancy was a crisis often related to the experiences of their partner at the time of the pregnancy, and that they had experienced it as a crisis through their partner having been in a crisis. Thus,

responses coded for men include those relating to experiences of their partner. Furthermore, numbers of male participants in some categories were small, and further analyses of reasons why it was a crisis are described for women only.

**Figure 4.5 Reasons why women described pregnancy as a crisis pregnancy, by pregnancy outcome**



\* indicates significant pregnancy outcome differences ( $p < 0.05$ )

+ indicates nearing significant pregnancy outcome differences (non-significant)

Figure 4.5 compares reasons given by women to explain why the pregnancy was experienced as a crisis across pregnancy outcomes. Reasons given by women who had an abortion or gave birth did not differ statistically. Women whose pregnancy resulted in birth reported that it was a crisis because it was not planned (44%), they were too young (21%) or not married (17%). Alternatively, those whose pregnancy resulted in abortion explained that the crisis was due to relationship difficulties (23%), that they did not want the baby/pregnancy (23%), that they were too young (22%) or that it was not planned (21%). Finally, for a very small number of women ( $n=3$ ) the pregnancy occurred as a result of being raped and thus was described as a crisis pregnancy.

Analysis of reasons that it was described as a crisis by age at pregnancy indicated significant differences across age at time of pregnancy (table 4.5). Older women were

significantly more likely to report that the pregnancy was experienced as a crisis because they believed that their family was already complete ( $p < 0.001$ ). For example, one woman explained:

I didn't want to be pregnant as I already had five children.

Younger participants were more likely to report actual or anticipated negative family reaction ( $p < 0.01$ ), not being married ( $p < 0.05$ ) or being too young ( $p < 0.001$ ) as reasons that it was experienced as a crisis, as described by the following participants:

I was not married – had left college and taken a year out and was going back to college.  
I was afraid my boyfriend would get rid of me and my parents would not approve.

I wasn't married – I couldn't tell my parents.

**Table 4.5 Reasons why women described pregnancy as a crisis pregnancy, by age at crisis pregnancy**

	<b>Under 18 (n=22) %</b>	<b>18-25 (n=144) %</b>	<b>26-35 (n=63) %</b>	<b>36-45 (n=15) %</b>	
Very young or new baby/ gave birth recently	0	6	11	12	
Existing children/family complete	0	1	22	21	***
Too young	71	22	0	3	***
Not married	14	21	7	3	*
Relationship difficulties	1	17	17	6	
School/college commitments/plans	20	9	0	0	
Financial reasons	0	5	4	4	
Not planned	26	42	50	33	
Work commitments/plans	0	4	3	0	
Actual or anticipated negative family reaction	32	8	0	0	**
Relationship new/ not steady	13	11	1	0	
Emotionally difficult experience	4	6	5	4	
Did not want baby/ pregnancy	11	5	8	3	
Medical difficulties	0	3	11	19	

\* indicates significant pregnancy outcome differences ( $p < 0.05$ )

\*\* indicates significant pregnancy outcome differences ( $p < 0.01$ )

\*\*\* indicates significant pregnancy outcome differences ( $p < 0.001$ )

Reasons given by women for describing the pregnancy as a crisis were analysed by duration of time since the crisis pregnancy occurred: 0-10 years ago ( $n=137$ ), 11-20 years ago ( $n=75$ ) and 21-30 years ago ( $n=30$ ). Significant differences were observed for those giving the reason that they were not married. Two-thirds (67%) of those for whom the crisis pregnancy occurred 21-30 years ago described it as a crisis because they were not married, compared with 20% of those for whom it occurred 11-20 years ago and 8% for crisis pregnancies occurring 0-10 years ago ( $p < 0.001$ ).

Thus, themes that emerged to explain why the pregnancy was described as a crisis reflect those found by Mahon et al. (1998):

- Social stigma
- Unplanned nature of the pregnancy
- Other commitments, e.g. school, work, college, other children
- Economic/financial factors
- Partner relationship.

While the results of this study regarding societal attitudes toward lone parenting are primarily positive, many women explained that their non-marital status was a crucial factor in the pregnancy being experienced as a crisis. Most men and women did not expand beyond stating 'not married', thus it is difficult to establish if this experience of stigma is mainly due to their beliefs about what other people may think or what they themselves actually believe. The dissemination of findings concerning societal attitudes to lone parenting reported in this survey may help to minimise this perceived social stigma.

#### 4.2.3 Relationship status

- 41% of women had a steady relationship with the sexual partner at the time of conception, 24% had known the sexual partner for a while but did not have a steady relationship and 24% were married or engaged.
- 47% of men had a steady relationship with the sexual partner at the time, with 22% married or engaged and 12% knowing each other but not having a steady relationship.
- The majority of women who were married or engaged (99%) and living together (93%) at the time of conception gave birth, compared with 69% of those who were not in a relationship.

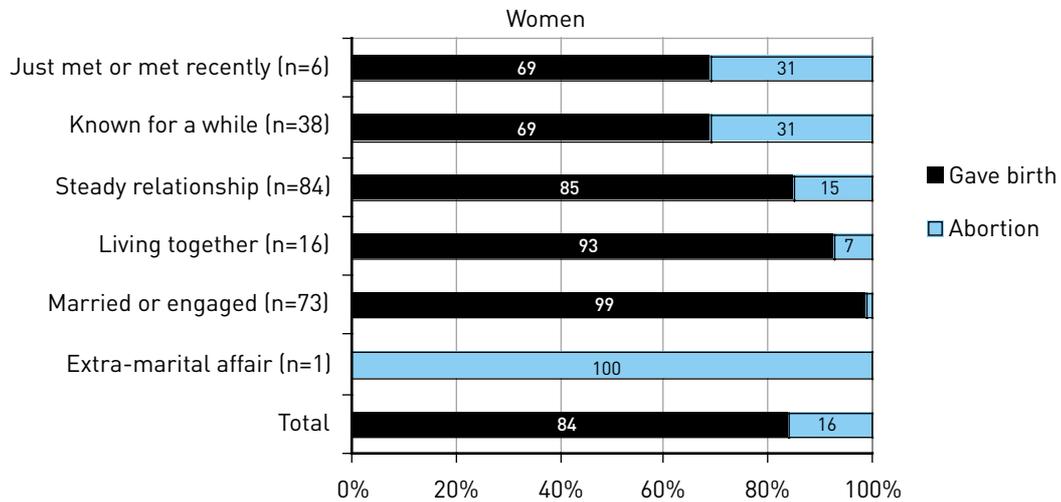
Participants were asked to describe their relationship with the sexual partner at the time of the conception. Of the women, 41% had a steady relationship, 24% had known the sexual partner for a while but did not have a steady relationship and 24% were married or engaged. Almost half of the men (47%) had a steady relationship with the sexual partner at the time, with 22% married or engaged, 12% knowing each other but not having a steady relationship and a further 11% living together at the time (table 4.6).

**Table 4.6 Relationship status at time of conception**

	<b>Women (n=245) %</b>	<b>Men (n=90) %</b>
Just met or met recently	4	7
Known for a while, but no steady relationship	24	12
Steady relationship	41	47
Living together	6	11
Married or engaged	24	22
Extra-marital affair	<1	0
Other	1	1
Total	100	100

As displayed in figure 4.6, there were significant differences in pregnancy outcome (miscarriage and stillbirth were excluded since these outcomes were not a choice) across women’s relationship status at time of conception ( $p < 0.01$ ). The majority of those who were married or engaged (99%) or living together (93%) at the time of conception gave birth. In contrast 69% of those who had known each other for a while but did not have a steady relationship and 69% of those who had just met or met recently gave birth. While the results are statistically significant and indicate a variation across categories, it is important to bear in mind that some categories contain small numbers, as indicated in figure 4.6 (just met or met recently:  $n=6$  and extra-marital affair:  $n=1$ ). Thus caution must be advised in interpreting these groups.

**Figure 4.6 Descriptions of relationship at the time of conception, and pregnancy outcome for crisis pregnancy (women)**



Study findings concerning pregnancy outcomes for different types of relationship at the time of conception indicate that there was a significantly increased likelihood of birth being the outcome if the relationship had developed to cohabiting, engagement or marriage. Those in less advanced stages of a relationship (i.e. just met, known for a while) were more likely to choose abortion than those in more steady relationships. As partner support is an important aspect of coping with a crisis pregnancy (Mahon et al. 1998), results indicate that level of partner support, through relationship status, may influence pregnancy outcome.

Regarding the sexual experience that resulted in the crisis pregnancy, 94% of women reported that they had been willing, with 2% feeling that they had had to be persuaded and 4% reporting being unwilling to have sex. The majority of men (98%) felt that they had been willing to have sex, with the remainder (2%) feeling that they had been persuaded.

Two-thirds of women (67%) said that their partner in the pregnancy would also have described it as a crisis pregnancy, 20% felt that their partner would not have described it as a crisis, 7% were unsure and 6% said that their partner did not know about the pregnancy; 90% of men said that their partner would also have described it as a crisis pregnancy.

#### 4.2.4 Contraceptive use

- 36% of women reported that contraception had been used when the crisis pregnancy occurred, 62% said that it had not been used and 2% were unsure. 44% of men reported that contraception had been used and 56% that it had not been used.
- Of those who had used contraception, 31% of women and 20% of men said they did not know why it had failed. Others reported condom failure (23% of women, 22% of men), contraceptive pill failure (20% of women, 7% of men), or that they had thought it was a safe period (9% of women, 16% of men).
- Of those who had not used contraception, women (51%) and men (52%) said that the reason for non-use was that sex was not planned or they were not prepared, with 17% of women and 26% of men explaining that non-use was as a result of drinking alcohol or taking drugs.
- In total, 41% of women and 55% of men reported alcohol or drug use at the time of the conception.

Participants were asked whether any method of contraception or precaution had been used (by themselves or their partner) at the time of conception. A third of women (36%) reported that contraception had been used, 62% that it had not been used, and 2% did not know whether contraception had been used at the time. There were interesting trends (but not significant differences) across age at crisis pregnancy. Fewer women experiencing a crisis pregnancy at younger ages had used contraception, with 73% of under-eighteen year olds (n=22), 64% of 18-25 year olds (n=144), 58% of 26-35 year olds (n=63) and 49% of 36-45 year olds (n=15) not using contraception at the time of conception.

Alternatively, 44% of men reported that contraception had been used and 56% that it had not been used. Those who had used contraception were asked which method was used (excluding emergency contraception), with 44% of women and 27% of men saying that the contraceptive pill had been used, and a further 32% of women and 46% of men reporting that a condom had been used (table 4.7).

**Table 4.7 Contraception and other precautions used at time of conception**

	Women (n=89) %*	Men (n=38) %*
Contraceptive pill	44	27
Condom	32	46
Coil/ IUD/ Mirena	1	0
Cap/ diaphragm	0	0
Spermicides (Gels/sprays/pessaries)	0	0
Persona	1	0
Safe period/ rhythm method (excl. Persona)	8	15
Withdrawal	14	16
Injections/ implanted capsules /patches/ring	1	0

\* Participants could select more than one response, thus totals may be greater than 100%.

These participants were then asked why the contraception had failed (table 4.8). While 31% of women and 20% of men said they did not know why the contraception had failed, others gave reasons of condom failure (23% of women and 22% of men), contraceptive pill failure (20% of women and 11% of men) or that they had thought it was a safe period (9% of women and 16% of men).

**Table 4.8 Reasons for contraceptive failure at time of conception**

	<b>Women (n=89) %</b>	<b>Men (n=38) %</b>
Don't know	31	20
Condom burst/split	16	19
Condom came off	7	3
Thought it was a safe period	9	16
Forgot one or more pills/ not taken properly	9	8
Pill failed due to stomach upset	4	2
Pill failed due to taking antibiotics	7	1
Other contraceptive failure	6	9
Other	11	22

Previous Irish research with unmarried young mothers has found low levels of contraceptive use (Richardson 2000, Fitzpatrick et al. 1997). This study has found similarly low levels of contraceptive use among participants who, for the most part, did not want to become pregnant. Additionally, those of a younger age at time of conception were less likely to have used contraception. While over a third of women reported that contraception was used at the time of conception, the majority further explained a range of technical failures or contraceptive misuse, with many reporting uncertainty regarding reasons for contraceptive failure.

Of those who had not used contraception, women (51%) and men (52%) said that the reason for non-use was that sex was not planned or they were not prepared (table 4.9). A further 17% of women and 26% of men said the reason was because of drinking alcohol or taking drugs. Further analysis of women's comments under 'other reason' highlighted a small number of recurring issues for these women. The most notable issues were a casual attitude towards contraception or a lack of knowledge of pregnancy risk. Additionally, some participants cited a period of contraceptive method change, for example, becoming pregnant shortly after stopping taking the contraceptive pill or while in between contraceptive methods.

Interestingly, the most common reasons for non-use of contraception reported by those who experienced a crisis pregnancy (sex was not planned/not prepared and drinking alcohol or taking drugs) parallel the reasons given by participants who did not use contraception in the last year (section 3.3.2) or on the most recent occasion (section 3.3.3). These situational factors provide a strong basis for recommending contraceptive planning behaviour, for example, carrying condoms whenever spontaneous sex is a possibility. The previous finding of a relationship between alcohol use and non-use of contraception across the whole survey population also demands an appropriate strategic response, as discussed previously.

**Table 4.9 Reasons for not using contraception at time of conception**

	<b>Women (n=152) %*</b>	<b>Men (n=50) %*</b>
Wanted to become pregnant	<1	4
Unlikely to conceive because of menopause	1	0
Unlikely to conceive because possibly infertile	2	1
Don't like contraception/methods are unsatisfactory	2	0
Partner doesn't like or won't use contraception	1	0
Not my responsibility	0	1
I/my partner forget(s) to take the contraceptive pill	3	1
Difficult to discuss contraception with partner	1	0
Can't get contraception/contraceptive services	3	0
Against beliefs/religion to use contraception	1	0
Drinking alcohol/ taking drugs	17	26
Sex not planned/ not prepared	51	52
Did not care if pregnancy happens	4	0
Other reason	20	15

\* Participants could select more than one response, thus totals may be greater than 100%.

In addition to the finding that 17% of women and 26% of men had not used contraception because of drinking alcohol or taking drugs, women (n=239) and men (n=87) were also asked whether they or their partner had been drinking alcohol or taking drugs at the time of the conception. In total, 41% of women reported alcohol or drug use at the time of the conception. Of these women, 87% reported that both they and their partner had been drinking alcohol or taking drugs, 10% that they had been drinking and 3% that their partner had been drinking at the time of the conception. Furthermore, 91% reported that only alcohol had been involved, with 9% reporting both alcohol and drug use by themselves or their partner at the time of conception. Over half of men (55%) reported that alcohol or drugs had been used, with 99% of these reporting that both they and their partner had been using alcohol or drugs, and the remainder that only they themselves had been using alcohol or drugs. Additionally, 77% reported consumption of alcohol only, 3% of drugs only and 21% of alcohol and drugs at the time of conception.

Analysis of use of contraception and use of alcohol or drugs at the time of conception highlighted interesting trends (non-significant) for women. A quarter (26%) of those who had been drinking alcohol or taking drugs had used contraception, compared with 43% of those who had not been using alcohol or drugs at the time of conception. There were no differences in use of contraception by use of alcohol for men. Use of alcohol or drugs was then analysed by relationship status with significant differences found for women (p<0.001) (table 4.10) and for men (p<0.05) (table 4.11). While numbers of participants in some groups are small (just met or met recently, extra-marital affair), findings indicate alcohol as a factor in crisis pregnancy, particularly in casual relationships.

**Table 4.10 Use of alcohol or drugs at time of conception by women**

<b>Drinking alcohol or taking drugs at time of conception:</b>	<b>Yes %</b>	<b>No %</b>
Just met or met recently (n=6)	94	6
Known for a while, but no steady relationship (n=39)	81	19
Steady relationship (n=97)	27	73
Living together (n=16)	14	86
Married or engaged (n=77)	22	78
Extra-marital affair (n=2)	47	53

**Table 4.11 Use of alcohol or drugs at time of conception by men**

<b>Drinking alcohol or taking drugs at time of conception:</b>	<b>Yes %</b>	<b>No %</b>
Just met or met recently (n=4)	100	0
Known for a while, but no steady relationship (n=12)	100	0
Steady relationship (n=41)	51	49
Living together (n=10)	50	50
Married or engaged (n=19)	27	73
Extra-marital affair (n=0)	0	0

Policy initiatives to prevent crisis pregnancy need to be cognisant of the two main factors that result in crisis pregnancy: non-use of contraception and technical failure. In terms of adopting a strategy to address non-use of contraception, a multi-pronged approach is necessary to tackle the complexity of issues impacting on contraceptive use. Policy to reduce crisis pregnancies resulting from technical failure calls for the implementation of educational strategies that focus on knowledge and ability to use contraception correctly. These strategies could be channelled through a variety of service providers (e.g. pharmacists), medical practitioners and health professionals. While issues concerning technical failure of the contraceptive pill (e.g. impact of antibiotics etc. on protection) are easily communicated by medical practitioners and reinforced by a pharmacist when a prescription is presented, the challenge of addressing technical failure of condoms is more difficult. Since they are typically obtained without contacting a health professional (e.g. over-the-counter or from vending machines) there is little opportunity for giving advice. Advice in this format may indeed appear unwelcome or obtrusive. Educational strategies to ensure that condoms are used effectively will need to engage the relevant audiences in an unthreatening way. In other countries, humour has been used as a way to both attract attention to and to get educational messages across about condom use.

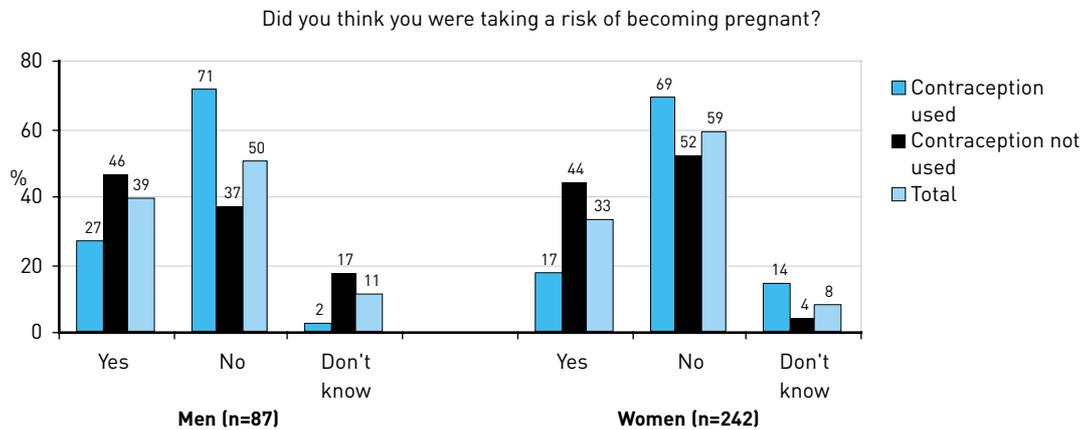
Participants were asked who had made decisions about contraception on the occasion in question. Table 4.12 displays decision making about contraception by gender and by contraceptive use and non-use. One-quarter of women (75%) and men (73%) who had not used contraception felt that no one had taken responsibility for contraception at the time of conception. Interestingly, one-quarter (24%) of men and 19% of women felt that they had made a joint decision with their partner not to use contraception.

**Table 4.12 Decision-making about contraception at time of conception**

	Men %			Women %		
	Contraception used at time of conception					
	Yes (n=39)	No (n=49)	Total (n=88)	Yes (n=88)	No (n=152)	Total (n=240)
My decision	12	3	7	22	5	11
Partner's decision	9	0	4	4	1	3
Joint decision	47	24	34	61	19	34
No one took responsibility	32	73	55	13	75	52
Total	100	100	100	100	100	100

They were next asked whether they thought they were taking a risk of becoming pregnant at the time of the sexual experience. Half (50%) of women and 60% of men said that, at the time, they did not think they were risking becoming pregnant, with 39% of women and 32% of men thinking that they were taking a risk and 11% of women and 8% of men unsure. Figure 4.7 shows participant perceptions of risk of becoming pregnant at the time of the conception, with a breakdown by gender and by contraceptive use and non-use.

**Figure 4.7 Participant perceptions of risk of becoming pregnant, by gender and contraceptive use**



Despite a possible awareness of contraceptive failure at the time of sexual intercourse by many of those who had used contraception, and although 39% of women and 33% of men thought they were at risk of pregnancy, only 10% of women and 5% of men said that they, or their partner, had taken the emergency contraceptive pill. Table 4.13 shows reasons for non-use of ECP among women who had used and who had not used contraception at the time of conception. Of women who had not used contraception at the time of conception, one-third (33%) did not use the ECP because they did not think they would get pregnant and a further 33% felt that they did not consider using it or did not know why they had not used it. It is clear from the above findings that action must be taken to help people recognise the risk of pregnancy, particularly those not using contraception, and also to increase awareness of the ECP and promote consideration of its use.

Use of emergency contraception following technical failure is dependent upon an accurate evaluation of the risk of pregnancy following technical failure, which previous research has shown to be limited among some groups of women (Free et al. 2002, Pearson et al. 1995). This is further supported in the present study, where the majority of those who did not use contraception reported that they did not think they were taking a risk of becoming pregnant.

**Table 4.13 Reasons for non-use of ECP following sexual intercourse, by use of contraception at time of conception (women)**

<b>Did you use contraception at time of conception (excluding ECP):</b>	<b>Yes (n=79) %*</b>	<b>No (n=142) %*</b>	<b>Total (n=221) %*</b>
Don't know/ did not consider it	20	33	30
Thought we were covered by the contraceptive method we had used	34	1	13
Could not access it/ was not available at the time/ was not aware of it	4	12	9
Could not afford it	0	0	0
Against religious/ moral beliefs	1	5	4
Embarrassment	0	3	2
Took a chance on this occasion	1	13	9
Partner didn't tell me condom failed	7	0	3
Didn't think I would get pregnant	28	33	31
Other	8	5	6

*\*Participants could select more than one response, thus totals may be greater than 100%.*

#### 4.2.5 Confirming the crisis pregnancy

- 57% of women first thought they might be pregnant in the month following the sexual experience, with 89% having the pregnancy confirmed in the first three months following the sexual experience.
- Their GP confirmed the pregnancy for 38% of women, with 34% visiting a family planning or Well Woman clinic and 17% using a home-testing kit.

Women were asked at what point after sexual intercourse they thought they might be pregnant. Over half (57%) first thought they might be pregnant in the month following the sexual experience with 89% having the pregnancy confirmed in the first three months following the sexual experience (table 4.14).

**Table 4.14 First awareness of possible pregnancy and pregnancy confirmation, by pregnancy outcome (women)**

	<b>Gave birth</b>	<b>Abortion</b>	<b>Miscarriage/ stillbirth</b>	<b>Total</b>
	<b>% (n=190)</b>	<b>% (n=28)</b>	<b>% (n=22)</b>	<b>% (n=240)</b>
<b>At what point after sex did you think you might be pregnant?</b>				
In the 3 days following sex	10	16	20	12
In the month following sex	54	69	66	57
1 to 3 months after sex	28	15	14	25
4 to 6 months after sex	7	0	0	5
Over 6 months after sex	1	0	0	1
<b>When was the pregnancy confirmed?</b>				
In the month following sex	24	69	45	33
1-3 months after sex	62	31	48	56
4-6 months after sex	14	0	7	11
Over 6 months after sex	<1	0	0	<1
<b>How was the pregnancy first confirmed?</b>				
Own GP	41	20	43	38
Another GP	7	6	0	7
Family planning/ Well Woman clinic	32	46	36	34
Home pregnancy testing kit	15	28	21	17
Other	5	0	0	4

There were significant differences in when the pregnancy was first confirmed across pregnancy outcomes, with more (69%) of those who had an abortion than those who gave birth (24%) or had a miscarriage/ stillbirth (45%) confirming pregnancy early, i.e. within the month following the sexual experience ( $p < 0.0005$ ).

Their own GP confirmed the pregnancy for 38% of women, with 34% visiting a family planning or Well Woman clinic and 17% using a home testing kit. There were trends (but not significant differences) across pregnancy outcomes, with more women who gave birth (41%) and had a miscarriage or stillbirth (43%) having the pregnancy confirmed by their own GP, than women who had an abortion (20%) (table 4.14).

Most men (65%) reported that they first found out that their partner was pregnant in the month following the sexual experience, with 30% finding out 1-3 months after, 3% finding out 4-6 months after, 2% over 6 months after and 1% finding out after the birth.

4.2.6 Emotional experience of crisis pregnancy

- Women experienced a number of negative emotions during their crisis pregnancy: 43% reported mostly feeling ‘very nervous’ or ‘downhearted and blue’ and 29% mostly felt ‘so down in the dumps that nothing could cheer them up’.

Participants were asked to rate how much of the time during the pregnancy they experienced a number of emotional states, on a six-point scale ranging from none of the time to all of the time (questions were taken from a standardised mental health inventory). Figure 4.8 highlights a number of negative emotions experienced by women during their crisis pregnancy, with 43% reporting mostly feeling ‘very nervous’ or ‘downhearted and blue’. Additionally, 29% said they mostly felt ‘so down in the dumps that nothing could cheer them up’. On the other hand, a substantial number (29%) said they were mostly ‘a happy person’ and/or ‘calm and peaceful’ during the pregnancy.

Figure 4.8 Emotional profile of women during their crisis pregnancy

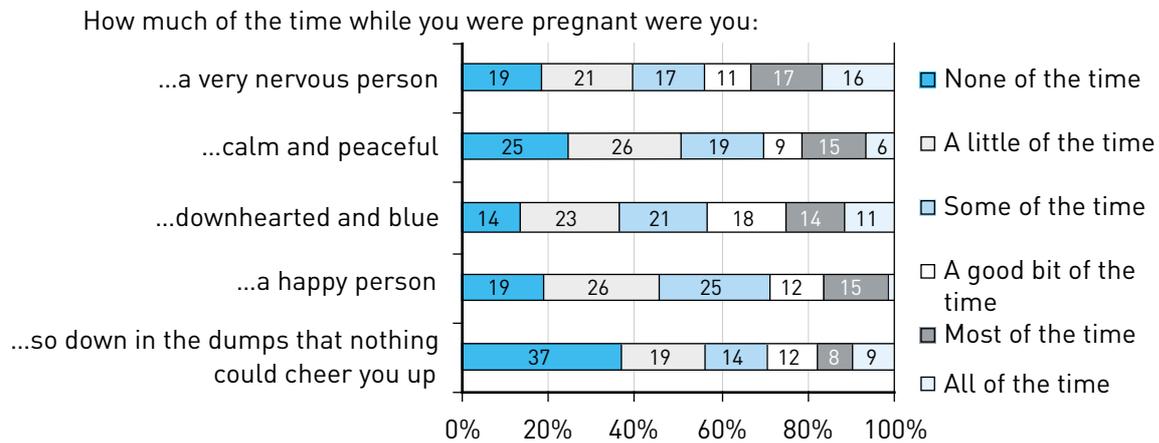
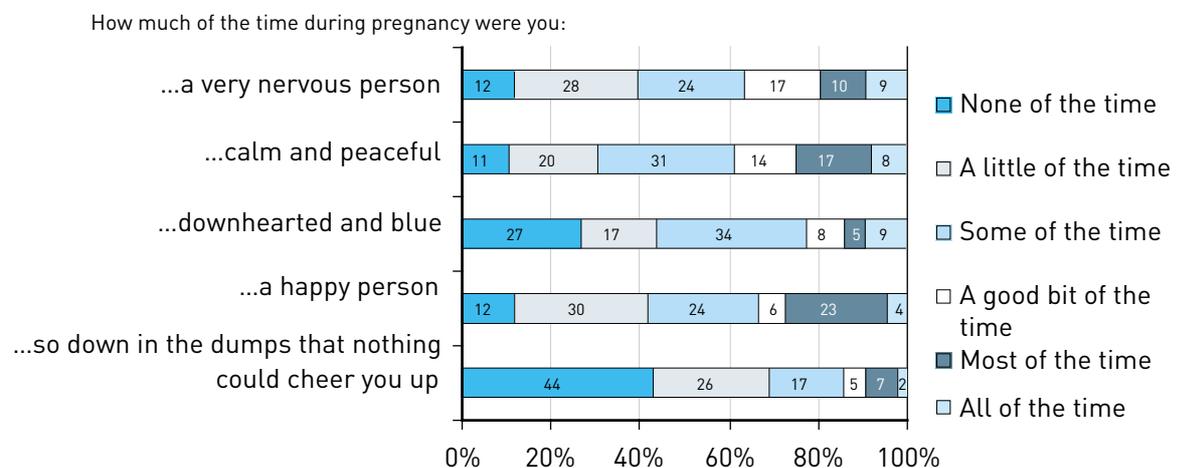


Figure 4.9 shows the experiences of emotional states reported by men. One-third (36%) felt they were ‘very nervous’, with 22% mostly feeling ‘downhearted and blue’, and 14% mostly feeling ‘so down in the dumps that nothing could cheer them up’ during the pregnancy.

Figure 4.9 Emotional profile of men during the crisis pregnancy

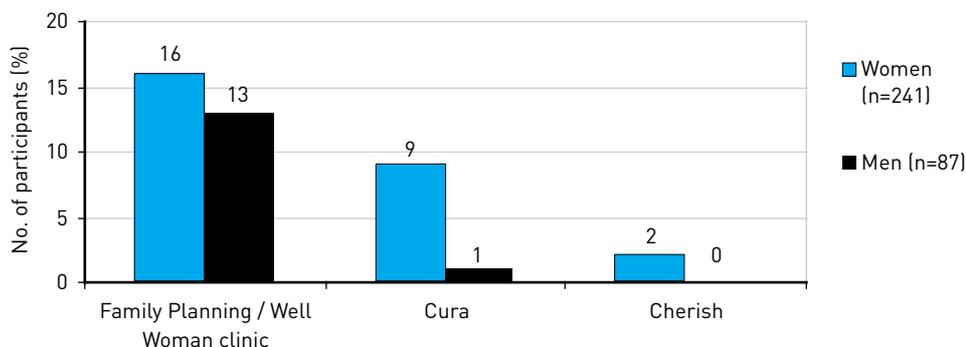


#### 4.2.7 Personal and professional supports and services

- 16% of women and 13% of men had contact with a family planning or Well Woman clinic during their crisis pregnancy. A further 9% of women and 1% of men had had contact with Cura, and 2% of women with Cherish. No participants reported contact with LIFE or PACT.
- Over half of women (55%) first told the sexual partner involved about the crisis pregnancy, with 19% first telling a friend.
- There were differences in the supportiveness of sexual partners across pregnancy outcomes, with 71% of those who gave birth and 66% of those experiencing a miscarriage or stillbirth reporting that the sexual partner had been supportive, compared with 34% of those who had an abortion.
- More of those who gave birth (72%) reported that their parents had been supportive or very supportive than those who had an abortion (30%) or a miscarriage/stillbirth (20%). Many of those who had an abortion (45%) or a miscarriage/stillbirth (52%) did not tell their parents about the pregnancy.
- 46% of women said there was nothing that would have made the situation easier at the time, 26% that counselling or having someone to talk to at the time would have helped, with 10% suggesting information on all their options. 7% said that money would have helped, 6% suggested local pregnancy services, 6% family support and 5% stated that partner support or a committed relationship may have made the situation easier at the time.
- 71% of women felt they did not need ongoing support or services after the crisis pregnancy.

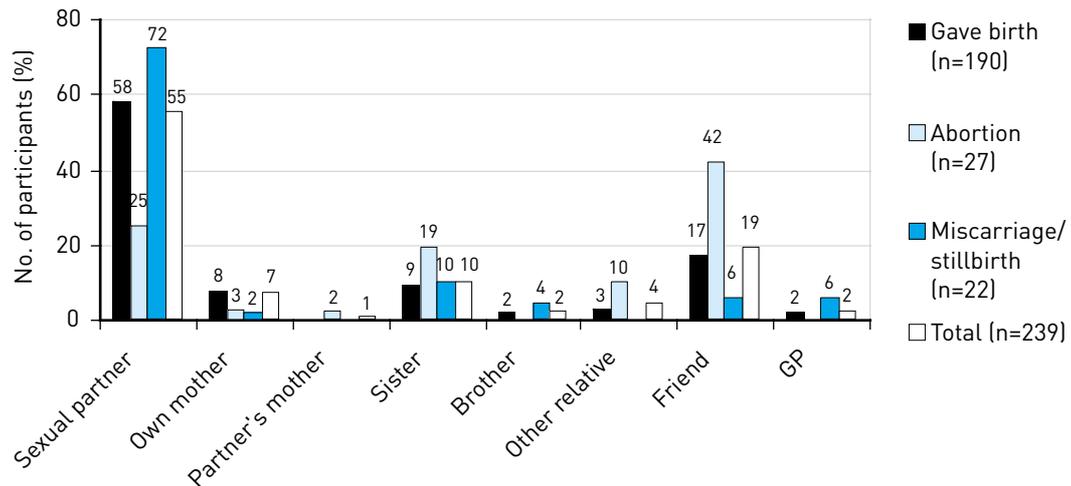
Participants were asked whether they had had any contact with a pregnancy agency during their crisis pregnancy. The most common contact was with a family planning or Well Woman clinic (mentioned by 16% of women and 13% of men). A further 9% of women and 1% of men had had contact with Cura, and 2% of women with Cherish (figure 4.10). No participants reported contact with LIFE or PACT.

Figure 4.10 Contact with pregnancy support agencies during a crisis pregnancy



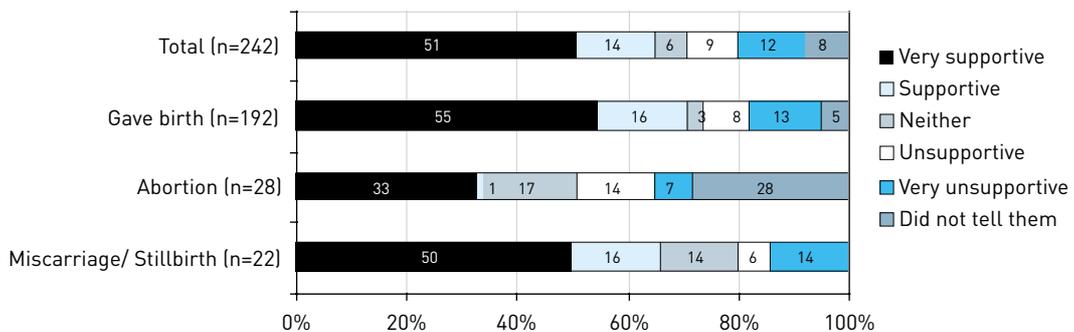
In relation to personal supports, women were asked which person they first told about the pregnancy (figure 4.11). Over half (55%) first told the sexual partner involved, with 19% first telling a friend. While numbers of participants are relatively small, it is interesting to note that participants who had an abortion were less likely to first disclose to the sexual partner involved (25%) and more likely to first tell a friend (42%).

Figure 4.11 Women’s first disclosure of crisis pregnancy, by pregnancy outcome



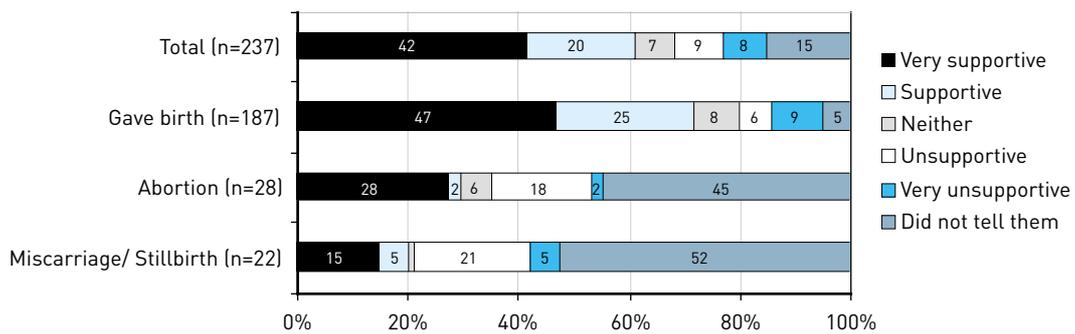
Women were asked how supportive the sexual partner involved was concerning the pregnancy (figure 4.12). Over half (51%) reported that the sexual partner had been very supportive, with a further 14% saying that he had been supportive. There were significant differences across pregnancy outcomes, with 71% of those who gave birth and 66% of those experiencing a miscarriage or stillbirth reporting that the sexual partner had been supportive or very supportive, compared with 34% of those who had an abortion. Additionally, 28% of those who had an abortion reported that they did not tell the sexual partner, compared with 5% of those who gave birth and none of those who had a miscarriage or stillbirth ( $p < 0.01$ ). Thus 66% of those who had an abortion had either not told, or had an unsupportive response from, the sexual partner involved with the pregnancy.

Figure 4.12 Support provided by sexual partner to women experiencing crisis pregnancy, by pregnancy outcome



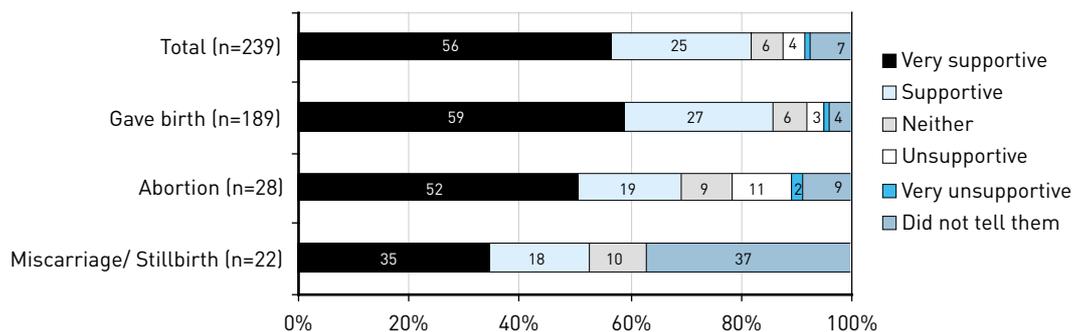
There were also significant differences across pregnancy outcomes in reports of how supportive parents had been towards the pregnancy ( $p < 0.001$ ) (figure 4.13). More of those who gave birth (72%) reported that their parents had been supportive or very supportive than those who had an abortion (30%) or a miscarriage/stillbirth (20%). More of those who had an abortion (45%) or a miscarriage/stillbirth (52%) did not tell their parents about the pregnancy.

**Figure 4.13 Support provided by parents to women experiencing crisis pregnancy, by pregnancy outcome**



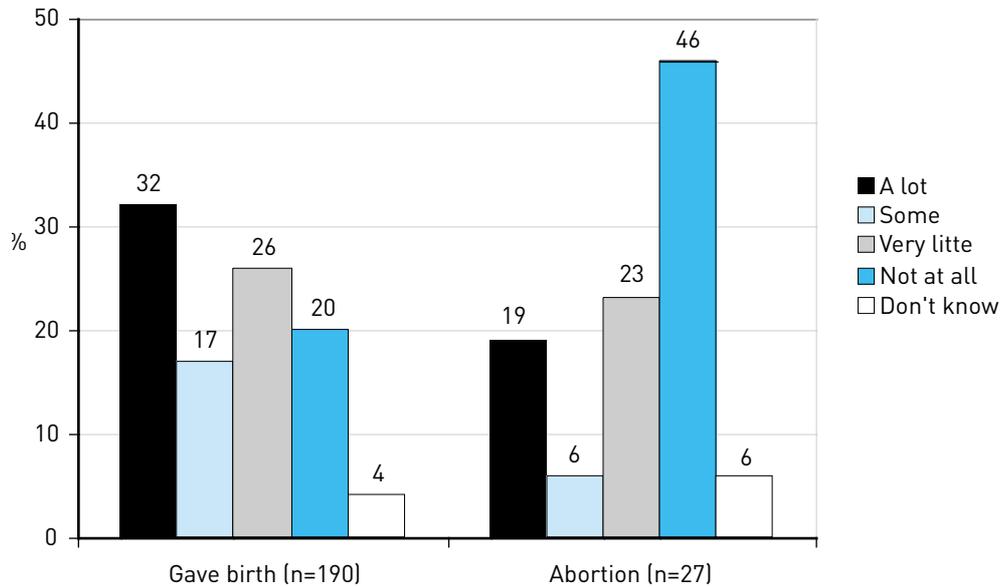
Participants were also asked to rate how supportive their friends were concerning the pregnancy. Significant differences were again observed across pregnancy outcomes ( $p < 0.05$ ) (figure 4.14). Those who gave birth were most likely to report that their friends were supportive or very supportive (86%), compared with those who had an abortion (71%) or a miscarriage/stillbirth (53%). Fewer of those who had a miscarriage/stillbirth told their friends (63%), than those who had an abortion (91%) or gave birth (96%).

**Figure 4.14 Support provided by friends to women experiencing crisis pregnancy, by pregnancy outcome**



Women were asked how much the reaction or expected reaction of the sexual partner involved affected the final decision regarding the outcome of the pregnancy (figure 4.15).

**Figure 4.15 Extent to which the sexual partner’s reaction or expected reaction affected women’s decisions regarding the pregnancy outcome**



There were interesting differences across pregnancy outcomes, with 46% of women who had an abortion compared with 20% of those who gave birth saying that the reaction or expected reaction of the sexual partner did not affect the final decision regarding the outcome. Conversely, half of those who gave birth (49%) and 25% of those who had an abortion reported that the reaction or expected reaction affected the final decision a lot or to some extent. Women were also asked how much other people’s reactions or expected reactions affected the final decision regarding the outcome of the pregnancy. Of those who gave birth, 14% reported other people’s reactions or expected reactions affected the final decision a lot, 18% reported they affected the final decision to some extent, 25% very little, 39% were not affected at all, and 4% did not know. Alternatively, of those who had an abortion, 6% reported that other people’s reactions or expected reactions affected the final decision a lot, 20% to some extent, 14% very little, 54% not at all and 6% did not know.

Men were asked how much influence they felt they had on the final decision regarding the outcome of the pregnancy. Those for whom the crisis pregnancy resulted in birth felt that they had a lot (39%) or some (22%) influence, with 19% feeling that they had very little influence, a further 19% having no influence and the remainder unsure. Similarly, for those whose crisis pregnancy resulted in abortion, 23% felt that they had a lot, 44% some, 10% very little and 17% no influence on the final decision regarding the outcome, with the remainder unsure.

Over half of the women who experienced a crisis pregnancy told a partner first. Research has shown that partners can impact on pregnancy outcome (Evans 2001). Frost and Oslak (1999) found that, in terms of social support, 34% of participants indicated that the baby’s father was most important in helping them decide to continue with the

pregnancy, with 23% saying that they themselves were most important; 25% identified their mother and 15% another relative as most important. Further to this, it is positive to note that many women in the present study (65%) reported that their partner was supportive. This level of support decreases for those who chose an abortion. Also, over one-quarter of those who had an abortion reported that they did not tell the partner. This may reflect the finding that those who chose abortion are more likely to have 'just met' or 'known each other for a while', compared with those in a steady relationship, married or engaged, who are more likely to choose parenthood and to tell the partner involved. This supports an earlier conclusion that casual relationship status is a particularly important factor to consider when addressing issues such as non-use of contraception. The negative consequences of a crisis pregnancy are increased when it occurs within a casual relationship and the context in which these pregnancies are resolved may be more problematic (significantly less likely to have partner support, more likely to choose abortion and less likely to tell the partner involved). While we do not know why the partners of those choosing abortion are less likely to be told, we might speculate that this could be attributed to the fact that the relationship was very brief.

Sihvo et al. (2003) report that agreement was higher between couples who experienced an unintended pregnancy and who chose to continue with a pregnancy than between those experiencing unintended pregnancies that ended with an abortion. However, of partner, family and friends, friends provided the most support for those who chose abortion. These findings highlight the difficulties faced by women who experience crisis pregnancy: although a majority of those who gave birth did receive support from partners, parents and friends, between one-fifth and one-third did not. The situation is even more difficult for those who chose abortion. The context of their crisis pregnancy seems to be one of isolation and lack of appropriate support.

An interesting juxtaposition found in this report was that, although a majority of respondents stated that they believed a woman should have a choice to have an abortion, many of the women who had experienced abortion had not told others and/or felt that partners, family and friends were unsupportive of their choice. This issue needs to be explored in public discourse. The CPA states:

Crisis pregnancy demands a change in culture which, in turn, will require education of both men and women in their personal lives, as well as that of Irish society in its public discourse (Crisis Pregnancy Agency 2003: 4)

Women (n=242) were asked whether there was anything else that, if available, may have made the situation easier for them at the time of the crisis pregnancy (they could specify a number of options so percentages are of all women responding). While 46% said that nothing would have made the situation easier, over a quarter (26%) said that counselling or having someone to talk to would have helped, with 10% suggesting information on all their options. 7% said that money would have helped, 6% suggested local pregnancy services, 6% said that family support and 5% that partner support or a committed relationship may have made the situation easier at the time. There were no significant differences in preferences across pregnancy outcomes, age at crisis pregnancy, duration since crisis pregnancy occurred or social class for any of these suggestions.

In relation to support services, women were asked about requirements for ongoing support services after the crisis pregnancy. Almost a third of women (29%) felt they

needed ongoing support or services after the crisis pregnancy, with little difference across women who gave birth (28%), had an abortion (31%) or had a miscarriage (34%).

Those who felt they needed ongoing support were asked which supports, from a pre-determined list, they needed. Two-thirds (66%) indicated a need for counselling or advice, 60% said they needed support from family and friends, 52% medical help or check-up, 28% information on their rights and entitlements and 13% information on accommodation sources (table 4.15).

**Table 4.15 Women's requirements for ongoing support after the crisis pregnancy, by pregnancy outcome (for those indicating that support was needed)**

	<b>Gave birth (n=46) %</b>	<b>Abortion stillbirth (n=12) %</b>	<b>Miscarriage/ (n=8) %</b>	<b>Total (n=66) %</b>	
Medical help/ check-up	54	26	88	52	*
Counselling or advice	67	75	48	66	
Information on accommodation sources	7	29	33	13	
Information on rights and entitlements	33	9	27	28	
Support from family and friends	53	83	67	60	

\* indicates significant pregnancy outcome differences ( $p < 0.05$ )

In summary, over a quarter of women said that counselling or having someone to talk to during the crisis pregnancy would have helped. Almost one-third of women reported that they needed ongoing support or services after the crisis pregnancy, with most (two-thirds) needing counselling or advice. Ease of access to affordable crisis pregnancy counselling must, therefore, be a priority for policy makers and service providers. These services appear to be needed equally by those making very different pregnancy outcome decisions. Thus, during and post-crisis pregnancy support was noted as being as necessary by those choosing to give birth as those choosing abortion. This is important since it could be erroneously concluded that a social climate which is more accepting of unplanned births, including single parenthood, means that this outcome is no longer problematic for individuals.

#### 4.2.8 Outcome of crisis pregnancy

- Women who gave birth reported partner/family/relationship support and moral/personal beliefs as factors influencing the outcome of the pregnancy.
- Women whose crisis pregnancy resulted in abortion reported existing life commitments/plans, being too young, having relationship difficulties/no stable relationship or not being ready for motherhood/not wanting a child as factors influencing the outcome.
- The majority of women who gave birth (98%) and those who had an abortion (95%) felt that the outcome of the pregnancy was the right one.
- 92% of women who gave birth and 68% of those who had an abortion reported no regrets at the final outcome of the crisis pregnancy.

Participants were asked their views on the outcome of the pregnancy. Firstly, women were asked what was the main factor influencing the outcome of the pregnancy (parenthood, adoption, abortion). Responses were recorded qualitatively and re-coded, resulting in a number of themes. Participants could give a number of responses, so percentages are of total responding for each pregnancy outcome. The most common factors influencing the outcome of the pregnancy for those who gave birth (n=192) were partner/family/relationship support (28%) and moral/ personal beliefs (25%). For many respondents, this question posed certain difficulties in terms of endeavouring to explain briefly a past and very complex event. Many participants did not go beyond a simple explanation that they wanted the child, which may be a result of subsequently having given birth as a result of what was initially a crisis pregnancy.

For those participants whose crisis pregnancy resulted in abortion (n=28), different themes arose:

- Existing life commitments/plans (career/travel/college/children) (43%)
- Too young (19%)
- Relationship difficulties/new or not stable relationship (17%)
- Not ready for motherhood/did not want a child (14%).

Women who gave birth and who had an abortion were asked whether they felt they had a choice in the outcome of the pregnancy. Most of those who gave birth (81%) and 74% of those who had an abortion agreed that they had had a choice in the outcome. 15% of those who gave birth and 26% of those who had an abortion disagreed that they had had a choice, and the remainder neither agreed nor disagreed.

Participants were asked how they felt now about the outcome of the pregnancy in terms of whether it was the right thing to do or if they wished another outcome had been chosen. The majority of women who gave birth (98%) and those who had an abortion (95%) felt that the outcome of the pregnancy was the right thing to do, with the remainder wishing that another outcome had been chosen. Interestingly, 61% of those who experienced a miscarriage or stillbirth felt that had been the right outcome, with the remainder wishing that another outcome had occurred. Most of the men whose partner gave birth (93%) felt it was the right outcome, with 61% of those with abortion and 28% of those with miscarriage as the outcome feeling that it was the right outcome (table 4.16).

**Table 4.16 Outcome of pregnancy: retrospective assessment of whether outcome was the correct one, by gender and pregnancy outcome**

	Men (n=79) %			Women (n=228*) %		
	Gave birth (n=52)	Abortion (n=21)	Miscarriage /stillbirth (n=6)	Gave birth (n=190)	Abortion (n=26)	Miscarriage /stillbirth (n=12)
Right outcome	93	61	28	98	95	61
Another outcome preferable	7	39	72	2	5	39
Total	100	100	100	100	100	100

\* Question not answered by 4 participants.

They were then asked whether they had any regrets now about the outcome that was chosen (table 4.17).

**Table 4.17 Current regret regarding outcome of pregnancy, by gender and pregnancy outcome**

	Men (n=79) %			Women (n=232) %		
	Gave birth (n=52)	Abortion (n=21)	Miscarriage /stillbirth (n=6)	Gave birth (n=192)	Abortion (n=28)	Miscarriage /stillbirth (n=12)
A lot of regrets	0	18	36	1	10	0
Some regrets	4	49	40	7	22	22
No regrets	96	33	24	92	68	78
Total	100	100	100	100	100	100

More of the men who experienced abortion had 'some' or 'a lot' of regrets about the outcome (67%), than did women, most of whom (68%) had 'no regrets' about the chosen outcome. Similarly, 78% of women had no regrets that the outcome was miscarriage or stillbirth, compared with 24% of men. However, participant numbers in these groups are small.

Despite the negative experiences reported by those having a crisis pregnancy, some positive findings were reported. Women felt that they had a choice in relation to the pregnancy outcome and the vast majority of women across outcomes indicated that they now, on reflection, felt that their final choice concerning the outcome of the pregnancy was the right thing to do. Gender differences - men were less satisfied with each pregnancy outcome<sup>3</sup> - need to be explored further in qualitative research. Findings may indicate that the choices or preferences of women take precedence in crisis pregnancy situations.

<sup>3</sup> In one case, satisfaction figures for men are marginally higher than for women (96% of men and 92% of women had no regrets about giving birth).

## 5.0 Conclusions

- **Study participation rates:** This was a highly successful study in terms of the sample participation rate and participant willingness to disclose highly personal information about their lives. In particular, 335 individuals (245 women and 90 men or 10% of the sample) described personal experiences of a crisis pregnancy.
- **Sexual activity in Ireland:** Almost all of the sample (93%) had some experience of sexual intercourse in their lifetime, with 99% being heterosexual experiences. Similarly, 92% had been sexually active in the last year.
- **First sexual experience:** The average age at first sexual experience was between eighteen and nineteen years, with no gender differences. Younger people were over twice as likely to have had their first experience before the age of eighteen than were older people in the study.
- **Responsibility for sex education of children:** Most people see parents as having primary responsibility for the education of their children in sexual matters. Those who were older and/or were parents themselves were more likely to endorse this view. Among those in the study with children aged twelve to eighteen years, the majority had already spoken to their children about sexual matters. However, an important number of children had not been provided with such education by parents or others. It is not possible to aim to achieve good contraceptive and safe sex practices in the population if there is a sub-group of teenagers and young adults without basic sex education. More positively, three-quarters of parents were confident of their abilities in teaching their children about sexual matters. Nonetheless, a number of practical activities were endorsed, which could assist parents in this role. Booklets, parent meetings in schools and training in providing sex education to children were each endorsed by well over half of the parents.
- **Knowledge of sexual matters:** Fertility was chosen as one issue to assess because of its fundamental importance in terms of decisions about contraception. Irish information on this issue from ten years ago provided an unusual opportunity to compare knowledge levels over two decades. The finding that knowledge about the most fertile time in the female menstrual cycle is poorer in the 2003 sample of women than in the 1993 sample is profoundly worrying. While only 65% of women in 2003 knew the correct time, this level of knowledge was lowest in the youngest age group: 57% of 18-25 year olds knew the most fertile period of the month (compared with 67% of those aged 18-24 in 1993). It is of serious concern that so many recent school leavers do not know such a basic biological fact about human reproduction.
- **Contraceptive preferences:** Condoms were the most commonly used contraceptive (55% used condoms and 38% used the contraceptive pill in the past year). Those who were younger or more educated were also more likely to use condoms or the contraceptive pill. Older and less educated participants were more likely to have opted for permanent contraceptive options such as sterilisation.
- **Contraceptive use:** Most people reported always using contraception in the last year, with women, older people and those with higher education more likely to always use it. The results highlight particular targets for increasing

universal contraceptive use. Those who had their first sexual experience at earlier ages were less likely to use contraception in the last year. Those who do not plan for spontaneous sexual activity or who engage in sexual activity in the context of alcohol and/or drugs are more likely to do so without using contraception. Finally, regarding older groups in the study, it is unlikely that 18% of those aged 36-45 could be post-menopausal. Thus 'menopause' as an explanation for non-use of contraception by 18% of the older group is of concern. While fewer pregnancies were described as crises in this age group, it is still important to promote crisis pregnancy prevention for older women and their partners.

- **Contraceptive planning:** As an indicator of attitudes to preparation for contraception, attitudes to women carrying condoms were assessed. About a quarter of the sample saw this as an indicator of general sexual availability, with no gender or age differences. Those in casual relationships/not in relationships and those with lower educational attainment were more likely to hold these views. Reassuringly, very few people (women or men) reported difficult in speaking with a sexual partner about contraception. Low educational or occupational status and current casual relationship status identified those with most difficulty in this area. Similarly, most people would not be embarrassed to discuss these matters. However, those in lower social classes reported notable levels of difficulty.
- **Contraceptive services:** Women were much more likely to seek advice or contraceptive supplies from health professional sources (such as GPs), while men mainly used commercial sources (such as shops and vending machines). Preferences for sources of supplies mirrored current patterns of use. These differing types of location for women and men (i.e. health professional vs. commercial) present different challenges to health promotion agencies in terms of the messages and media needed to achieve targeted attitudinal and behaviour change.
- **Contraceptive availability:** Most people reported no difficulty in obtaining contraceptive advice or supplies. This is reassuring. Where there was a difficulty it was primarily about access, with much fewer people reporting embarrassment or financial or professional attitudes as barriers. Rural dwellers were twice as likely as urban participants not to have sought contraceptive advice in the past. Particular challenges for rural dwellers need to be addressed.
- **Contraceptive awareness (emergency contraceptive pill):** Over a quarter of sexually active women had used the emergency contraceptive pill in their lifetime. Younger and more educated women were more likely to have used it. Obtaining emergency contraception was not a problem for most people. Where it was, it was more about access than professional attitudes. The main problem with effective use of emergency contraception was knowledge: just over half the women studied (57%) knew about the correct timescale for use. Many believed the timescale for coverage to be a lot shorter than is actually the case. Younger people were also much more likely to be willing to use emergency contraception in the future if needed.
- **Contraceptive acceptability:** One-third of participants, particularly men and

older respondents, believed that condoms reduce sexual pleasure. In parallel, over half of the group felt that the contraceptive pill had dangerous side effects and two-thirds felt that taking a break from the pill was a good idea. In terms of preferences, the pill was not 'appealing' to one-third of participants (particularly older people and women). The concept of contraceptive choices for lifestyles is a very important one, given the range of beliefs of individuals concerning varying attributes of different contraceptives.

- **Role of alcohol and drugs:** Use of alcohol and drugs was associated with increased risk of unprotected sex, particularly for men, those with low levels of education and those in new or early periods of relationships.
- **Possibility of pregnancy now:** A substantial number (41%) of those who could become pregnant (but who were not currently pregnant or actively planning to be so) reported that pregnancy would be a positive or very positive outcome for them. There are no comparisons to make from other studies or countries to judge if this is a very high or low percentage. It does, however, have significant implications for (consistency of) contraceptive use. If many people 'would not mind' or would be quite pleased to find that they/their partner were pregnant, it is difficult to promote a culture of consistent contraceptive use. Most (75%) knew what they would do in this situation, with 70% of the overall group saying they would complete the pregnancy and parent the child. Younger people were less certain about what they would do in these circumstances.
- **Pregnancy experiences:** Just under two-thirds of women who had experienced sexual intercourse (61%) had been pregnant, with 14% reporting miscarriage/stillbirth, 3% abortion and <1% adoption. In terms of all pregnancies reported by women, most (83%) had resulted in a live birth and parenthood, 12% in miscarriage, 2% in abortion, 1% in stillbirth and <1% in adoption. Abortions thus constitute a very small number of outcomes of all pregnancies. The numbers reported are substantially lower than international figures (c.10%) and are likely to reflect (an unknown) combination of differing pregnancy management practices and differing willingness to disclose an abortion in studies across countries.
- **Crisis pregnancy experiences:** Younger women were much more likely to describe a pregnancy as a crisis pregnancy, with almost half (42%) of pregnancies to those aged 18-25 years old described as crisis pregnancies. Furthermore, one in four crisis pregnancies in this age group (18-25 years) result in abortion. The figures for both younger (those aged seventeen and under) and older participants are similar (6-7%), and lower than the figure for the 18-25 age group. Those with lower educational status were less likely to choose abortion in a crisis pregnancy. In terms of decisions, most were now satisfied that they had made the right choice, with more women satisfied than men. The proportion of crisis pregnancies resulting in abortion over the past three decades has increased from 3% of crisis pregnancies 21 to 30 years ago to 20% of crisis pregnancies in the last ten years. While most abortions were obtained by younger women, it is not clear whether the increasing proportion of abortions in the last decade is related to young age or a generational shift in attitudes to abortion.

- **Crisis pregnancy contraception profile:** One in three reported using some contraception on the occasion that resulted in a crisis pregnancy. While a fifth reported contraceptive pill failure (a judgment which would be made retrospectively as a consequence of finding oneself pregnant), a similar number reported condom failure (a factor obvious at the time of the sexual experience). Notwithstanding such factors, over half assumed they were not at risk of pregnancy, despite unprotected sex. Few who had unprotected sex or an episode of obvious contraceptive failure used the emergency contraceptive pill as back-up contraception.
- **Crisis pregnancy needs:** A minority of those facing a crisis pregnancy availed of targeted services. Over a quarter said that counselling would have helped them at the time. This did not differ by pregnancy outcome. Following the pregnancy, whether the outcome was birth or abortion, almost a third said they needed services or supports, with over two-thirds of these needing counselling. Clearly, wider knowledge of, and availability of such services is required to meet the unmet needs of women during and after a crisis pregnancy.
- **Crisis pregnancy options:** The options available to those facing crisis pregnancy are continuing the pregnancy (and keeping the baby or having it adopted) or terminating the pregnancy. Apart from personal preferences and supports, these decisions are taken in a wider social context of what is acceptable and available in society at a particular point in time. Attitudes to various options were sought from the overall sample. Attitudes to lone parenting were very positive. Attitudes to abortion were more mixed. Half of the group believed that women should always have the choice of having an abortion and a minority thought women should never have this option. The remainder believed that threat to life/health of the mother and sexual abuse were legitimate reasons for abortion, but much fewer were willing to endorse abortion where the foetus was deformed or because of financial constraints on the parents. Regarding adoption, there were significant reservations. One-third did not see it as a positive option for the child involved, with most people also not seeing it as a positive option for the birth mother. Overall, compared with other crisis pregnancy outcomes, there appear to be substantial reservations about adoption as a pregnancy outcome.
- **Crisis pregnancy disclosures:** Most people experiencing a crisis pregnancy did (and most people asked hypothetically said they would) disclose a crisis pregnancy to those close to them (partner and family) and to a health professional. General practitioners featured in this and other sections of the study as the most commonly used and preferred source of contraception and crisis pregnancy-related support.
- **Crisis pregnancy service advertising:** CPA's information campaign (Positive Options) has achieved coverage of one-third of its targeted audience, mainly through its quite recent (October 2003+) TV advertisements. This is encouraging, considering the diversity and challenges of reaching this young target group through any one channel. There was some lack of clarity concerning the CPA's purpose among the sample that had seen the campaign. Over half thought that the Agency themselves provided counselling and advice services. This may not be problematic, since the role of the Agency, for those

who contact it, is to provide information on where to source the advice they need. However, public preferences for information and advice concerning crisis pregnancy are for face-to-face or telephone helpline methods (over three-quarters of women selected these options as preferences). With the exception of the Internet (preferred by about one in ten participants), electronic forms of communication such as teletext and text messaging were less favoured for crisis pregnancy purposes. Given these findings, other forms of information access, e.g. a telephone advice and referral line, may need to be considered to complement the CPA's text-messaging service.

## 6.0 Recommendations

This first Irish Contraception and Crisis Pregnancy (ICCP) Study found that 20% of sexually active young Irish adults not planning a pregnancy did not always use contraception in the last year. On the most recent occasion of heterosexual intercourse, 10% of those at risk of an unplanned pregnancy did not use contraception. This has implications for both pregnancy and risk of sexually transmitted infections. The former is the focus of this study.

**Recommendation 1:** Health promotion strategies are needed to reduce the number of unprotected sexual encounters where pregnancy is not intended or desired.

This study has shown that women were more likely to seek advice or contraceptive supplies from health professional sources (such as GPs), while men mainly used commercial sources (such as shops and vending machines). Preferences for sources of supplies mirrored current patterns of use. Similarly, younger people were more likely to use commercial than health professional sources of advice and supplies. They were also more likely to use personal contacts for advice and supplies. Those with less education and from lower social classes were also more likely to have used commercial sources or not to have sought contraceptive advice than others. These differing ways of accessing contraceptive supplies and advice present challenges to health promotion agencies in terms of the messages and media needed to achieve targeted attitudinal and behaviour change.

**Recommendation 2:** Health promotion strategies concerning contraception need to be targeted appropriately to reach distinct groups in Irish society.

There were very varied attitudes to the main contraceptive options, with some people finding condoms unacceptable and others having concerns about aspects of the contraceptive pill. Differences related to gender, age, educational level and social class. For instance, one-third of participants, particularly men and older people, believed that condoms reduce sexual pleasure. In parallel, over half felt that the contraceptive pill had dangerous side effects and two-thirds felt that taking a break from the pill was a good idea. In terms of preferences, the pill was not 'appealing' to one-third of participants (particularly older people and women). The concept of contraceptive choices for lifestyles is a very important one, given the range of attitudes of individuals concerning the acceptability of various forms of contraception. Health professionals should proactively explore contraceptive choices that suit an individual's lifestyle choices. This may require additional training or information support for some professionals.

**Recommendation 3:** Health promotion strategies need to encompass the concept of contraceptive choice, given the very varied range of attitudes concerning the acceptability of various forms of contraception.

There is a clear need to promote a culture of both consistent contraceptive use and responsibility for consistent contraceptive use. The study found that those who did not plan for the possibility of spontaneous sexual activity or who engaged in sexual activity in the context of alcohol and/or drug use were much more likely to do so without using contraception. The study also found attitudinal barriers to planning for protected sex. Evidence of forward planning concerning sexual encounters (i.e. a woman carrying condoms) was negatively judged by about a quarter of those interviewed (she would be seen as 'easy' or looking for sex). Thus, more positive attitudes to responsibility for contraception and to planning for contraception in possible sexual encounters need to be developed. Public campaigns used in other countries, which focus on the irresponsibility (in terms of both contraception and sexually transmitted infections) of unprotected sex, need to be considered. These could parallel current Irish campaigns on the irresponsibility of drinking and driving. The importance of being able to negotiate safe-sex practices (including abstinence) and to prevent crisis pregnancy is vital. While this study found that most people had no difficulty in aspects of planning for protected sex, e.g. discussing contraception with a partner or obtaining condoms, the evidence suggests that being able to do something is not the same as actually doing it. Aspects of self-efficacy (believing one can engage in a certain behaviour) need to be combined with attitudes (believing it is important to always engage in the behaviour), if consistently protected sexual encounters are to be achieved.

**Recommendation 4:** Health promotion strategies need to foster more responsible public attitudes to planning for contraception and safe sex.

Planning for safe sexual encounters needs to address the general context of unexpected sexual encounters, as already outlined, but also the more specific context of sex while under the influence of alcohol or drugs. Alcohol and drugs were associated with an increased risk of unprotected sex, particularly for men, those with low levels of education and those in new or early stages of relationships. Reducing the negative impact of alcohol and drugs on contraceptive and safe-sex practices needs a stronger, clearer policy focus across all sectors providing education, information and services relating to sexual health and contraception. The new National Alcohol Policy needs to take account of this clear link between alcohol and unprotected sexual behaviour. Similarly, the life skills programmes, provided as part of the RSE and SPHE programmes in schools, (which include an exploration of the impact of alcohol on sexual behaviour and particularly risk-taking behaviour) need to be reconsidered, to determine how best to address the challenges of alcohol/drugs in sexual situations. For those young people who may be 'less accessible' (i.e. early school leavers), alternatives to current RSE and SPHE strategies need to be developed to provide important messages concerning contraception and safe sex generally, to include the topic of alcohol/drug use.

**Recommendation 5:** Health promotion strategies need to foster more responsible public behaviour concerning alcohol and drug use, given their role in unprotected sexual encounters.

Assessment of risk of pregnancy may be an important determinant of behaviour. When intentions or circumstances result in an unprotected sexual encounter, emergency contraception is a retrospective form of protection. Over a quarter of those surveyed had used (or a partner had used) the emergency contraceptive pill on some occasion. In relation to effective use of emergency contraception, the main area of difficulty identified in this study was knowledge. While obtaining emergency contraception was not a problem for most people, almost half of the women studied did not know about the correct timescale for its use. Many believed the timescale for coverage to be a lot shorter than is actually the case. Further to this, a fifth reported contraceptive pill failure (a judgment that would be made retrospectively, as a consequence of finding oneself pregnant) on the occasion that resulted in a crisis pregnancy. A similar number reported condom failure (a factor obvious at the time of the sexual experience). Over half of these assumed they were not at risk of pregnancy, despite obviously unprotected sex. Few who had unprotected sex or an episode of obvious contraceptive failure used the emergency contraceptive pill as back-up contraception. Thus public awareness of how to use (timescale for coverage) and when to use (when at risk of pregnancy) emergency contraception is needed. A related assessment of risk concerns those who believed (but did not have medical confirmation) that they were infertile and those who believed that they could not become pregnant because of the menopause. A substantial minority of women in this study (aged under 46 years, as this was the study cut-off point) believed themselves to be unlikely to become pregnant because of their age. However, few women are menopausal by age 45 years.

**Recommendation 6:** Education concerning pregnancy risk and decisions about when and how to use contraception, including emergency contraception, is needed.

It is difficult in lengthy general population surveys such as this to comprehensively assess levels of knowledge about sexual health matters. Knowledge of the most fertile time in a woman's menstrual cycle was chosen as a specific item to assess because of its fundamental importance in terms of decisions about contraception. It is of serious concern that 46% of those surveyed did not know such a basic biological fact about human reproduction (with knowledge being even lower for the 18-25 year age group, i.e. those most recently finished secondary school). Based on a previous study, this knowledge gap appears to have worsened over the past ten years and steps need to be taken, both with adult and youth populations, to improve this particular area of knowledge. In terms of school education, the Department of Education's Relationships and Sexual Education (RSE) topics for Senior Cycle students include a module on human growth and development. This module covers the issue of fertility and family planning. However, not all schools have implemented the RSE programme. This question concerned only one knowledge item. It is unclear what other information deficits exist in knowledge about sexuality in the Irish population.

**Recommendation 7:** Knowledge about basic aspects of reproduction, sexual behaviour and contraception and protection practices in distinct population sub-groups should be evaluated.

Regarding parental education of children, this study found that most parents had spoken to their older children about sex and were confident of their abilities in teaching their children about sexual matters. Nonetheless, parents also endorsed a number of

practical activities that could further assist them in this role. Booklets, parent meetings in schools and training in providing sex education to children were each endorsed by over half of the parents.

**Recommendation 8:** Parents need to be acknowledged as primary sex educators of their children and supported in this task through school- and community-based initiatives.

The options available to those facing crisis pregnancy are continuing with the pregnancy (and keeping the baby at birth or having it adopted) or terminating the pregnancy. Apart from personal preferences and supports, these decisions are taken in a wider social context of what is acceptable and available in society at a particular point in time. Attitudes to various options are thus important to understand and were sought from the overall sample. Attitudes to lone parenting were very positive. Attitudes to abortion were more mixed, with half of the group believing that women should always have the choice, a minority thinking they should never have a choice and the remainder believing that there were more and less legitimate reasons for abortion. Regarding adoption, there were significant reservations. One-third did not see it as a positive option for the child involved, with most people also not seeing it as a positive option for the birth mother. Overall, compared with other crisis pregnancy outcomes, there appear to be substantial reservations about adoption as a pregnancy outcome. Until now, there has not been a contemporary or comprehensive national profile of attitudes, behaviours and outcomes concerning crisis pregnancy. This Irish Contraception and Crisis Pregnancy Study provides a unique evidence base from which to encourage public discussion of how things are in Irish society and how we, as citizens, would like them to be in the future.

**Recommendation 9:** A public debate concerning unprotected sex, contraception, crisis pregnancy and their outcomes in contemporary Ireland is needed.

In this study, a minority of those facing a crisis pregnancy availed of specialised services. Over a quarter said that counselling would have helped them at the time. This did not differ by pregnancy outcome (whether individuals chose to have an abortion or to give birth and keep the baby or arrange an adoption). Following the pregnancy (again, regardless of the outcome), almost a third said they needed services or supports and over two-thirds of this group needed counselling. Notably, the need for counselling and support was similar regardless of the pregnancy outcome. Most people experiencing a crisis pregnancy did (and most people asked hypothetically said they would) disclose a crisis pregnancy to those close to them (partner and family) and to a health professional. General practitioners featured in this and other sections of the study as the most commonly used and preferred source of contraception and crisis pregnancy-related support.

**Recommendation 10:** Counselling and other support services need to be available to and accessible by women and their partners both during and after crisis pregnancy.

To be effective, services need not only to be available but also to be accessible. A variety of services are available nationally to support those experiencing crisis pregnancy. The aim of the CPA text-messaging service was to put all of these services into a format that could be accessed easily and confidentially. First contact with services in the often distressing and confusing circumstances of crisis pregnancy is very important. Preferences of those surveyed for information and advice concerning crisis pregnancy were for face-to-face or telephone-helpline methods (over three-quarters of women

selected these options as preferences). With the exception of the Internet (preferred by about one in ten participants), electronic forms of communication such as teletext and text messaging were less favoured for crisis pregnancy purposes. An intermediate measure between the more passive internet and text-messaging information-provision options and the more interactive telephone or face-to-face counselling options is the provision of an interactive information service by telephone. This could assist those seeking services to find what best meets their needs and possibilities (including travel to use services). In making this point, a balance needs to be struck between use of scarce resources and efficient service delivery. Clearly a text-messaging service can reach many individuals in an up-to-date and confidential manner. Whether its coverage is comprehensive enough to ensure that all who face crisis pregnancy have an information finding strategy that works for them needs to be determined. An interactive information service poses other challenges in a system where agencies with very differing crisis pregnancy management philosophies endeavour to provide services to the same overall pool of clients. However, difficulties in achieving a balanced information provision service should not deter those aiming to provide the best individual choice for all who face a crisis pregnancy.

**Recommendation 11:** Accessibility of information on crisis pregnancy services needs to be assessed.

Information is a key pre-requisite to effective planning and service evaluation in crisis pregnancy services, as elsewhere. Many of the issues discussed in this study were, of necessity, assessed in an 'overview' manner because of the large number of issues to be assessed and the nature of the study (a telephone interview with a reasonable maximum length). Thus the study raises as many questions as it provides answers. A major asset of a large epidemiological study such as this is to identify those issues that require more detailed questioning or analysis with specific sub-groups of the population. Projects of this nature have already been commissioned by the CPA. A second important role for this study is to serve as a baseline from which to observe change in the future - whether because of unrelated cultural shifts or because of specific interventions concerning crisis pregnancy by health or other organisations. Integration of related research activities is the most effective and efficient way to achieve a greater understanding of issues concerning contraception and crisis pregnancy. Without adequate understanding, efforts to predict or change attitudes and behaviour are unlikely to be successful.

**Recommendation 12:** Research activities concerning contraception and crisis pregnancy in Ireland should be integrated to ensure the best use of public resources in developing a knowledge base capable of informing policy and practice.

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## Appendix 1

### Abortion law and major events affecting abortion law in Ireland, 1861-2001

Year	Law/event	Impact
1861	Offences Against the Person Act Article 58 and Article 59	Abortion made a criminal offence if procured by the women herself or if assisted by another person.
1983	Eighth Amendment to the Constitution Article 40.3.3	The state acknowledged the right to life of the unborn but gave due regard to the equal right to the life of the mother.
1986	In the High Court SPUC takes cases against Dublin Well Woman, Open Door Counselling and Student Unions to stop them providing information on abortion	The provision of information on where and how to obtain an abortion found to be in breach of article 40.3.3. as it undermines the right to life of the unborn
1988	The Supreme Court	Upholds the High Court's (above) decisions
1991	The European Court of Justice	Ruled that students' unions cannot distribute information on abortion services because they have no financial links with clinics providing the services in Britain
1992 (Feb)	High Court - "The X Case"	Granted an injunction preventing 14-year-old rape victim from leaving Ireland to have an abortion
1992 (Feb)	Supreme Court	Overtaken High Court's decision on the grounds that there was a real risk to the mother's life, as distinct from health, which could only be avoided by a termination of her pregnancy. Also ruled that only women whose lives were endangered could travel to secure an abortion.
1992	European Court on Human Rights	Ruled that the ban on abortion information was in breach with Article 10 of the European Convention on Human Rights which guarantees freedom of expression
1992	12th Amendment- exclude self destruction as grounds for abortion; 13th-freedom to travel; 14th-right to info. about services in other states	Amended Article 40.3.3 to safeguard the right to travel and to information. The Twelfth amendment was defeated.
1995	Regulation of Information Act	Legalised the provision of information, advice and counselling on abortion. Outlined conditions under which abortion information can be provided
1996	Constitutional Review Group	Recommended that legislation should be introduced to implement the "X case" judgement, outlining conditions under which abortion could be carried out lawfully in Ireland

Year	Law/event	Impact
1997	Supreme Court	Lifted injunction against the students' unions
1998	District Court - "The C Case"	Persons subject to care orders can be prohibited from travelling for abortion if not deemed likely to take their own lives as a result of the pregnancy
1998	Abortion Working Group	Took submissions for a Green Paper on Abortion
1999	Green Paper On Abortion	Seven options outlined from absolute ban to permitting abortion on grounds beyond "X case"
2000	The All-Party Oireachtas Committee	Series of public oral hearings, received over 100,000 submissions
2001	Irish Government	Announced plans to hold referendum dealing with 1992 X case. Established Crisis Pregnancy Agency
2002	25th Amendment of the Constitution (Protection of Human Life in Pregnancy) Bill 2002	This bill was defeated and the 1992 X case ruling upheld

Source: Irish Family Planning Association 2003, Kingston, Whelan, Bacik 1997, Mahon et al. 1998

## Appendix 2

### National survey on contraception and pregnancy

#### Introduction

##### *General*

Hello, my name is \_\_\_\_\_. I'm phoning you about a survey which is being carried out by the Royal College of Surgeons in Ireland and the Economic and Social Research Institute. I'm from the ESRI.

We are doing this confidential survey of the general population dealing with attitudes and behaviour.

We do not know your name or address or the name or address of your household.

As part of our survey we would like to interview [males and females between the ages of 18 and 45].

We selected your phone number at random by a computer, like the way the numbers are selected in the lottery.

All of the information you give us is treated in the strictest confidence and is not passed on to anyone in any way that could identify you or your household. Remember that I don't know your name and address anyway.

##### *To Respondent*

Hello, my name is \_\_\_\_\_. The Royal College of Surgeons in Ireland is doing a survey, in conjunction with the Economic and Social Research Institute, the ESRI. We are doing a survey for a state funded agency called the Crisis Pregnancy Agency who are looking at attitudes towards contraception and pregnancies in Ireland today.

All of the information you give to us is treated in the strictest confidence and is not passed on to anyone in any way that could identify you or your household. Remember that I don't know your name and address anyway.

If you are concerned about the authenticity of the study I can give you a freephone number (XXXX XXXXXX) OR

The ESRI's main switchboard is Dublin XXXXXXX and is open from 9.00a.m. – 5.00p.m. Monday to Friday OR

I can call a local Garda station of your choice and confirm with them that I am doing the survey and will phone you back with the name of the garda whom I speak to OR

During office hours tomorrow I will fax a letter to the local Garda station of your choice and will confirm with them that I am doing the survey and could arrange to talk to you at another time when you have been satisfied that this is a genuine call.

Have you any questions you want to ask me?

Can I first re-check your age? DO NOT INTERVIEW IF LESS THAN 18 YEARS.

## Appendix 3

### Addressing Respondent Distress

#### *Stopping the Interview Due to Distress*

If the respondent has let you know that they want to stop the interview due to distress, or you feel that the interview should be stopped for any reason, try to work through the following suggestions as to how to deal with this situation. The 'right' words are not important. If you are concerned, your voice and manner will show it. Let the person talk, and be willing to listen to whatever they have to say.

- Be empathic. Let them know that you realise that what they have just told you is very difficult to talk about.
- Ask them what they think they might do to feel better. Do they have someone they could talk to? If alone, do they know of someone they could call? Who would be a source of strength and reassurance to them?
- Have they discussed this issue with a professional before? A counsellor? Their GP? If not, would they be willing to do so? Do they have someone in mind? Would they like referral numbers of agencies who help others with these sorts of issues? Offer the freephone text number which will allow them to access numbers for a large number of crisis pregnancy agencies (XXXX). Ask them to write the number down, as sometimes people don't think they need it, but later wish they had the number.
- Tell them you'd like to stop the interview at this point and would like to call them back tomorrow to see how they are doing. Let them know the call is not to finish the survey – that is their decision. Explain what the topics of the remaining sections are about. If they want to finish the survey, tell them you'll set up another appointment to complete the survey tomorrow.





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