Crisis Pregnancy Programme Report No. 24

Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-2010)

A Survey of the General Population

Orla McBride, Karen Morgan and Hannah McGee

RESEARCH

2012

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

crisispregnancyprogramme

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ISBN: 978-1-905199-32-7

Foreword

The HSE Crisis Pregnancy Programme, (formerly the Crisis Pregnancy Agency) has implemented two national strategies to prevent crisis pregnancy and provide supports for those experiencing crisis pregnancies. The Crisis Pregnancy Programme leads the coordination and implementation of a range of services, programmes and initiatives in the areas of sexual health protection and crisis pregnancy support.

Research, knowledge transfer and evidence-based policy development are strategic priorities for the Programme. To date, the Programme has published over 35 research reports in the fields of sexual health and reproductive decision-making. Several of these are seminal studies and all have made a direct impact on choices and directions the Programme has taken in defining problems, assessing needs, responding to trends, measuring effectiveness and impacts of initiatives and developing proposals for change and improvement.

The Irish Contraception and Crisis Pregnancy Study (ICCP) 2010 is critical. It comes ten years after the establishment of the former Crisis Pregnancy Agency and it follows the implementation of two national strategies in this complex and at times divisive area. The results of ICCP 2010 have fed directly into a new set of strategic priorities identified by the Programme.

We hope the findings from this study will help with policy developments in this important area. The study findings will help to identify challenges that need to be addressed; they will also set out key measures which allow strategies in this area to be evaluated.

I would like to thank the members of the Advisory Group for giving their time and expertise to this important and complex research project.

I would like to thank the research team, led by Professor Hannah McGee in the Royal College of Surgeons in Ireland.

I would like to thank the Director of the Crisis Pregnancy Programme, Dr. Stephanie O'Keeffe and the staff of the Programme for their commitment and for leading such a strong evidence-based approach to strategy implementation.

Finally, I would like to thank all of the anonymous participants in this survey who gave their time and input to help us understand sexual health needs and do our work more effectively and efficiently.

Dr. Kevin Kelleher
HSE, Assistant National Director, Health Protection

Introduction

This is the third national survey undertaken by the Crisis Pregnancy Programme (CPP (formerly the Crisis Pregnancy Agency)). The first, The Irish Contraception and Crisis Pregnancy Study (ICCP), was commissioned in 2002 when the Crisis Pregnancy Agency (CPA) was first established. ICCP was designed to establish baseline measures for crisis pregnancy prevalence in addition to a broad range of sexual health indicators related to crisis pregnancy. These indicators did not exist in an Irish context prior to this survey.

A second, much larger sexual health survey was undertaken in 2004 with the Department of Health and Children: the Irish Study of Sexual Health and Relationships (ISSHR). This was a much larger piece of work, with double the sample size of the earlier survey. The ISSHR addressed a much broader range of behaviours, including behaviours among the population with experience of same-sex relationships exclusively. The ISSHR mirrored international studies undertaken in the field, both in its scale and its measures.

This third survey, The Irish Contraception and Crisis Pregnancy Study (ICCP) 2010, allows us to assess the impacts of the CPP's work since 2003. Two national strategies have been implemented since the establishment of the former Crisis Pregnancy Agency. A significant investment has been made in sexual health protection and crisis pregnancy activities over a ten-year period. It is important to analyse the work that has been undertaken and assess its impact. Several kinds and levels of data are required to do this successfully. Survey data capturing key measures is one key component.

In terms of outcomes, we have seen significant impacts on several indicators since the inception of the former CPA. On a population level, we see decreasing levels of abortion, particularly among women in their early twenties. We have seen decreases over a ten-year period in the number and rate of births to teenagers. From a service provision point of view, we have seen the full integration of crisis pregnancy counselling and post-abortion support services, which have been expanded by over 50% nationally. We have also seen examples of progressive developments in the area of service provision for young people. We have seen the initiation and implementation of highly effective national social marketing campaigns designed to challenge behavioural and attitudinal norms that give rise to unsafe sexual behaviours.

This survey data demonstrates that there have been improvements in a range of sexual health behaviours over a seven-year period. Findings suggest strongly that trends being observed on a population level can be explained by better and more effective use of contraception. Findings also suggest improvements in sex education over the same period. We need to continue to build on the positive results in this survey. We also need to redouble our efforts to make impacts in areas where we have been unsuccessful or where new challenges have emerged.

We will work to disseminate the findings from this report and to continue to promote an evidence-based approach to policy formation in this field. We hope these findings will inform a broad range of stakeholders, from policy makers, to health, education and social care professionals, researchers and a range of organisations and individuals working in the broad field of sexual health.

I would like to thank all of the 3,002 people who agreed to participate in this survey, in addition to the 261 women from Nigeria and Poland who agreed to participate in the supplementary sample. This survey had a response rate of 69%, which is very impressive for a survey of this type and on this topic. We are very grateful to the men and women who agreed to share their thoughts and experiences with the interviewers.

I would like to thank the research team for leading and coordinating this research project so professionally. Thank you to Professor Hannah McGee, Dr Orla McBride and Dr Karen Morgan, Royal College of Surgeons in Ireland. I would also like to thank Gerard O'Neill, Wendy Kehoe, Corona Naessens (Amárach Research) and the interview team for ensuring the data obtained is of the highest quality.

I would like to thank the members of the Advisory Group for giving their time and expertise in the interests of ensuring this research is as robust and useful as it can be. I would like to thank Laurence Bond (Equality Authority) for chairing the group and to members Professor Andrew Murphy (National University of Ireland, Galway), Dr Aidan O'Hora, (HSE Health Protection Surveillance Centre), Caroline Hogg (Pharmaceutical Society of Ireland) and Mary Smith, (HSE Crisis Pregnancy Programme).

I would like to thank all of the staff of the Crisis Pregnancy Programme for working on this project in one guise or another. In particular, I would like to thank the research staff, Mary Smith (formerly CPP) and Maeve O'Brien for their commitment and skill in managing a complex study and bringing the publication to fruition.

Dr Stephanie O'Keeffe
Director, HSE Crisis Pregnancy Programme

About the authors

Dr Orla McBride is a postdoctoral researcher within the Department of Psychology, Population Health Sciences, Royal College of Surgeons in Ireland (RCSI). She is the research coordinator for the Irish Contraception and Crisis Pregnancy Study (ICCP-2010). Dr. McBride has a BSc (Hons) in Applied Psychology, a PhD in Psychology, and a Postgraduate Certificate in Higher Education Practice, from the University of Ulster, Northern Ireland. She has worked as a researcher at the National Drug and Alcohol Research Centre, University of New South Wales (Australia) and at the Department of Epidemiology, Michigan State University (USA). Dr. McBride's main research interests include mental health and analyzing data from large, general population health surveys.

Dr Karen Morgan is currently working as a lecturer in psychology at Perdana University-Royal College of Surgeons in Ireland (PU-RCSI) in Kuala Lumpar, Malaysia. She has a BA in Psychology and an MA in Social and Organisational Psychology. Dr. Morgan's PhD was completed as part of Healthy Ageing and Research Programme (HARP) at RCSI, which was a multi-disciplinary, cross-institutional and cross-border project. Her research interests include cardiovascular health, quality of care, ageing and population health. Dr. Morgan was the research manager for the *Survey of Lifestyles, Attitudes and Nutrition in Ireland* (SLÁN, 2007) and she acts as methodological consultant on a number of national/international health surveys. She is the Secretary of the European Health Psychology Society.

Professor Hannah McGee is a health psychologist and professor of psychology at RCSI. Her research profile includes national studies of ageing, cardiovascular care, sexual health and population health behaviour. She has been principal investigator on many interdisciplinary health services research projects, with over 100 peer-review publications and books. She chaired the working group to develop the government's National Cardiovascular Policy (2010-2019): *Changing Cardiovascular Health*. Professor McGee is the current Dean of the Faculty of Medicine and Health Sciences at RCSI. She is the principal investigator on the ICCP-2010 study.

Acknowledgements

The Irish Contraception and Crisis Pregnancy Study (ICCP-2010) was commissioned by the Health Service Executive Crisis Pregnancy Programme (CPP), formerly the Crisis Pregnancy Agency (CPA).

The ICCP-2010 has been a team effort and as researchers we have benefited greatly from the input and assistance of a wide range of people. Our first thanks go to the survey participants – over 3,000 people across the country who gave their time to provide us with important information about their sexual health and experiences of pregnancy. We thank the project management team at Amárach Research, in particular Corona Naessens, Wendy Kehoe (now at GlaxoSmithKline, UK), David Dunleavy and Mary Mulcahy, who ensured that the fieldwork and data entry ran smoothly and efficiently.

As a team, their expertise was crucial in sampling a diverse group of respondents and providing participants with a range of options for completing the survey. We would also like to thank the large team of telephone interviewers at Amárach Research who worked tirelessly to ensure a high response rate and top-quality data was obtained: Adrienne Montgomery, Amy Moroney, Anita Scallon, Anji Padayachee, Annmarie O'Neill, Aoife Denieffe, Christine McKeever, Ciara McGrath, Ciara Sherlock, Debra McGrath, Edel King, Eileen Purcell, Georgina Redmond, Geraldine Courtney, Jacinta Healy, Jean Matthews, Josephine Kelly, June Duncan, Malgorzata Grudzien, Margaret Desay, Marilyn Purcell, Samantha Gallagher, Sarah Gardener, and Stasia Ennis. We are also grateful to the field interviewers for their work in recruiting the supplement sample and respondents in the supplement sample who assisted them in recruiting other respondents.

A large number of other people contributed to the development of the methodology protocols and data analysis of the ICCP-2010. We are very grateful to Professor Dorothy Watson and Professor Richard Layte of the Economic and Social Research Institute (ESRI) and the Department of Sociology at Trinity College Dublin (TCD), for their assistance and expertise in relation to the survey methodology. The following were members of the Advisory Group Committee for all or part of the project: Dr Stephanie O'Keeffe (CPP), Mary Smith (CPP), Professor Andrew Murphy (NUIG), Dr Aidan O'Hora (HSE), Laurence Bond (Equality Authority), Caroline Hogg (Pharmaceutical Society of Ireland), Maeve O'Brien (CPP), Caroline Spillane (formerly CPP), Marsha Williams (CPP), and Gerard O'Neill (Amárach Research).

We hope the findings of this study – the third 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 CPP for funding this study and are pleased to be able to advance the evidence base on sexual health issues in Ireland.

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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Glossary

AOR	Adjusted odds ratio
BMW	Border, Midland and Western (region)
CATI	Computer-assisted telephone interviewing
CI	Confidence intervals
CPA	Crisis Pregnancy Agency
CPP	Crisis Pregnancy Programme
CSO	Central Statistics Office
ECP	Emergency contraceptive pill
ESRI	Economic and Social Research Institute
GMS	General Medical Scheme
GP	General practitioner
HIV	Human immunodeficiency virus
HSE	Health Service Executive
ICCP	Irish Contraception and Crisis Pregnancy Study
IMB	Irish Medicines Board
IUD	Intra-uterine device
IUS	Intra-uterine system
ISSHR	Irish Study of Sexual Health and Relationships
LARCs	Long-acting reversible contraception
MHI	Mental Health Inventory (index)
QNHS	Quarterly National Household Survey
RCSI	Royal College of Surgeons in Ireland
RDD	Random digit dialling
RSE	Relationships and Sexuality Education
SAVI	Sexual Abuse and Violence in Ireland Study
SC	Social class
SES	Socio-economic status
SLÁN	Survey of Lifestyle, Attitudes and Nutrition
SPHE	Social, Personal and Health Education
STI	Sexually transmitted infection
VAT	Value-added tax
WHO	World Health Organization

Executive summary

Introduction

The Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-2010) is a cross-sectional telephone survey of adults aged from 18 to 45 years and living in Ireland. ICCP-2010 follows on from two other national sexual health surveys: the 2003 Irish Contraception and Crisis Pregnancy Study (ICCP-2003) and the 2006 Irish Study of Sexual Health and Relationships (ISSHR). It seeks to provide: (1) data on current knowledge, attitudes and behaviours in relation to sex, contraception and pregnancy in Ireland; and (2) an opportunity to explore trends in relation to sex, contraception and pregnancy in Ireland over a number of years.

An overview of the main findings from ICCP-2010, as well as comparisons with ICCP-2003, are presented in this report. Tests were conducted to explore whether differences between the two surveys were statistically significant, where appropriate, and are highlighted below and in the main report.

Sample and methods

Respondents for ICCP-2010 were recruited through one of two samples. The primary 'national' sample consisted of 3,002 adults aged 18 to 25 randomly selected and recruited from the general population using mobile and landline telephones. ICCP-2010 was the first national survey in Ireland to recruit respondents via mobile and landline telephones. All interviews were conducted using computer-assisted telephone interviews (CATI). The overall response rate for this sample was 69% (79% for the landline telephone strand and 61% for the mobile telephone strand). The sample was representative of the general population in Ireland when compared with 2010 Quarterly National Household Survey (QNHS) figures and was further weighted to match the QNHS for analysis. The data were analysed by gender and age. The results of ICCP-2010 are compared with those of ICCP-2003 where possible, and ISSHR where relevant.

The 'supplement' sample consisted of a sample of Polish and Nigerian women aged 18 to 34 years, who moved to Ireland after the age of 13 (n=261). This opportunistic sample was recruited to obtain an overview of the views, practices and service needs of non-Irish women in relation to sexual behaviour, sexual health and pregnancy. These women spent the majority of their childhood in different social, educational and cultural environments and may have different knowledge, attitudes, behaviours and needs in relation to sex, contraception use and pregnancy. Data from this sample are analysed separately in Chapter 11 of the report.

Results

Experiences of first heterosexual intercourse

Experiencing sexual intercourse for the first time is a significant personal life event. Many individual, cultural and social factors influence sexual behaviour and sexual initiation. Early onset of sexual intercourse is associated with a range of negative health and social outcomes, including sexually transmitted infections and unplanned pregnancy. Understanding the determinants of early onset of sexual intercourse could be important factors to take into account when seeking to establish and maintain long-term sexual health.

Key findings include:

- A sizeable proportion of young people living in Ireland wait until adulthood to have sex for the first time. This trend appears to have been sustained in recent years, with 15% of adults aged 18 to 25 reporting that they have never had sex, compared with 13% in the same age group in ICCP-2003.
- The median or average age for experiencing sex for the first time among 18-25 year olds was 17 for men and 18 for women. In 2003 the median age for young men and women was 17.
- Another large group experienced sex for the first time before the legal age of consent in Ireland (i.e., 17 years). The proportion of men having sex before the age of 17 (28%) has remained stable since ICCP-2003 (29%), but the proportion of women increased from 14% to 17% between 2003 and 2010.
- The proportion of young women aged 18 to 25 who had experienced sex for the first time before the age of 17 was 26% in 2010, an increase from 21% in 2003. For young men it was 37% (compared with 39% in 2003).
- It has become more common to use contraception on the occasion of first sexual intercourse: 89% of 18 to 25 year olds and 80% of 26 to 35 year olds reported using contraception the first time they had sexual intercourse, compared with 61% of 36 to 45 year olds.
- Nevertheless, specific groups of people have been identified as being 'at risk' for not using contraception at first sexual intercourse. These include men, people with a pre-Leaving Certificate education, those in the lower social classes and those who have sex for the first time before the age of 17.

Contraception use

Consistent use of contraception is the most effective way to reduce the risk of experiencing an unwanted pregnancy or acquiring a sexually transmitted infection. Despite this, many individuals, including those who do not want a pregnancy and those who are not in a monogamous relationship, fail to adhere to a regular contraceptive routine. Decisions relating to the use of contraception are complex and involve a variety of individual, cultural and social factors. Obtaining a clear picture of the current issues

or factors that influence adults' decisions to use contraception is imperative in order to advise policy and reduce the number of crisis pregnancies.

Key findings include:

- Use of any contraceptive method(s) to avoid pregnancy during the previous year by adults who were having sex but not actively trying to conceive was similar in ICCP-2010 (92%) and ICCP-2003 (94%).
- Consistent contraception use at every occasion of sexual intercourse by adults not actively trying to conceive was lower among all adults in ICCP-2010 (78%) than in ICCP-2003 (83%); however, more younger adults (18-25 years) surveyed in 2010 used contraception consistently every time they had sex (79%) than did in 2003 (76%).
- The proportion of respondents who had not used contraception because 'sex was not planned/not prepared/no contraception available' fell by more than two-thirds from 48% in ICCP-2003 to 15% in ICCP-2010; and the percentage of 18 to 25 year olds giving this as a reason dropped from 58% in 2003 to 19% in 2010.
- Older adults, married people and those in the lower social classes were less likely to use contraception than younger adults, single people and those in the higher social classes.
- Condoms and the contraceptive pill remain the most commonly used contraceptives, with their use increasing from ICCP-2003 (57% and 39% respectively) to ICCP-2010 (62% and 43% respectively).
- More adults had been sterilised in ICCP-2003 (8%) than in ICCP-2010 (6%).
- Use of the contraceptive ring, patch, injections or implanted capsules increased from 3% in ICCP-2003 to 8% in ICCP-2010, with the biggest increase among 18 to 25 year olds (from 4% in 2003 to 12% in 2010).
- Use of long-acting reversible contraceptives (e.g., intra-uterine devices or intra-uterine systems) increased overall from 6% in ICCP-2003 to 11% in ICCP-2010. This trend is particularly evident in the older age groups.
- Not using contraception due to drinking alcohol or taking drugs was less common in ICCP 2010 (16% gave this reason) than in ICCP 2003 (21%).

Accessing contraception

Many factors impact on whether a person uses contraception when having sex; however, it is undeniable that the ability to access contraceptive supplies and services is an important issue in determining use. Up-to-date national data on issues relating to access help identify those factors that influence use of contraception.

Key findings include:

- The proportion of adults who had sought advice on contraceptive supplies remained relatively stable: 10% of adults in ICCP-2010 reported that they never sourced contraceptive supplies or advice, compared with 12% in ICCP-2003.

- Nearly half (47%) of women surveyed in 2010 stated that they would prefer to get their contraception at a pharmacy (chemist shop), with just over one-third (37%) preferring to get contraception from their GP; the opposite trend was true in 2003 (50% preferring a GP and 26% a pharmacy).
- Men's preference to obtain contraception from a pharmacy or commercial outlet has remained stable since 2003.
- The vast majority of respondents had no difficulty in accessing contraception; however, the proportion of women and men who experienced some level of difficulty in accessing contraceptive services increased from 4% and 6% respectively in ICCP-2003 to 15% and 9% respectively in ICCP-2010.
- The three main reasons given by those who had difficulty in accessing contraception were access/locality, embarrassment and cost.
- Of the 11% of respondents who had difficulty in accessing contraception, approximately 1 in 4 reported embarrassment as a factor. More young adults than older adults reported embarrassment as a barrier to accessing contraception, but most 18-25 year olds did not report problems with embarrassment or accessing contraception.
- More adults who had difficulty in accessing contraception reported the cost of contraception as a barrier than did in ICCP-2003 (24% versus 17%).
- More younger women (aged 18 to 25) reported that the cost of their contraceptive pill, ring or patch prescription prevented them from refilling their prescription (13%), compared with older women (aged 36 to 45) (4%).
- The cost of condoms was a bigger issue for young men (10%) and women (7%) aged 18 to 25 than it was for those aged 36 to 45 (3% of men and 2% of women).

Pregnancy outcomes

Experiencing a pregnancy is a significant life event for the woman or couple involved. Once a pregnancy occurs, there are a number of possible outcomes. Some outcomes are chosen by the woman or couple involved (e.g., a live birth followed by parenthood or adoption, or an abortion), whereas others are usually determined by medical conditions (e.g., a miscarriage or stillbirth). Whilst national statistics provide information on the annual birth rates, obtaining a more detailed picture of the lifetime experiences of all pregnancy outcomes is necessary for planning pregnancy-related services.

Key findings include:

- 52% of adults had had sex that resulted in a pregnancy at some point in their lifetime; this is similar to ICCP-2003 (54%).
- Adults living in Ireland in 2010 have experienced a wide variety of pregnancy outcomes; this situation has changed somewhat since ICCP-2003: the proportion of all pregnancies ending in a live birth decreased (82% in 2003; 74% in 2010), those ending in miscarriage increased (13% in 2003; 18% in 2010), those ending in abortion also increased (2% in 2003; 4% in 2010), whereas those ending in adoption or stillbirth remained low and stable (1% or less in 2003 and 2010).

Experiences of crisis pregnancy

It is estimated that approximately half of all pregnancies across the world are unplanned. This is problematic because such pregnancies do not always have the opportunity to benefit from pre-pregnancy and early antenatal promotion activities that have been proven to improve infant outcomes. Reducing the number of unplanned or unwanted pregnancies, therefore, is a global challenge. ICCP-2010 defined a crisis pregnancy as a pregnancy that represents a personal crisis or an emotional trauma in either of the following circumstances: (a) a pregnancy that began as a crisis, even if the crisis was subsequently resolved or (b) a pregnancy that develops into a crisis before the birth due to a change in circumstances. Understanding the antecedents of crisis pregnancy, and the level of service use by people experiencing a crisis pregnancy, helps service planning. Identifying changes in how crisis pregnancies are experienced is vital if services are to meet the needs of people dealing with a crisis pregnancy.

Key findings include:

- Approximately 1 in 5 men and 1 in 3 women with experience of pregnancy have experienced a crisis pregnancy. More women experienced a crisis pregnancy in ICCP-2010 (35%) than did in ICCP-2003 (28%); the proportion of men experiencing a crisis pregnancy has remained stable (21% in 2010; 22% in 2003).
- Younger women or women with a pre-Leaving Certificate education are more likely than older women or women with higher levels of education to have experienced a crisis pregnancy.
- For women, 1 in every 7 pregnancies was a crisis pregnancy. The proportion of pregnancies experienced as crises by women decreased with age in both ICCP surveys: 44% among 18 to 25 year olds in 2010 (41% in 2003), 19% of 26 to 35 year olds (15% in 2003) and 11% of 36 to 45 year olds (7% in 2003).
- For men, 1 in every 11 pregnancies was a crisis pregnancy. The proportion experienced as crises by men also decreased with age in both ICCP surveys: 33% of 18 to 25 year olds in 2010 (32% in 2003), 10% of 26 to 35 year olds (15% in 2003) and 7% of 36 to 45 year olds (4% in 2003).
- For men and women in 2010, "not planned" and "too young" were the most common reasons why the pregnancy was viewed as a crisis. Financial reasons were more commonly cited in 2010 compared to 2003, for both men (13% in 2010 vs. 12% in 2003) and women (9% in 2010 vs. 2% in 2003).
- In both ICCP surveys, men and women who experienced a crisis pregnancy reported greater psychological distress at the time of the crisis pregnancy, compared with the general population.
- A small, but significant, group of women reported feeling very nervous, downhearted and blue, or so down in the dumps that nothing could cheer them up, 'a good bit of the time', 'most of the time' or 'all of the time' during their crisis pregnancy (n=107). 26 of these women experienced thoughts of harming themselves or ending it all (labelled as 'suicidal ideation') during the crisis pregnancy.

- For women, the outcome of all crisis pregnancies were: parenthood (62%), miscarriage (14%), abortion (21%), adoption (1%) and currently pregnant (1%).
- For men, the outcome of all crisis pregnancies were: parenthood (54%), miscarriage (20%), abortion (22%), adoption (1%) and 1% of men surveyed had a partner who was experiencing a crisis pregnancy at the time of the interview.
- More adults in ICCP-2010 (46% of women; 56% of men) felt that an unexpected or unplanned pregnancy would be a positive event at this time in their lives, than did in ICCP-2003 (35% of women; 47% of men). However, there was greater uncertainty about which outcome would be chosen in the event of an unplanned pregnancy in the future. Of those who chose a definite outcome, the proportion choosing parenthood decreased from 72% in 2003 to 68% in 2010, whereas the proportion choosing abortion or adoption remained low and stable.

Sex education

Understanding the extent to which people receive sex education when they are growing up, what topics are addressed and by whom, is important when trying to explain people's sexual behaviour and pregnancy experiences in later life.

Key findings include:

- Nearly three-quarters of adults surveyed (72%) had received sex education at some point in their lives. More adults aged 18 to 25 had received sex education (86%), compared with adults aged 36 to 45 (57%).
- The topic of 'sex and sexual intercourse' was the most commonly covered topic, with six in ten respondents receiving education on this issue.
- Of those respondents who had received sex education, 32% received sex education both at home and at school, 50% at school only, 8% at home only and 10% outside of the home and school environment.
- Adults who received sex education outside of the home and school environment were 1.5 times less likely to use contraception the first time they had intercourse, when compared with those who received sex education at home and/or at school.
- More 18 to 25 year olds believed their sex education was very helpful or helpful in preparing for adult relationships (71%), compared with those aged 26 to 35 (60%) or 36 to 45 (55%).
- Adults who perceived their sex education as very helpful or helpful were almost twice as likely to use contraception when having sex for the first time, compared with those who did not perceive it to be helpful.
- Fewer parents surveyed in ICCP-2010 had talked to their children about sex and related topics (70%), compared with ICCP-2003 (82%).

Knowledge, attitudes and behaviours towards contraception and fertility

Sexual behaviour is a complex behaviour that is the outcome of a mixture of rationality, social attitudes, beliefs about the world and level of knowledge, in addition to a variety of situational factors, emotions and desires. A person's knowledge, attitudes and behaviours towards contraception and fertility are particularly important when pregnancy is not a desired outcome of his or her sexual activities. Identifying trends in attitudes and behaviours, or gaps in knowledge, among the general population over time is important to understand changing patterns in contraceptive use and pregnancy experiences.

Key findings include:

- 24% of adults surveyed had a negative attitude towards women carrying condoms as a precautionary measure for unanticipated sexual encounters while not in a relationship; this attitude has remained stable since ICCP-2003.
- Fewer adults believe that the contraceptive pill has dangerous side effects, compared with ICCP-2003. However, a large proportion of adults still have concerns about the long-term use of the contraceptive pill: 55% of 18 to 25 year olds, 67% of 26 to 35 year olds and 77% of 36 to 45 year olds reported such concerns.
- Knowledge about the '72-hour window' in which the emergency contraceptive pill can be used effectively has remained relatively stable (41% in ICCP-2010; 39% in ICCP-2003).
- Somewhat fewer adults were able to identify correctly the most fertile time within a monthly cycle when a woman is more likely to become pregnant (50%), compared with ICCP-2003 (54%).

Knowledge of and testing for HIV and sexually transmitted infections (STI)

Regular screening for HIV and STIs among those who are sexually active is important for the identification and treatment of infections that have a negative impact on health and fertility. Levels of knowledge about the transmission and consequences of HIV and STIs may influence a person's view regarding their susceptibility to these infections, which could ultimately impact on their decision to be screened for HIV or STIs.

Key findings include:

- The majority of adults had a good general knowledge of how HIV can be transmitted and how using contraception can be an effective way to reduce the risk of transmission.
- Over one-third of adults (26% of men and 45% of women) reported that they had been tested for HIV in their lifetime, with less than 1% of these adults being diagnosed with HIV.
- 1 in 5 men and nearly 1 in 3 women had been screened for an STI other than HIV, with 1 in 7 of these reporting a positive diagnosis.

Attitudes towards abortion and abortifacients

Issues surrounding the legality of abortion in Ireland have a long-standing history. Cultural and societal attitudes towards abortion have an impact on the range and type of supports required for people experiencing crisis pregnancy or abortion. Up-to-date data on abortion-related issues is important, therefore, to provide an accurate measure of the degree of change in public attitudes over time.

Key findings include:

- 1 in 11 adults (9%) believed that abortion is not permissible in any circumstance; this finding is remarkably similar to ICCP-2003 (8%).
- Attitudes towards specific circumstances where abortion is permissible also remained very stable. For instance, the majority of men and women (over 85%) in both ICCP-2010 and ICCP-2003 agree that a woman should have the choice to have an abortion if the pregnancy is a result of rape or incest, or endangers her health or life.
- 1 in 8 adults had heard of medications or herbs that can be taken to induce an abortion (abortifacients).
- When questioned about the legality of using abortifacients in Ireland, 75% thought the practice was illegal, 6% thought it was legal and 19% were unsure.
- Of the 13% of adults, men and women, who were aware of abortifacients (n=371), seven adults (3%) reported that they or their partner had used these types of medication or herbs in Ireland.

Pregnancy experiences of Polish and Nigerian women living in Ireland

The population profile of Irish society has been transformed following significant levels of immigration and emigration over the last decade or so. Current pregnancy services and sexual health clinics in Ireland provide a range of services to a diverse population of people from different ethnic and cultural backgrounds. In order to provide the best possible service to all, research is needed to investigate the sexual health and pregnancy needs of people who live in Ireland but have spent a significant proportion of their life in another country. Little is known about their knowledge, attitudes and beliefs about sexual behaviour, sexual health and pregnancy. To help address this deficit, ICCP-2010, through the inclusion of an opportunistic 'supplement' sample, provides information about the sexual health and pregnancy experiences of Polish and Nigerian women living in Ireland.

Key findings include:

- Knowledge of contraceptive methods was high: 84% of Nigerian women and 90% of Polish women were aware of products or methods that men and women could use or do to avoid pregnancy.
- The majority of women surveyed had experienced sex (96%) and had used some type of contraception during the previous year (94%).

- Over two-thirds (68%) of respondents had children, with a higher proportion of Nigerian women (88%) than Polish women (60%) reporting that they had children.
- 23% of women said that they had been pregnant when they did not want to be.
- Differences between Polish and Nigerian women were evident in relation to what happened after they discovered they were pregnant with an unwanted pregnancy.

Conclusion

ICCP-2010 is the third national study in Ireland in the area of sexual health and pregnancy. The results of this survey, in combination with other surveys, provide a wealth of information on important trends in sexual behaviour, contraceptive use and pregnancy outcomes among adults living in Ireland over the period from 2003 to 2010. This evidence-based information will be valuable for developing national policies for the provision of sexual health and pregnancy-related services. Recommendations developed by the HSE Crisis Pregnancy Programme are contained in Chapter 13.

1.0 Introduction

1.1 Current knowledge

Sexual health and pregnancy-related services and policy responses need to be tailored to the preferences and circumstances of specific groups and individuals if they are to be effective. Over the last decade, two national surveys in the area of sexual health and pregnancy have been conducted in Ireland. The first, the Irish Contraception and Crisis Pregnancy Study (Rundle et al., 2004), was conducted in 2003 (and is hereafter referred to as ICCP-2003). The second, the Irish Study of Sexual Health and Relationships (Layte et al., 2006), was published in 2006 (and is hereafter referred to as ISSHR). Both of these studies covered a wide range of issues, including first experiences of sexual intercourse, knowledge and use of contraception, satisfaction with sexual relationships, level of sexual education and experiences of pregnancy. By interviewing adults from different age groups, these studies drew a national picture of how adults living in Ireland experience sex and pregnancy throughout their lives. They provided strong evidence that people living in Ireland are not a homogeneous group in relation to their experiences of, and attitudes towards, sex, contraception and pregnancy. Findings from both studies provided evidence-based recommendations for planning and development of appropriate initiatives and national policies.

1.2 Context and rationale for the study

The current survey, which is a cross-sectional survey of adults aged from 18 to 45 years and living in Ireland in 2010, is the Irish Contraception and Crisis Pregnancy Study 2010, which will be referred to as ICCP-2010 throughout this report.

ICCP-2003 and ISSHR were ground-breaking national studies. Over time, people's knowledge, attitudes and behaviours in relation to contraception, sex and pregnancy may change. It is important to examine trends and changes in relation to these important issues in order to help plan for the provision of services in the future. Although the time period between ICCP-2003, ISSHR and ICCP-2010 is relatively short, the high levels of immigration and emigration during the period, and the national economic difficulties at the end of the 2000s, changed the demographic landscape of Ireland considerably. ICCP-2010 will provide an accurate picture of the knowledge, attitudes and behaviours of people living in Ireland at the current time, as well as over time, in relation to sex, contraception and pregnancy. This will help facilitate the development of future government policies and the provision of services at local and national levels.

1.3 Aims and objectives of the present study

ICCP-2010 sought to collect reliable, nationally representative data on the incidence of and responses to crisis pregnancy, which would inform: (1) current knowledge of, use of, and attitudes towards, contraception; and (2) robust comparisons with the previous

evidence (ICCP-2003 and ISSHR) that will identify patterns of change. More specifically, the research aimed to provide nationally representative data on:

- The incidence of crisis pregnancy in Ireland, the profile of women and men experiencing crisis pregnancies and their use of crisis pregnancy services, as a snapshot and to track changes in knowledge, attitudes and behaviours since ICCP-2003.
- The current status of knowledge, attitudes and behaviours relating to the use of contraception and contraceptive services in Ireland, including any changes since ICCP-2003.
- Emerging areas and issues in contraception and contraceptive services, as well as crisis pregnancy and crisis pregnancy services, to support and inform public policy development.

The study also aimed to provide details of the experiences of adult women living in Ireland who grew up in an educational, social and cultural environment outside Ireland, in relation to sex, contraception use and pregnancy.

The research objectives are to provide robust, reliable and valid data in order:

- To discuss and analyse the data in its own right but also in comparison with the data from ICCP-2003 and ISSHR, where possible.
- To explore current patterns in crisis pregnancy, contraceptive use and use of services in these areas as well as to identify changes over time by comparison with data from ICCP-2003.
- To examine the relationship of key independent variables, demographic (e.g., sex, age, socio-economic status, geographical location, source of information about sex, educational attainment, relationship status or religiosity) or other (e.g., socio-psychological factors such as stigma, sexual competence and alcohol/drug use), on behaviour and attitudes including choices made with regard to contraception and crisis pregnancy.
- To assess knowledge and use of services and supports relating to crisis pregnancy and contraception.
- To conduct a detailed examination of the experiences of adult women who live in Ireland, but who grew up in an educational, social and cultural environment outside Ireland, in relation to sex, contraception use and pregnancy.

2.0 Methodology

2.1 Introduction

The overall aim of the survey was to generate nationally representative and scientifically reliable data on attitudes and knowledge towards contraception, crisis pregnancy and related services in Ireland. Specifically, the survey examined new and emerging issues in this area, including assessing the needs and experiences of non-Irish national women in relation to contraception and pregnancy. As described in detail in the following sections, the survey was conducted in two strands, using telephone interviewing. The survey protocol received ethical approval from the Research Ethics Committee of the Royal College of Surgeons in Ireland (RCSI).

2.2 Sample

This survey recruited two samples: A national sample and a supplement sample.

2.2.1 National sample

The primary 'national' sample, recruited using a telephone interview methodology, was a cross-sectional representative sample of 3,002 men and women who were aged 18 to 45 years and living in Ireland. Adults in this age range were targeted in the national sample to focus attention on those individuals for whom contraceptive practices, service perceptions and service usage are most relevant in terms of contemporary evaluation of services and planning for the future. Quota sampling was used to ensure that the sample was representative of the general population. A similar sample was targeted in ICCP-2003, therefore facilitating a comparison between the two surveys.

2.2.2 Supplement sample

The secondary 'supplement' sample was an opportunistic sample of 261 Polish and Nigerian women aged 18 to 34 years who had moved to live in Ireland after the age of 13 years. This sample was recruited to obtain an overview of the views and practices of women who were not born in Ireland (referred to as non-Irish nationals) in relation to pregnancy, sexual behaviour and sexual health. The rationale for recruiting this sample is that women who have moved to Ireland having spent the majority of their childhood in a different social, educational and cultural environment may have different knowledge, attitudes and behaviours in relation to sex, contraception use and pregnancy. Women from Poland and Nigeria were targeted specifically because data from the 2006 Census revealed that the majority of immigrants living in Ireland were originating from these two countries: approximately 63,000 Polish (1.5% of the population) and approximately 16,000 Nigerians (0.4% of the population) (CSO, 2008).

Given the diversity within the general population in Ireland, it is likely that men and women who were not born in Ireland would be recruited as part of the national sample. However, there was a specific age criterion for the supplement sample (i.e., respondents

had to be 13 years or older when they first moved to Ireland) to ensure information would be collected from non-Irish national women who had spent most of their childhood and adolescence in an environment outside Ireland. In order to provide effective support and services, it is important for pregnancy-related services in Ireland to understand how the experiences and practices of these women may differ from those of Irish women. Information obtained from the supplement sample is presented in Chapter 11 of this report.

2.3 Measures

2.3.1 Interview schedule for the national sample

Designing the questionnaire or interview schedule is one of the most important elements in the development of a survey because it defines the nature and quality of the information collected. Given that one of the major aims of the present study was to collect comparable data to ICCP-2003, it was very important to keep the questionnaires similar. Nevertheless, it was also necessary to eliminate questions that were considered redundant for the aims of the study and to add new questions to collect information in relation to the specific aims of ICCP-2010 that had not been addressed in ICCP-2003. The questionnaire was refined through discussion with an Advisory Group. Using this process, the final interview schedule was able to address the specific issues and key constructs of interest to the HSE Crisis Pregnancy Programme (CPP).

The interview schedule for the main national sample was separated into sections, based on topic and relevance to specific respondent experiences. An overview of the questionnaire content is provided next. A copy of this questionnaire is available at: www.crisispregnancy.ie/research3.php

Introduction and respondent agreement

A standardised introduction detailed who was carrying out the survey, the study's confidential nature and how the telephone numbers had been randomly selected. Following agreement to participate, information on survey verification procedures was offered, and interviewers confirmed that the respondent was over 18 years of age.

Section A – Personal details

This section collected information on age, marital and relationship status, number of people living in the household and residential location.

Section B – Children and sex education

Respondents were asked whether they had children, and if they did, the ages of those children. Other questions in this section pertained to talking to children about sex and relationships, as well as whether the respondents received any sex education while they were growing up. Respondents who had received sex education were asked about the helpfulness of this education in preparing them for adult relationships.

Section C – Knowledge and attitudes about contraception

The first part of this section gathered information relating to sexual history, including lifetime experience of heterosexual/homosexual intercourse and sexual experiences during the previous year. It was considered important to ascertain this information early in the interview so that respondents could be routed to questions that would be relevant to them based on their personal experiences. Other questions in this section included age of first sexual intercourse and the use of contraception on that occasion. Respondents were then asked to provide information on their (or their partner's) current pregnancy status (i.e., currently pregnant, trying to become pregnant or neither). These questions were followed by a number of attitudinal and belief statements relating to sexual behaviour and contraception.

Section D – Contraception use over the last year

The first few questions in this section related to knowledge about different methods of contraception. Respondents who were not pregnant or trying to conceive were asked about their use of different contraceptive methods to prevent pregnancy during the previous year. The remaining questions in this section related to regularity of contraceptive use, the cost of contraception and reasons for not using contraception or precautions to avoid pregnancy over the previous year.

Section E – Sourcing contraception and contraceptive services and knowledge of HIV, sexually transmitted infections (STIs) and testing

Respondents were asked about the sources from which they had ever obtained contraceptive supplies or sought advice on contraception. This was asked of respondents who had never had sex, or who had had heterosexual sex, but not of those who were sterilised, infertile or whose religious beliefs prevented contraception use. Respondents who had ever obtained supplies or sought advice on contraception were asked about their preferred source for obtaining contraceptive supplies. These questions were followed by a number of questions directly relating to factors that may prevent access to contraceptive services. The final questions in this section gathered information on HIV/STI testing and diagnoses and included knowledge questions relating to HIV.

Section F – Most recent partner

All respondents 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 relationship with their most recent sexual partner and their use of contraception to prevent pregnancy on that occasion (where appropriate, these questions were not asked if the respondent was sterilised, infertile or did not use contraception on religious grounds).

Section G – Experiences of pregnancy, including crisis pregnancy

This section concerned respondents' 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 respondents felt that they had experienced a crisis pregnancy. Those respondents who indicated that they had experienced a crisis pregnancy were then asked the questions in Section X (men) or Section Y (women).

Sections X and Y – Crisis pregnancy

These sections gathered more detailed information relating to respondents' most recent experience of a crisis pregnancy. They covered sexual behaviour at the time of conception (e.g., use of contraception or reasons for not using contraception, including the role of alcohol and drugs), experience during the pregnancy (e.g., services used and how supportive or otherwise important people in their lives were towards the pregnancy), decision making relating to the outcome of the pregnancy and experience of support and services after the crisis pregnancy.

Section H – Knowledge of crisis pregnancy services/abortion

The first question in this section related to knowledge of crisis-pregnancy counselling services and was asked of everyone involved in the survey. The next series of questions explored how respondents thought they would feel and act if they were to experience a crisis pregnancy in the future (these questions were not asked if the respondent was sterilised, infertile or did not use contraception on religious grounds). The next questions contained a number of attitudinal and belief statements relating to pregnancy outcomes, including attitudes towards single parenting, adoption and abortion. The final questions in this section explored knowledge, attitudes and use of abortifacients during pregnancy (including a variety of herbs or medications that can be sourced and used to terminate a pregnancy).

Section J – Demographics, including household classification

This final section gathered additional demographic information from all respondents concerning employment status, educational attainment, household income, nationality, religion, general medical scheme (GMS) card (i.e., medical card) status, disability and telephone ownership.

2.3.2 Interview schedule for the supplement sample

After consultation with migrant groups and pilot studies with non-Irish national women, a shortened and simplified version of the national sample questionnaire was designed for administration to the supplement sample. This process was considered necessary to enhance the validity of the data being collected. The following is an overview of the layout of this questionnaire.

Introduction and respondent agreement

This standardised introduction to the study detailed 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 18 years of age.

Section 1 – About you

This section gathered information about each respondent's current age, the age she was when she moved to Ireland, educational attainment and occupation status.

Section 2 – Knowledge of contraception

The first questions in this section collected information on knowledge of methods of contraception. Then respondents were asked if they had had sexual intercourse ever in their lifetime and then specifically during the previous year. Women who had had sex during the previous year were asked if they were currently pregnant. This question was followed by questions relating to general methods the women used if they wanted to have sex but did not want to become pregnant. Respondents were then asked whether they had specifically heard of and used condoms and the contraceptive pill, as well as about their reasons for using or not using these methods to prevent pregnancy and infection.

Section 3 – Experiences of pregnancy

This section gathered data on the women's experiences of pregnancy, including live births, abortions and miscarriages. It was decided that the definition of a crisis pregnancy used for the main sample may be too culturally specific for the supplement sample to comprehend, due to language and cultural differences. In light of this, all women who experienced a pregnancy were asked if there was ever a time that they were pregnant when they did not want to be. The final questions in this section asked for details about these experiences, including reasons for not wanting to be pregnant at that time. All women were asked whether they would like to have children in the future.

Section 4 – Knowledge of abortifacients

The questions in this section were very similar to those administered to the national sample. They related to knowledge and use of herbs or medications to induce an abortion.

Section 5 – You and your household

The final section in the questionnaire gathered additional demographic information from all respondents concerning employment status, educational attainment, household income, medical card status and telephone ownership.

2.4 Telephone interview procedure

The choice of data collection methodology has important implications for the type of information collected. Similar to ICCP-2003, the chosen method for data collection was telephone interviewing. Telephone interviews provide respondents with a sense of anonymity once it has been explained and understood that their number was chosen at random. This technique has been widely and successfully used in knowledge, attitudes and behaviours surveys in Ireland, for example in the Sexual Abuse and Violence in Ireland Study (SAVI) (McGee et al., 2002), ICCP-2003 (Rundle et al., 2004) and ISSHR (Layte et al., 2006).

Two main differences exist between ICCP-2003 and ICCP-2010:

1. ICCP-2010 interviews were conducted using computer-assisted telephone interviewing (CATI), whereas interviewers in ICCP-2003 used paper questionnaires.
2. ICCP-2010 utilised landline and mobile telephone numbers to recruit respondents, whereas ICCP-2003 recruited solely using landline telephone numbers. ICCP-2010 was the first Irish general population survey to recruit respondents using mobile telephone numbers.

The reasons for the differences between the two surveys are important. First, CATI reduces errors that may occur during interview recording or data entry using traditional paper questionnaires and improves the flow of complex questionnaire routing, thus lessening the burden on respondents. Second, recent research in the United States, Australia and Europe has demonstrated that the percentage of the population that does not have a landline telephone in their home has steadily decreased over the last few decades (Boland et al., 2006; Dal Grande and Taylor, 2010; Kempf and Remington, 2007; Kuusela et al., 2007).

The most recent comprehensive statistics relating to the ownership of landline and mobile telephones in the Republic of Ireland can be obtained from the Household Budget Survey 2004–2005 (CSO, 2007). This survey suggests that 84% of households had access to a mobile telephone, whereas 89% of households surveyed had a fixed landline telephone. More recently, in SLÁN 2007, although 61% of respondents living in Ireland had access to both a mobile and a landline telephone where they lived, a substantial proportion (23%) of individuals had access to a mobile telephone only (Morgan et al., 2008). Thus, sampling mobile phone users in national telephone surveys is important to gain access to the growing proportion of households that use mobile telephones exclusively or extensively (Brick et al., 2007). Moreover, extensive research in the United States has revealed that households exclusively using mobile telephones are disproportionally young, male, single and living in rental accommodation when compared with households that have a landline telephone (Blumberg et al., 2006; Nagelhout et al., 2010). This population of 'mobile telephone only' adults are also more likely to have higher rates of health risk behaviours when compared with adults who live in a household that uses a landline telephone (Blumberg and Luke, 2009).

2.4.1 Generating telephone numbers for the national sample

Landline and mobile telephone numbers for ICCP-2010 were randomly generated using random digit dialling (RDD), as is standard practice in population telephone surveys. This procedure is described below. It is important to note that no telephone numbers, either landline or mobile, were purchased from a database or an external provider. As all the telephone numbers are randomly generated, a large volume of the numbers are not useable (e.g., not in service, businesses, phone boxes, faxes). The process means that the project team has absolutely no details regarding the owners of these phone numbers. The only estimation that can be made is in terms of geographic region, but this only applies to

landline numbers by utilising the area code. Adopting this approach ensures that data is collected from a fully randomised sample of adults.

Landline telephone numbers

Landline telephone numbers were generated using the RANSAM system of the ESRI. 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'.

Mobile telephone numbers

Currently, there is no publicly available source of mobile telephone numbers in Ireland. Mobile operators automatically opt out all their subscribers from direct marketing calls and place all their customers on the National Directory Database Opt-Out Register. Mobile phone customers have to actively remove themselves from this register, which means that the volume of publicly available mobile numbers is very low. In light of this, a methodology had to be devised to create a large database of mobile telephone numbers in order to contact potential participants for this study.

Amárach Research conducts a great deal of research for various projects by interviewing respondents face to face. Participants' names and telephone numbers are recorded as part of this process. The main reason for collecting this information is to facilitate internal validation checks on the data collected. As a result, Amárach Research has established a large file of 'real' mobile telephone numbers. These real mobile telephone numbers were used as the 'stems' for the mobile database created for this study. Similar to the landline telephone number approach, the last two digits of the 'real' mobile telephone number were substituted with digits from 00 to 99. This results in 100 mobile telephone numbers being generated. The 'real' mobile telephone numbers were then omitted from the database because data protection legislation stipulates that telephone numbers are only permitted to be used for the purpose for which they were supplied. A proportion of the generated numbers will be ineligible as they are business or inactive telephone numbers. This process ensures that both listed and unlisted numbers will be covered. Using this approach, Amárach Research has built up a substantial database of mobile telephone numbers, distributed throughout the country from all network providers.

2.5 Procedure

2.5.1 Telephone interviewer training

Interviewer training is extremely important in all areas of survey research, but especially when the survey covers sensitive subjects such as sex and pregnancy. A small team of seven senior interviewers conducted the pilot feasibility study prior to the main fieldwork. A team of approximately 25 female interviewers worked on the entire project. All of the interviewers had a great deal of experience of using the CATI system to administer

questionnaires via landline and mobile telephone. Many of the interviewers had previous experience of working on surveys that were sensitive in nature.

All the interviewers working on this project participated in a comprehensive two-day training session, which was administered by the project team. The training session covered the following topics:

- background to the survey and survey content;
- sensitivity-and-awareness training related to issues around sex, sexuality and pregnancy;
- procedures for legitimising the research should respondents have concerns about the authenticity of calls; and
- procedures for handling respondent distress.

This training session was followed by a three-day 'role-playing' workshop, whereby the interviewers practised conducting mock interviews using the CATI system. This process allowed the interviewers to become very familiar with the wording and format of the questions and the detailed routing schedule of the entire questionnaire. Following the workshop, a small number of interviewers began conducting live interviews, which were listened in to by other small groups of interviewers. This training process lasted for a number of weeks as it continued until the project team was satisfied that all interviewers would be able to administer the questionnaire in a competent and sensitive manner. The progress of all interviewers was monitored by members of the project team throughout the survey, as outlined in Section 2.5.7.

2.5.2 Testing the questionnaires on the CATI system

Prior to the pilot or main studies, the project team spent an intensive two-week period ensuring that the comprehensive routing schedule created for the questionnaire was working effectively. This process ensured that respondents were asked only those questions that were relevant and applicable to their personal experiences.

2.5.3 Piloting the interview schedule

The interview schedule was piloted with 192 randomly selected members of the public. Interviewers reported positive feedback from respondents. The piloting resulted in the rewording of some questions, shortening of the interview schedule and further clarification of definitions relating to crisis pregnancy and forms of contraception.

2.5.4 Recruitment of the supplement sample

Experienced interviewers recruited respondents door to door in areas identified as having higher than average proportions of Polish and Nigerian adults. When a woman in the target sample was identified, the interviewer introduced the nature of the study in the same manner as was done on the telephone. The interviewer impressed upon eligible women how important it would be for them to participate in the survey. Once

a woman agreed to participate in the study, the interviewer completed a recruitment questionnaire, recording basic demographic details (to ensure eligibility) and contact details (i.e., telephone number, either mobile or landline). Potential respondents were given a one-page summary of the research following this encounter to further encourage participation. This face-to-face recruitment process also involved a strategy called 'snowballing'. This means that the interviewer asked each eligible respondent if they knew of any other eligible women in the area. If another potential respondent was identified, the interviewer called to that address and invited the woman to participate in the study using the same recruitment process.

Each field interviewer sent the completed recruitment questionnaires to the telephone interviewing centre on a weekly basis and the details of all eligible women were entered into a database. These women had given their consent to receive a call from a member of the telephone interviewing team within the two-week period following the recruitment process. All interviews for the supplement sample were conducted in a similar manner to those for the national sample, using the CATI system. All women who completed the survey were invited to take part in a draw for a prize of €500.

2.5.5 Telephone interview procedure

Telephone interviews were conducted by an experienced interviewer at the designated CATI call centre at Amárach Research. Telephone interviewers received on-going support from the core project team throughout the interview phase. The project coordinator was on site at the call centre on a weekly basis to talk to the interviewing team and get feedback in terms of how the survey was progressing.

2.5.6 Confidentiality and survey verification procedures

Clear survey verification procedures were necessary so that respondents could check that the interviewer was from a legitimate research organisation. This was achieved in a number of ways:

- Details of the survey were placed on the CPP (www.crisispregnancy.ie/whatsnew.php) and the RCSI (www.rcsi.ie/ICCP2010#sexualhealth) websites.
- A freephone telephone number was set up so that respondents could contact the RCSI project team with any questions they had in relation to the survey.
- Respondents were offered the opportunity to contact the supervisor's office in the CATI call centre to verify the survey.
- Respondents were given the website address for Amárach Research (www.amarachresearch.com).
- Respondents could request that the interviewer would fax a survey confirmation letter to their local Garda station, and agree a time to telephone again when the respondent had had an opportunity to confirm with the Garda station that the survey was genuine.

2.5.7 Quality control

All interviewers were trained by the CATI call centre director and the project coordinator. This training ensured that interviewers were fully aware of the routing schedule of the questionnaires on the CATI system. This process meant that all interviewers were completely confident and comfortable with administering the questionnaire, which in turn made the respondent more comfortable in answering the questions, ensuring high-quality data.

The CATI director, interview supervisors and/or the RCSI project coordinator listened into live calls in the CATI call centre office. The CATI systems allow the senior staff to view the interviewers' screen in real time and to listen in to the telephone call so they can monitor all elements of the interview. They can confirm that the interviewers are saying what they should be saying, check how they are recording the data and assess their delivery and demeanour on the phone to the respondent. As the interview is monitored, the supervisor completes a review sheet, noting any issues (positive or negative) within the interview that require attention and grading different aspects of the interview.

When the interview is complete the supervisor then invites the interviewer into the office and a full debrief of the interview takes place. The supervisor takes the interviewer through the entire interview and provides feedback on all the different aspects. If there are any particular areas that require attention or further work on the interviewer's part, these are highlighted and are recorded on the interviewer's file. The interviewer will then be listened in to again on another day to ensure that these issues have been addressed.

Senior interview staff also circulated on the call centre floor, so they were constantly listening in to the interviewers calling, recruiting and interviewing respondents. This process ensured that any errors or issues occurring with interviewers were identified and solved in a prompt manner.

2.5.8 Respondent support

Interviewers monitored respondent distress and used a range of strategies throughout the interview process to manage distress. Telephone interviewers could direct respondents to information sources (e.g., helplines and website addresses) or, where respondents showed distress or disclosed traumatic events, interviewers followed a protocol sheet (see Appendix 1). A protocol was in place whereby these respondents would be re-contacted the following day (with their consent) by a member of the project team to ensure their well-being. This protocol, which had been used previously in Irish studies, including SAVI (McGee et al., 2002), ICCP-2003 (Rundle et al., 2004) and ISSHR (Layte et al., 2006), follows World Health Organization's 2001 guidelines for good practice in domestic violence research.

Very few respondents were upset by the content of the survey; to the best of our knowledge, no respondent was distressed by the survey. The distress call-back protocol was not implemented at any stage in the study.

2.5.9 Data entry and analysis

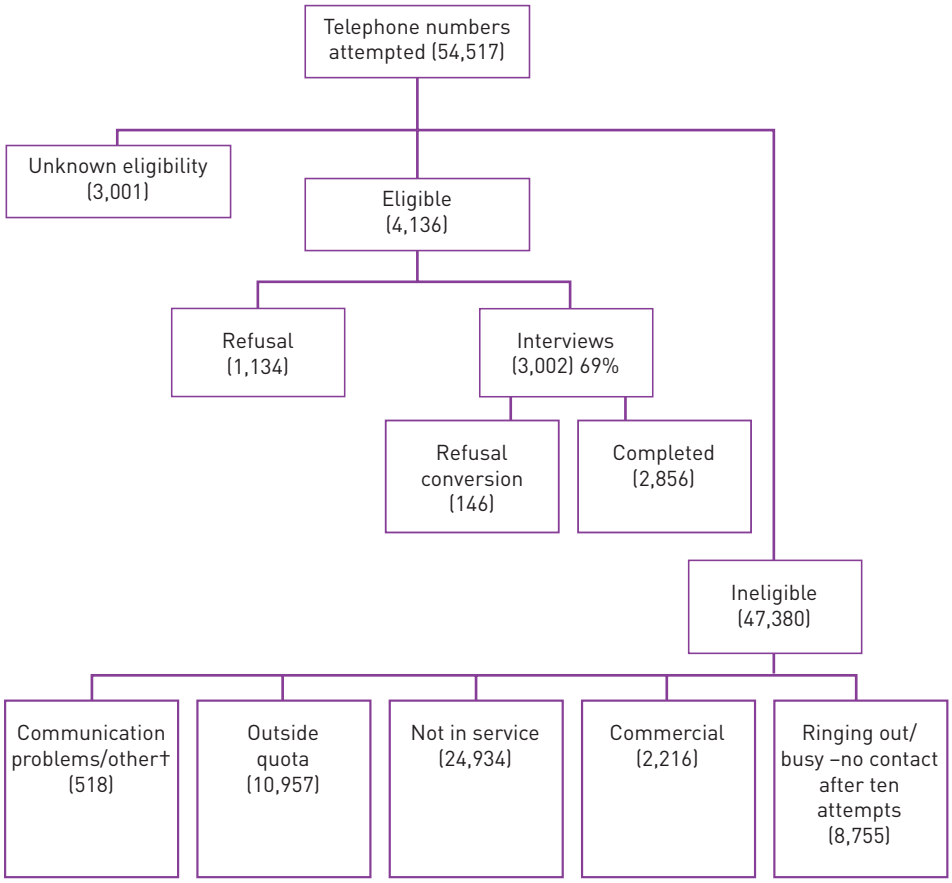
Quantitative analysis of the data was performed using PASW Statistics Version 18 (Norusis, 2010). Basic descriptive statistics and more complex statistical analyses were conducted to address specific research questions within the objectives of the study. Means are reported with confidence intervals (standard deviations are not reported for weighted data). Relationships between variables were analysed using chi-square tests (unless otherwise stated) because they were considered to give the best measure of significance without making assumptions concerning the direction of any possible relationship. Chi-square test results are not listed, since the output for weighted survey data has no interpretation in the conventional sense. Tests for statistical significance can be conducted to explore the probability that an observed relationship is due to random chance. This significance is represented using asterisks. A number of different significance levels (p) are used in this report and are represented using asterisks (see key at the bottom of tables). For example, a statistically significant difference between young adults (aged 18 to 25) and older adults (aged 36 to 45) at the $p<0.01$ level means that a significant difference was assumed with a 1% chance of being incorrect. Conducting multiple statistical tests increases the likelihood that a statistically significant difference will be found. Indeed, it is important to note that a statistically significant result does not necessarily mean that the finding is important or of practical or clinical significance (Daniel 1998). Thus, statistical significance testing is used sparingly throughout this report, and only when there is a specific rationale for using this type of test.

Regression analysis is used in this report to examine the influence of major demographic factors on outcome variables of interest in the study. When the outcome variable of interest in a regression analysis is binary coded, for example whether a person ever experienced sexual intercourse or not, the analysis is known as a binary logistic regression analysis. In this type of analysis, one category in the outcome variable is used as a reference category, to which all the others are compared. A binary logistic regression analysis produces an index called an adjusted odds ratio (AOR). The AOR is a measure of the expected increase or decrease in the likelihood of members in a specific group (e.g. men) having experienced the event of interest (e.g. sexual intercourse) compared with another group (e.g. women), whilst controlling for the effects of other important socio-demographic characteristics (e.g. socio-economic status).

2.6 Response rates

In total, 54,517 unique telephone numbers (25,268 landline telephone numbers and 29,249 mobile telephone numbers) were called as part of the main fieldwork of ICCP-2010. Figure 2.1 summarises the call outcomes for the survey overall (landline and mobile telephone strands combined). The total number of interviews completed was 3,002 (1,416 landline and 1,586 mobile). The overall response rate for the survey was 69% (79% for the landline strand and 61% for the mobile telephone strand). The value of conducting call conversions was illustrated given that 143 (5%) of the completed interviews were achieved in this manner.

Figure 2.1 Profile of unique phone numbers called and outcome classification for survey



† Individuals could not participate in the study for a number of reasons, mainly hearing/speech difficulties, or unsuitable timing (e.g., sudden death in family).

2.7 Demographic profile and representativeness

Data from all sample surveys must be weighted, or statistically adjusted, prior to analysis. The purpose of this adjustment is to compensate in the completed sample for any potential bias that may occur due to sampling error or differential response rates among sub-groups of the population. Weighting ensures that the completed sample is wholly representative of the target population from which it has been selected. The control totals used for weighting come from the best available national source, such as the Census or the Quarterly National Household Survey (QNHS). (See Appendix 2 for a description of the demographic variables/characteristics that were used to create the weight variable.)

The weighting procedure involves constructing respondent weights such that the distribution of respondents post-weighting is identical to the corresponding distributions for the population as a whole. This was accomplished using a minimum distance algorithm that adjusts an initial weight so that the distribution of characteristics in the sample matches that of the set of control totals in the population as a whole. All analyses in the report are based on weighted data to ensure that the results are representative of the population.

2.7.1 Sample

Table 2.1 outlines the characteristics of the sample. A comparison of the ICCP-2010 sample with general population estimates from the 2010 QNHS is presented in Appendix 3. The high response rate and effective re-weighting mean that results are very representative of the general population of 18 to 45 year olds living in Ireland. For comparison purposes, an overview of the ICCP-2003 sample is included in Appendix 4. A breakdown of the ICCP-2010 sample by telephone type (landline versus mobile) is presented in Table A5.1 in Appendix 5.

Table 2.1 Demographic characteristics of sample compared with the population, by gender

Demographic characteristics	Men			Women		
	Un-weighted sample	Un-weighted sample	Weighted sample†	Un-weighted sample	Un-weighted sample	Weighted sample†
	n	%	%	n	%	%
All	1,440	48	49	1,562	52	51
Age						
18–25 years	340	24	24	377	24	24
26–35 years	577	40	41	652	42	42
36–45 years	523	36	35	533	34	34
Marital status††						
Single	598	42	46	569	36	41
Married/cohabiting	799	55	52	916	59	55
Separated/divorced/						
widowed	41	3	2	75	5	4
Highest education						
Pre-Leaving Certificate	222	15	20	136	9	14
Leaving Certificate	370	26	31	361	23	30
Post-Leaving Certificate	848	59	49	1,065	68	56
Region						
Dublin	476	33	29	468	30	29
Border, Midland and Western (BMW)	343	24	26	398	25	26
Rest of country	621	43	45	696	45	45

† Weighted percentages are those percentages derived when a 'weight' design variable is applied to the data. This procedure ensures that the percentages reported are representative of the general population. (See Appendix 2 for more details on the 'weight' variable.)
†† Marital status data is missing for four cases (n=2,998).

2.7.2 Social class

Social class is a useful summary measure of occupational success and income level. The Central Statistics Office (CSO, 1986) measure of social classification was used to identify

social class for each respondent. Table 2.2 provides an overview of the distribution of social class in the ICCP-2010 sample. The largest grouping is social class 1 or 2 (higher or lower professional and managerial) at 36%, followed by social class 3 or 4 (clerical/ administrative or skilled manual) at 35%. A sizeable proportion (18%) of the ICCP-2010 sample was categorised into social class 7 (unknown, including never worked), which is larger than in ICCP-2003 (12%) – see Technical notes for slight differences between the surveys in relation to social class questions.

Table 2.2 Household social class of sample, by gender

Social class (SC)	Men (n=1,440) % (w)	Women (n=1,562) % (w)	Total (n=3,002) % (w)
Higher professional and managerial (SC 1) or lower professional and managerial (SC 2)	34	38	36
Clerical/administrative (SC 3) or skilled manual (SC 4)	35	35	35
Semi-skilled manual (SC 5) or unskilled manual (SC 6)	11	11	11
All others, including never worked/unknown (SC 7)	20	16	18

Note: % (w) = weighted percentages.

It is not uncommon in national surveys for respondents to be unclassified with regards to social class, particularly when the sampling frame includes young adults who may not be employed yet. In this report, members of social class 7 are analysed as a separate group and reported on separately. To aid interpretation of the members of this social class, Table A5.2 in Appendix 5 displays demographic information for respondents in each of the seven social classes. It can be seen that compared with each of social classes 1 to 6, social class 7 has the highest proportions of men, 18–25 year olds, single people, those with a pre-Leaving Certificate education, and those living outside Dublin and the Border, Midland and Western (BMW) region of the country.

2.7.3 Country of birth

Migration patterns in Ireland changed dramatically during the 2000s. In ICCP-2003, the majority of respondents were born in the Republic of Ireland, Northern Ireland or Britain (96%). As can be seen in Table 2.3, 84% of respondents in ICCP-2010 were born in Ireland or the United Kingdom, with 9% being born in the rest of the European Union, and a further 7% outside the EU. These findings illustrate the greater diversity of the ICCP-2010 sample, which is important to bear in mind when making comparisons with ICCP-2003.

Table 2.3 Country of birth of sample, by gender

Country of birth	Men (n= 1,440) % (w)	Women (n=1,562) % (w)	Total (n=3,002) % (w)
Republic of Ireland	78	78	78
Northern Ireland	1	1	1
Great Britain	4	5	5
Rest of EU	9	9	9
Africa	3	3	3
Asia	3	1	2
USA/Canada/Australia/New Zealand	<1	2	1
Elsewhere	2	1	1

Note: % (w) = weighted percentages.

2.7.4 Geographical location

As outlined in Table 2.4, approximately one-quarter (26%) of ICCP-2010 respondents live in a rural area, with a further 27% living in a city. The majority of the sample live in a town (35%), with a small proportion living in a village (12%).[1] The geographical breakdown of the ICCP-2003 sample was different, with approximately one-third of the sample living in a rural area, one-third living in a city and one-third living in a village or town. These differences are likely due to the different methodological approaches of the two surveys (i.e., landline telephone only recruitment in ICCP-2003 versus landline and mobile telephone recruitment in ICCP-2010).

Table 2.4 Location of residence of sample, by gender

Location of residence	Men (n=1,440) % (w)	Women (n=1,562) % (w)	Total (n=3,002) % (w)
Rural area	26	25	26
Village	11	12	12
Town	33	38	35
City	30	25	27

Note: % (w) = weighted percentages.

2.7.5 Employment status

ICCP-2010 was conducted during a time of economic recession in Ireland. In ICCP-2003, the overall unemployment rate in the sample was 6% (7% among men). Table 2.5 outlines the employment status for respondents in ICCP-2010. The unemployment level in the sample was high at 13% overall (20% among men). The highest level of unemployment was in the 18–25 age group (17%), followed by the 35–45 age group (13%) and then the 26–35 age group (12%). These results indicate that the sample is representative of the general population, given that national estimates from the CSO indicate that the annual average unemployment rate for 2010 was 14%.

1 A village was defined as having between 200 and 1,499 habitants. A town was defined as having 1,500 habitants or more.

Table 2.5 Employment status of sample, by gender

Employment status	Men (n=1,439) % (w)	Women (n=1,561) % (w)	Total (n=3,000) % (w)
Employee	51	58	54
Self-employed or farming	16	4	10
Full-time student	9	10	10
Government training scheme	<1	<1	<1
Unemployed	20	7	13
Sick/disabled	2	2	2
Home duties	1	19	10
Retired	<1	<1	<1
Other	<1	<1	<1

Note: % (w) = weighted percentages.

2.7.6 Religious beliefs

Nearly three-quarters of the sample (74%) indicated that they belong to a religion, with the majority of these respondents stating that they are Roman Catholic (88%). All respondents who indicated that they belong to a religion were asked about how important religious beliefs are to them at the present time. Approximately half (52%) of respondents reported that religious beliefs are important to them, which is a decrease of 5% compared with ICCP-2003. More people (12%) in ICCP-2010 reported an indifference regarding the importance of religion in their life than did in ICCP-2003 (10%).

2.7.7 Relationship status

While marital status was used in weighting the sample to match the general population profile (see Table 2.1), 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 contextualising current sexual and contraceptive behaviour. As presented in Table 2.6, 42% of respondents were married and living with their spouse, 12% were living with a partner and 15% were in a steady relationship but living apart. In ICCP-2003, a lower proportion (48%) of respondents were married or cohabiting.

Table 2.6 Relationship status of sample, by gender

Relationship status	Men (n=1,440) % (w)	Women (n=1,562) % (w)	Total (n=3,002) % (w)
Married and living with spouse	40	44	42
Cohabiting	11	12	12
Steady relationship, not living together	15	15	15
Casual relationship	6	4	5
Not in a relationship	27	25	25
Relationship status unknown	1	<1	1

Note: % (w) = weighted percentages.

2.7.8 Medical card status

In Ireland, over a third of the population holds a medical card; these are general medical scheme (GMS) cards given to those on a low income, patients aged over 70 and certain other patients (e.g., those with severe medical conditions) (Boyle, 2010). There are two types of medical card available: full (provides cover for the cost of health care consultations and prescriptions) and GP-only (provides cover for the cost of health care consultations only). In ICCP-2010, all respondents were asked if they were currently covered by a medical card. In total, 29% were covered by a medical card: 24% had a full medical card and 6% had a GP-only medical card. In ISSHR, 18% of respondents aged 18 to 64 (16% of men and 20% of women) had a medical card (McGee et al., 2008). In SLÁN 2007, 33% of respondents aged 18 or older (28% of men and 37% of women) had a medical card (Morgan et al., 2008).

3.0 Early heterosexual experiences

3.1 Introduction

The onset of sexual intercourse is an event of immense social and personal significance, which also has major health implications (Hawes et al., 2010). For example, many research studies have reported that individuals who experience sexual intercourse early in adolescence are at increased risk for experiencing a host of negative outcomes (Coker et al., 1994), including sexually transmitted infections (STIs) and crisis pregnancy (Rundle et al., 2004), compared with those who wait until they are older to have sex for the first time. Identifying current risk factors associated with early initiation of sexual intercourse within an Irish context is very important for informing policy aimed at delaying the onset of sexual intercourse, and in turn reducing the incidence of crisis pregnancy (CPA, 2007).

To reduce the risk of infection and pregnancy, sexual health services aim to delay the age of onset of first sexual intercourse and to encourage the use of contraception from the very first time a person has sex. National research in the UK in the 2000s suggests that although the proportion of individuals who do not use contraception on the occasion of their first sexual intercourse experience has declined in recent times (Wellings et al., 2001), a high proportion of people still do not use an effective method of contraception the first time they have sex (Manlove et al., 2009; Parkes et al., 2009). It is important that empirical research explores the factors associated with contraceptive use on the occasion of first sexual intercourse within an Irish context so that professionals working in sexual health services can identify those people who are least likely to use contraception.

This chapter investigates these issues in greater detail by:

- exploring the sexual history of respondents involved in the survey;
- identifying trends over time in relation to age of first sexual intercourse;
- examining factors associated with the onset of sexual intercourse in early adolescence; and
- determining factors associated with the use of contraception on the occasion of first heterosexual experience.

In general, the results presented in this chapter refer to those respondents who have ever had heterosexual sex, unless otherwise stated.

A summary of the key findings is provided, followed by a full discussion of the findings for this chapter. This format is followed throughout the report.

Early heterosexual experiences: key findings

- A slightly higher proportion of adults in ICCP-2010 had experienced sex (95%), compared with ICCP-2003 (93%).
- The median age for experiencing sex for the first time among 18-25 year old adults has not decreased. The median age for first sex among men is 17 years, the same as in ICCP 2003; for women it is 18 years, a slight increase since the first ICCP survey.
- 15% of 18 to 25 year olds have yet to experience sex, which may suggest that they are waiting until they are older to have sex for the first time. This percentage has increased slightly from 13% of 18 to 25 year olds in ICCP-2003.
- Among those young adults (18 to 25 years) who have had sex, the proportion of women having sex for the first time before the age of 17 (i.e., the legal age of consent in Ireland) has increased: in ICCP-2010, 37% of young men and 26% of young women had sex before the age of 17, compared with 39% of young men and 21% of young women in ICCP-2003.
- Using contraception on the occasion of first sexual intercourse has increased. 9 in 10 young adults (aged 18-25) now report using some form of contraception when they experienced sex for the first time.
- Nevertheless, risk groups for not using contraception at first sexual intercourse were identified in this study: males, people with a pre-Leaving Certificate education, those in the lower social classes, and those having sex before the age of 17 were significantly less likely to use contraception at first sexual intercourse.

3.2 Sexual history

All respondents were asked whether they had experienced sexual intercourse. Respondents who had experienced sexual intercourse were asked about their sexual history. Table 3.1 presents sexual history data for those respondents who provided information on these questions. The percentage of respondents who had not yet experienced sex at the time of the interview decreased slightly from 7% in ICCP-2003 to 5% in ICCP-2010. Therefore, the proportion of adults who had experienced sex was slightly higher in ICCP-2010 (95%) than in ICCP-2003 (93%). The percentage of respondents who had had heterosexual and bisexual experiences remained stable across the two surveys. Higher proportions of men and women reported a homosexual sexual history in ICCP-2010 (2%) than did in ICCP-2003 (less than 1%).

Table 3.1 Respondents' sexual history of same and opposite sex partners, by gender

Sexual history	Men (n=1,440)		Women (n=1,557)		Total (n=2,997)	
	n	% (w)	n	% (w)	n	% (w)
Had sex with people of opposite sex only	1,315	91	1,444	93	2,759	92
Had sex with people of same sex only	27	2	16	2	43	2
Had sex with people of both sexes	28	2	26	<1	54	1
Never had sex	70	5	71	5	141	5

Note: % (w) = weighted percentages.

3.3 First heterosexual sexual experience

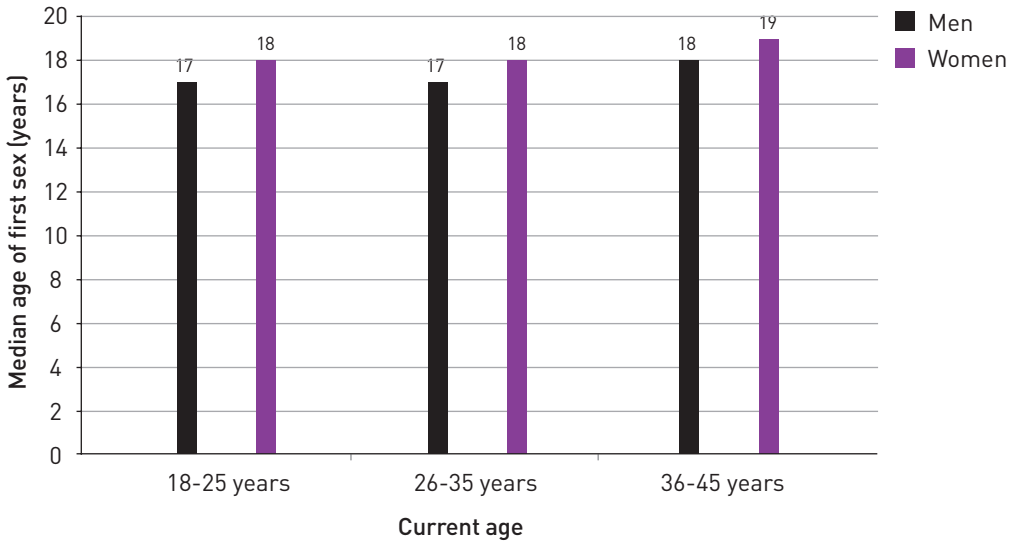
Research suggests that the current average age of first sexual intercourse is similar across developed countries, at approximately 17.5 to 18 years of age (Darroch et al., 2001). In this section, several different approaches are used to obtain information on age of first sex and the risk factors associated with having sexual intercourse for the first time at a younger age.

3.3.1 Median age of first sexual intercourse

The mean age of first sex represents most people's notion of the 'average' age; however, this value can be influenced by extreme values, for instance when a small number of individuals have sex very early or very late. The median age is not influenced by these values because it is the age at which 50% or more of a particular group first experienced heterosexual intercourse. Respondents who had experienced sexual intercourse with a person of the opposite sex were asked at what age they were when this event first occurred.

Figure 3.1 illustrates the median age of first 'opposite sex' sexual experience, by current age and gender. The overall median age for first heterosexual intercourse was 18 years, which has remained stable since ICCP-2003. For the two younger age groups, the median age for first heterosexual intercourse was 17 years for men and 18 years for women, demonstrating that the age of first sexual intercourse has not dropped since 2003; for young women the age has slightly increased. For the oldest age group, the median age was higher at 18 years for men and 19 years for women. These findings are consistent with those reported in ISSHR (Layte et al., 2006).

Figure 3.1 Median age of first heterosexual sex, by age group and gender



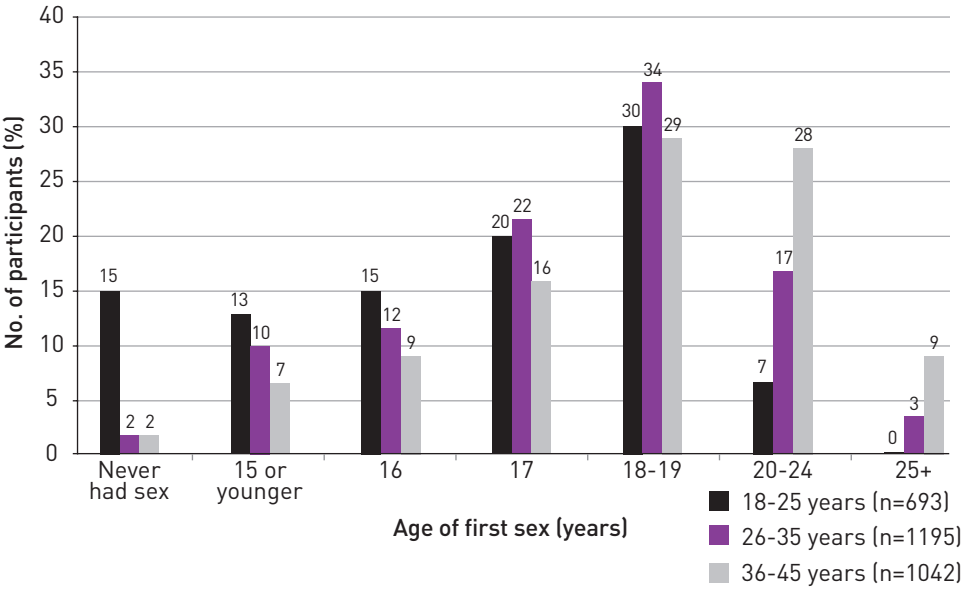
3.3.2 Age of first sexual intercourse by current age

A more detailed analysis of the specific age of first heterosexual sexual intercourse by current age is presented in Figure 3.2. Respondents who had sex with people of the same sex only, or who did not provide information regarding the age they were when they first had sex, are excluded. This figure illustrates that higher proportions of younger respondents (18 to 25 year olds) had their first sexual experience before the age of 18, whereas higher proportions of older respondents (36 to 45 year olds) had sexual intercourse for the first time at age 20 or older.

It is important to note that 15% of 18 to 25 year olds reported never having sex, compared with 2% of 26 to 35 year olds and 2% of 36 to 45 year olds. These percentages have changed somewhat since ICCP-2003, when 13% of 18 to 25 year olds, 4% of 26 to 35 year olds and 4% of 36 to 45 year olds reported never having sex. This tentatively suggests that a higher proportion of younger people may now be waiting to have sex until they are older. Delaying the onset of sexual intercourse is important (CPA, 2007), given that the results from ICCP-2003 indicate that individuals who experience sex for the first time early in life are at increased risk for experiencing a crisis pregnancy (Rundle et al., 2004); more analysis on this issue will be conducted in Chapter 7.

The characteristics of the 18–25 age group were explored in more detail. There was no significant gender difference between those who had or had not had sex in this age group, but higher proportions of those who had had sex had received sex education ($p<0.05$).

Figure 3.2 Age of first heterosexual sexual intercourse, by age cohort



3.3.3 Experiencing sexual intercourse before the age of consent

This section excludes those individuals who have never had sex and focuses on those who have had heterosexual intercourse. In the Republic of Ireland, the legal age of consent for sexual intercourse is 17 years of age. Research has demonstrated that having sex for the first time at an early age (generally before 16 years) is associated with a significantly increased risk of pregnancy (Wellings et al., 2001).

Table 3.2 displays information on the proportion of respondents who had their first heterosexual experience at 16 years or younger. In ICCP-2003, 29% of men and 14% of women had experienced heterosexual sex before the legal age of consent (17 years) in Ireland. In ICCP-2010, a higher proportion of men (28%) than women (17%) had experienced heterosexual intercourse for the first time before the legal age of consent. When compared with ICCP-2003, it appears that a similar proportion of men are still experiencing sex before the age of 17, whereas the proportion of women having sex before the legal age of consent has increased.

Table 3.2 Proportion of respondents experiencing heterosexual intercourse for the first time before the legal age of consent in Ireland (ICCP-2003 and ICCP-2010), by gender and age group

Survey	Men % (w)				Women % (w)			
	18–25 years	26–35 years	36–45 years	Total	18–25 years	26–35 years	36–45 years	Total
ICCP-2003	39	31	18	29	21	14	8	14
ICCP-2010	37	27	23	28	26	18	10	17

Note: % (w) = weighted percentages.

Comparisons of the estimates for age at first heterosexual intercourse from ICCP-2003, ICCP-2010 and ISSHR are important to explore whether the proportion of younger people having sex at an earlier age in Ireland may have changed over recent years. The following age groups were used in ISSHR: 18 to 24 years, 25 to 34 years and 35 to 44 years. The proportion of women who had had sex before the age of 17 in these age groups was 22%, 19% and 9% respectively. For men, the proportions were 31%, 27% and 20% respectively. The overall trend emerging is that between 2003 and 2010 the proportion of young adults (18 to 25 years old) who are having sex before the legal age of consent has been increasing.

3.3.4 Factors associated with experiencing heterosexual intercourse before 17 years of age

Understanding the factors that predict the occurrence of the first heterosexual intercourse experience is important, given that individuals who experience sex for the first time at a young age are at a higher risk for experiencing an unintended or crisis pregnancy (Tsui et al., 2010).

Analysis was conducted to explore the risk factors associated with experiencing heterosexual sex at 16 years of age or younger. This analysis is called a binary logistic regression. In this type of analysis, the variable of interest is whether the respondent experienced heterosexual intercourse for the first time at 16 years or younger (coded as yes versus no). The adjusted odds ratio (AOR) indicates the expected increase or decrease in the likelihood of members in a specific group having experienced sex at 16 years or younger, compared with a reference group, whilst controlling for the effects of all other variables in the model. For example, in Table 3.3, the AOR of 1.766 for men indicates that men were significantly more likely (nearly twice as likely) than women to have had their first heterosexual experience at 16 years or younger, controlling for the effects of current age, education level and social class. The confidence intervals (CI) represent the most likely spread of values of a population characteristic (parameter) when it is estimated from a sample characteristic.

Compared with the oldest respondent age group (36–45), respondents aged 18 to 25 were significantly more likely (nearly three times more likely) to have had their first heterosexual experience before the age of 17, controlling for the effects of gender, education level and social class. And respondents aged 26 to 35 were also significantly more likely (approximately 1.5 times more likely) to have had their first heterosexual experience before the age of 17, again controlling for the effects of gender, education level and social class.

Respondents with a pre-Leaving Certificate education were significantly (three times) more likely to have had their first heterosexual experience before the age of 17 when compared with those with a post-Leaving Certificate education, controlling for the effects of gender, age and social class. Respondents with a Leaving Certificate education were only slightly more likely to have had their first heterosexual experience before the age of 17 when compared with those with a post-Leaving Certificate education, again controlling for the effects of gender, age and social class.

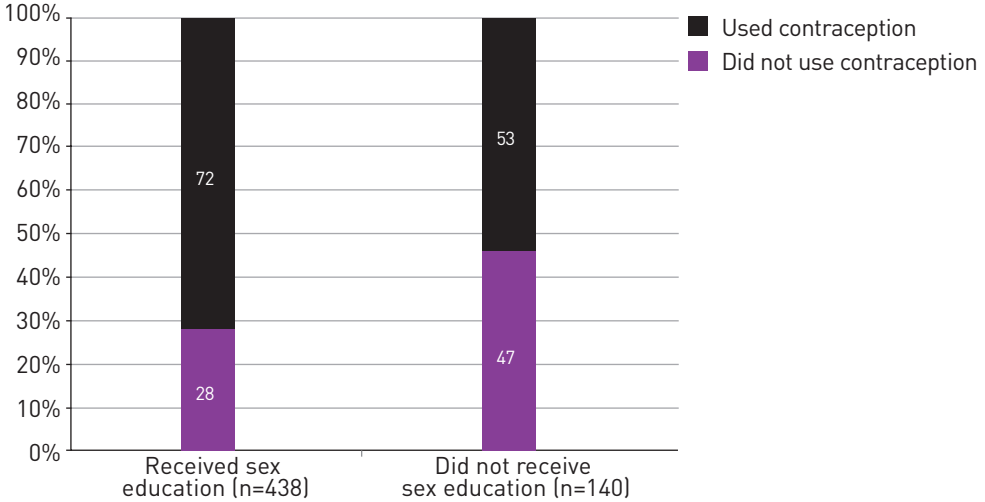
Table 3.3 Weighted adjusted odds ratio (AOR) and 95% confidence intervals (CI) for having sex before the legal age of consent in Ireland (compared with 17 years or older) among those who ever had heterosexual sexual experiences, by selected predictors

Socio-demographic characteristics	AOR	95% CI
Sex		
Men	1.766***	1.462–2.133
Women (reference group)	1.000	
Current age		
18–25 years	2.793***	2.165–3.603
26–35 years	1.671***	1.333–2.095
36–45 years (reference group)	1.000	
Education level		
Pre-Leaving Certificate	2.996***	2.336–3.843
Leaving Certificate	1.258*	1.005–1.574
Post-Leaving Certificate (reference group)	1.000	
Social class		
SC 1–2 (reference group)	1.000	
SC 3–4	0.985	0.779–1.247
SC 5–6	1.347	0.981–1.851
SC 7 (unknown/never worked)	1.453***	1.109–1.903

*Note: *** p<0.001; ** p<0.01; * p<0.05.*

Further analysis explored the relationship between sexual education and use of contraception on the occasion of first sexual intercourse among those who had initiated sex before the age of 17. As can be seen in Figure 3.3, a higher proportion of adults who had received sex education used contraception the first time they had sex (72%) than those who had not received sex education (53%), even when sex occurred before the age of 17. This finding highlights the importance of sex education in the lives of young people.

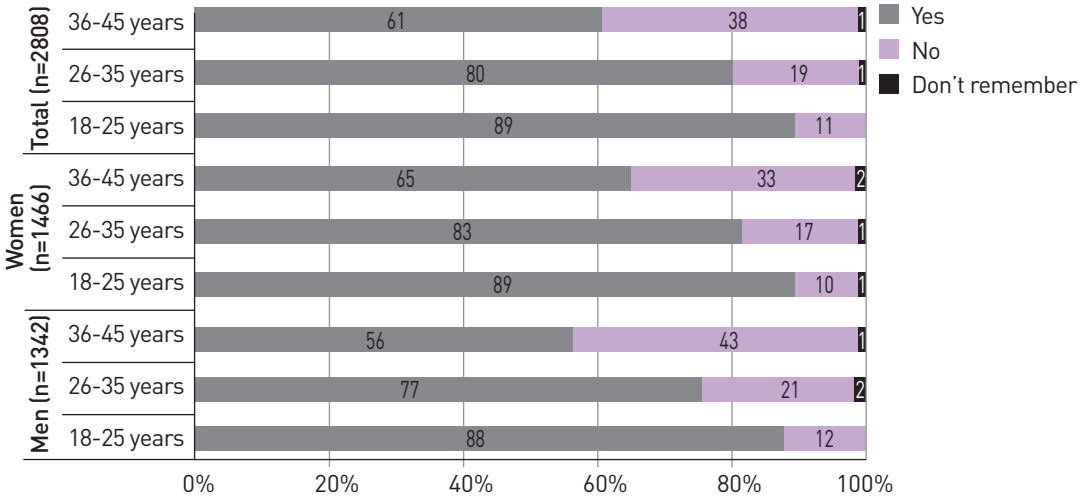
Figure 3.3 Relationship between sexual education and contraception use among adults who had sex for the first time before the legal age of consent in Ireland



3.4 Use of contraception at first sexual experience

This section examines the factors associated with the use of contraception at first heterosexual intercourse experience. Recent analysis of the National Surveys of Family Growth in the United States suggests that the proportion of people using contraception at the occasion of their first sexual intercourse increased from 56% in 1985 to 84% in the 2005–2008 period (Centers for Disease Control and Prevention, 2010). In ICCP-2010, respondents were asked if they used contraception on the first occasion they had sex. Figure 3.4 illustrates the proportion of respondents in each age category that used contraception on their first heterosexual intercourse experience.

Figure 3.4 Use of contraception on first sexual occasion, by gender and age group



Overall, higher proportions of younger adults (89% of 18 to 25 year olds and 80% of 26 to 35 year olds) used contraception the first time they had sex, compared with 61% of adults aged 36 to 45. The gender-specific proportions outlined in Figure 3.4 are comparable to three age groups in ISSHR (18–24, 25–34 and 35–44 year olds). In ISSHR, the proportion of respondents in each of these age groups using contraception at first vaginal intercourse for men was 88%, 78% and 67% respectively, and for women was 94%, 87% and 74% respectively. Together, these findings suggest that the use of contraception at first heterosexual intercourse has become more common in recent years and is likely to be more widely accepted.

A regression analysis was conducted to explore the factors associated with using contraception on the occasion of first heterosexual intercourse (see Table 3.4).

Table 3.4 Weighted adjusted odds ratio (AOR) and 95% confidence intervals (CI) for using contraception on the occasion of first heterosexual sex (compared with didn't use/ don't remember), by selected predictors

Socio-demographic characteristics	AOR	95% CI
Sex		
Men	0.803*	0.666–969
Women (reference group)	1.000	
Current age		
18–25 years	6.064***	4.474–8.220
26–35 years	2.893***	2.319–3.476
36–45 years (reference group)	1.000	
Age at first sex		
16 years or younger	0.484***	0.388–0.605
17 years or older (reference group)	1.000	
Education level		
Pre-Leaving Certificate	0.591***	0.461–0.759
Leaving Certificate	0.927	0.788–1.242
Post-Leaving Certificate (reference group)	1.000	
Social class		
SC 1–2 (reference group)	1.000	
SC 3–4	0.849	0.666–1.069
SC 5–6	0.712*	0.519–0.977
SC 7 (unknown/never worked)	0.683*	0.516–0.904

*Note: *** p<0.001; ** p<0.01; * p<0.05.*

This analysis indicates that men were significantly less likely than women (20% less likely) to use contraception on their first heterosexual experience, controlling for the effects of current age, age at first sex, education level and social class. The youngest age group (18–25) was approximately six times more likely, and the middle age group (26–35) approximately three times more likely to use contraception on their first heterosexual experience when compared with the oldest age group (36–45), controlling for the effects of gender, age at first sex, education level and social class. Respondents who had had sex when aged 16 or younger were significantly less likely (52% less likely) to have used contraception on their first heterosexual experience, compared with those who first had sex when aged 17 or older, controlling for the effects of gender, current age, education level and social class. In terms of education, respondents with a pre-Leaving Certificate education were significantly less likely to use contraception on their first heterosexual experience than those with a post-Leaving Certificate education, controlling for the effects of gender, current age, age at first sex and social class. Compared with those in social classes 1 and 2, those in social classes 5, 6 and 7 were significantly less likely to use contraception on their first heterosexual experience, controlling for the effects of gender, current age, age at first sex and education level.

4.0 Sexual experiences and contraception use during the previous year

4.1 Introduction

A large proportion of all pregnancies occurring across the globe are unplanned or unintended (Higgins et al., 2008). Whilst it is widely recognised that correct and consistent use of effective contraceptive methods during all occasions of sexual intercourse greatly reduces the likelihood of unintended pregnancy (Wu et al., 2008), many individuals fail to adhere to a regular contraceptive routine, even when pregnancy is not desired (Nettleman et al., 2007; Upson et al., 2010).

There are numerous reasons why people do not use contraception consistently, including method-related issues (e.g., concerns about side effects or effectiveness), user-related issues (e.g., perceived low risk of becoming pregnant), relationship-related issues (e.g., partner will not use contraception) or cost-related issues (e.g., cannot access contraception or services) (Lakha and Glasier, 2006; Nettleman et al., 2007). To understand these issues in more detail, it is useful to examine the patterns of contraceptive use and a broad set of factors including individuals' attitudes towards pregnancy and attitudes towards and experiences with contraceptive methods and service providers, as well as socio-demographic characteristics (Frost et al., 2007).

This chapter explores these issues in greater detail by:

- summarising the sexual history of the sample;
- describing current attitudes towards pregnancy;
- exploring factors associated with consistency of contraceptive use among those who are not actively trying to conceive; and
- investigating reasons for lack of consistent contraceptive use among those who are not actively trying to conceive.

Questions in this section of the survey were generally asked of heterosexual respondents who had been sexually active during the previous year and who were not currently pregnant (or did not have a partner who was currently pregnant) or actively trying to conceive.

Sexual experiences and contraception use during the previous year: key findings

- Most of the adults surveyed had had sex with someone of the opposite sex during the previous year (93%), which is comparable with ICCP-2003 (92%).
- 11% of the sample were pregnant (or had a partner who was pregnant) or were actively trying to conceive at the time of the 2010 survey.
- Adults' attitudes towards an unplanned pregnancy were assessed: more adults in ICCP-2010 (46% of women and 56% of men) felt that an unplanned or unexpected pregnancy would be a positive event at this time in their lives than was the case in ICCP-2003 (35% of women and 47% of men).
- 40% of men and 48% of women aged 18 to 25 felt that an unplanned pregnancy at this time would be a negative event for them.
- The proportion of adults using any method of contraception to avoid pregnancy during the previous year increased slightly from ICCP-2003 (92%) to ICCP-2010 (94%).
- Non-use of contraception to prevent pregnancy increased with age: 2% of 18 to 25 year olds, 5% of 26 to 35 year olds and 11% of 36 to 45 year olds did not use any method of contraception to prevent pregnancy during the previous year.
- Use of the contraceptive ring, patch, injections or implanted capsules increased from 3% in ICCP-2003 to 8% in ICCP-2010. The biggest increase was among the youngest age group (18–25): from 4% in 2003 to 12% in 2010.
- Fewer adults in ICCP-2010 always used a form of contraception each time they had sex (78%) than in ICCP-2003 (83%).
- Consistency of always using contraception is lowest in the older age groups. There was a relatively high level of ambivalence towards pregnancy occurring among the older age groups (14% of 26 to 35 year olds and 22% of 36 to 45 year olds), but this reason was not reported in the youngest age group.
- Among those adults who were not actively trying to conceive, married couples were 63% less likely to have used contraception than single people (i.e., never married). There was no significant difference between single and cohabiting respondents.
- The proportion of respondents who had not used contraception because 'sex was not planned/not prepared/no contraception available' fell by more than two-thirds from 48% in ICCP-2003 to 15% in ICCP-2010; the percentage of 18 to 25 year olds giving this as a reason dropped from 58% in 2003 to 19% in 2010.
- Lack of contraception use due to drinking alcohol or taking drugs was lower overall in ICCP-2010 (16%), compared with ICCP-2003 (21%).

4.2 Recent sexual activity

All respondents who had ever had heterosexual intercourse were asked if they had had sexual intercourse with someone of the opposite sex during the previous year. As outlined in Table 4.1, the majority of these respondents (93%) had had sex with someone of the opposite sex during the previous year, which is comparable with ICCP-2003 (92%).

Table 4.1 Have you had sex with someone of the opposite sex in the last year? (by gender)

	Men (n=1,343)		Women (n=1,470)		Total (n=2,813)	
	n	% (w)	n	% (w)	n	% (w)
Yes	1,270	94	1,359	91	2,629	93
No	72	6	107	9	179	7
Refused to answer	1	<1	4	<1	5	<1

Note: % (w) = weighted percentages.

Several items of information obtained from respondents were combined to determine what questions respondents would be asked depending on their personal history and experiences. A breakdown of the entire sample recruited in ICCP-2010 is provided in Table 4.2. Overall, 11% of respondents were pregnant (or had a partner who was pregnant) or were trying to conceive at the time of the survey, which is an increase from 7% in ICCP-2003.

Table 4.2 Current pregnancy status, by age group

Current pregnancy status	18–25 years (n=717) %	26–35 years (n=1,229) %	36–45 years (n=1,056) %	Total (n=3,002) %
Pregnant or trying to conceive	3	16	10	11
Not pregnant or trying to conceive	75	72	78	75
Never had sex	14	2	2	5
Did not have sex during the previous year	4	7	8	7
Same sex experiences only	3	2	1	2
Unknown	1	1	1	1

Given that the majority of this section of the questionnaire relates to the use of contraception during the previous year for the prevention of pregnancy, only respondents who were 'not pregnant or trying to conceive' were asked questions relating to their use of contraception during the previous year.

4.3 Attitudes towards an unplanned pregnancy

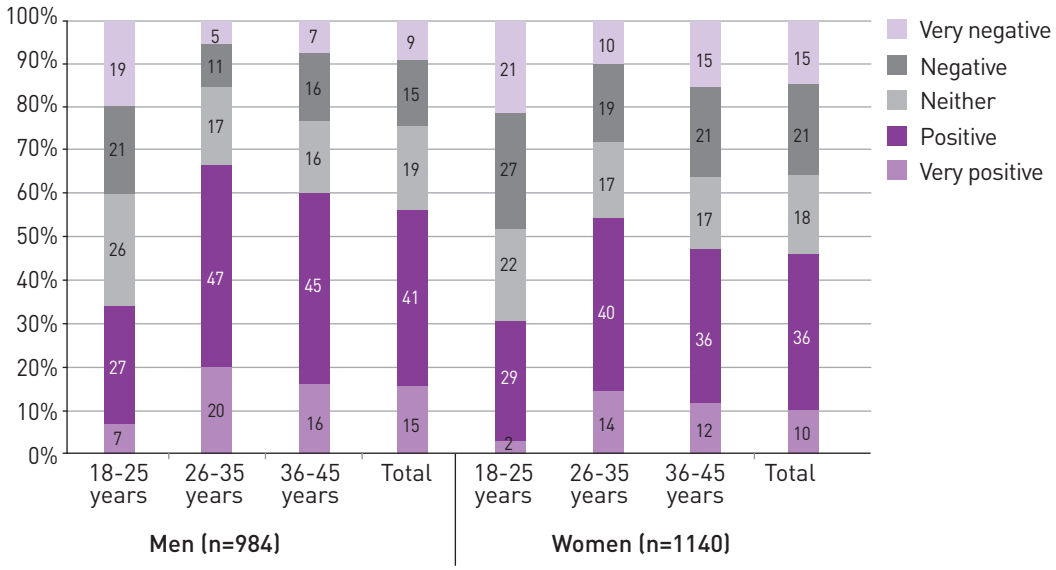
An understanding of pregnancy intentions helps to estimate the unmet need for contraceptive services and to target contraceptive programmes (Santelli et al., 2009).

In ICCP-2010, general attitudes towards experiencing a pregnancy at the present time were assessed. All individuals who were not pregnant or trying to conceive at the time of the survey and who were at risk of becoming pregnant in the future were asked what their response would be (very positive to very negative) if they or their partner became pregnant. Respondents who had never had sexual intercourse or who had not had sexual intercourse during the previous year were not asked this question. Figure 4.1 illustrates a breakdown of attitudes by gender and age.

Overall, 46% of women and 56% of men felt that an unexpected or unplanned pregnancy would be a positive event at this time in their lives. This represents an increase from 35% of women and 47% of men in ICCP-2003. Higher proportions of adults in the youngest age group (18–25) believed that an unplanned or unwanted pregnancy at this time would be negative (40% of men and 48% of women) than in the 26–35 age group (16% of men and 29% of women) and the 36–45 age group (23% of men and 36% of women).

Of those adults reporting that an unplanned pregnancy would be negative or very negative (n=567), 82% reported 'always' using contraception every time they had had sex during the previous year, while 13% said 'mostly', 3% said 'sometimes' and 2% said 'rarely'.

Figure 4.1 Rating of response to pregnancy if respondent (or partner) became pregnant at this time, by gender and age group



4.4 Use of any method of contraception during the previous year

Despite advances in contraceptive options across the developed world, millions of women who do not want a child or who want to delay childbearing do not use contraception (Frost et al., 2007; Singh et al., 2009). ICCP-2010 collected data relating to the recent contraceptive practices of the sample and found that 6% of respondents had not used any method of contraception to avoid pregnancy during the previous year. This figure is slightly lower than in ICCP-2003, when 8% of respondents did not use any method of contraception. Conversely, these figures imply that 94% of adults in ICCP-2010 used some method of contraception to avoid pregnancy during the previous year, compared with 92% in ICCP-2003. Overall, these results suggest contraception use is relatively high and stable.

The figures relating to non-use of contraception among those who are not actively trying to conceive (6% in ICCP-2010) is generally consistent with research in the United States that suggests that 7% of reproductive age women currently do not use a contraceptive method, despite being at risk for unintended pregnancy (Centers for Disease Control and Prevention, 2010). The proportion of respondents not using any method of contraception in ICCP-2010 increased with age from 2% in the youngest age group (18–25), to 5% in the middle age group (26–35), to 11% in the oldest age group (36–45).

The lack of contraception use among adults who are not actively trying to conceive is an area of concern for policy makers and researchers. A binary logistic regression analysis was conducted to explore the factors associated with using any method of contraception during the previous year (see Table 4.3).

As presented in Table 4.3, 18 to 25 year olds were almost five times more likely than 36 to 45 year olds to have used a method of contraception during the previous year, controlling for the effects of gender, current relationship status and social class. Respondents in the middle age group (26–35) were twice as likely as those in the oldest group to have used contraception during the previous year, controlling for the effects of gender, current relationship status and social class. These findings are consistent with recent research in the United States reporting that, compared with women aged 18 to 24, women in the 35–44 age group were 3.25 times more likely to not have used any method of contraception to avoid pregnancy during the previous year (Frost et al., 2007).

Compared with single people (never married), married couples were 63% less likely to have used contraception during the previous year, controlling for the effects of gender, current age and social class. There was no significant difference between the contraceptive use practices of single and cohabiting respondents. Compared with the highest social classes, those respondents in social classes 3 and 4 were 40% less likely to have used contraception during the previous year, controlling for the effects of gender, current age and current relationship status. Compared with social class 1, social classes 5, 6 and 7 were less likely to have used any method of contraception during the previous year, but these differences were not statistically significant ($p > 0.05$).

Table 4.3 Weighted adjusted odds ratio (AOR) and 95% confidence intervals (CI) for the probability of having used any method of contraception during the previous year (compared with no method used), among those at risk of pregnancy and not trying to conceive, by selected predictors

Socio-demographic characteristics	AOR	95% CI
Sex		
Men	0.889	0.612–1.293
Women (reference group)	1.000	
Current age		
18–25 years	4.871***	1.953–12.149
26–35 years	1.793**	1.191–2.700
36–45 years (reference group)	1.000	
Current relationship status		
Single (reference group)	1.000	
Cohabiting	0.818	0.368–1.817
Married	0.369***	0.209–0.652
Separated/divorced/widowed	1.710	0.332–8.801
Social class		
SC 1–2 (reference group)	1.000	
SC 3–4	0.604*	0.395–0.923
SC 5–6	0.609	0.334–1.110
SC 7 (unknown/never worked)	0.639	0.362–1.127

*Note: *** p<0.001; ** p<0.01; * p<0.05.*

4.5 Using different types of contraception

It is widely acknowledged that prescription contraceptives, including hormonal methods and intra-uterine devices (IUD), are more effective than non-prescription methods at preventing unintended pregnancy (Thonneau and Almont, 2008).

This section explores the different types of contraception used by the respondents recruited in ICCP-2010 and compares the findings with ICCP-2003. Table 4.4 provides an overview of age differences in contraceptive use for all respondents who had had sexual intercourse during the previous year, but who were not actively trying to conceive.

Table 4.4 Contraception and other precautions used during the previous year to avoid pregnancy, by age group (ICCP-2003 and ICCP-2010)

Contraception type	18–25 years %		26–35 years %		36–45 years %		Total %	
	ICCP-2003 (n=647)	ICCP-2010 (n=539)	ICCP-2003 (n=868)	ICCP-2010 (n=906)	ICCP-2003 (n=1,122)	ICCP-2010 (n=840)	ICCP-2003 (n=2,637)	ICCP-2010 (n=2,285)
Contraceptive pill	55	61	44	47	19	28	39	43
Condom	80	82	58	67	36	42	57	62
Contraceptive ring†	4	<1	4	1	2	1	3	1
Contraceptive patch†		2		2		1		2
Injections or implanted capsules†		9		5		3		5
Coil/IUD/IUS/ Mirena	2	4	4	10	10	17	6	11
Cap/diaphragm	<1	<1	<1	<1	1	1	1	<1
Spermicides (gels/ sprays/pessaries)	1	<1	<1	<1	<1	<1	1	<1
Persona	0	<1	<1	<1	1	<1	<1	<1
Safe period/rhythm method (other than Persona)	3	1	5	3	8	6	5	3
Withdrawal	5	3	6	4	6	6	5	5
Sterilisation (respondent or partner)	0	<1	4	2	19	14	8	6
Abstinence	2	2	2	3	3	4	2	3
Emergency contraception	5	9	2	3	<1	1	2	4
Other method	0	0	<1	0	1	0	<1	0

Note: Respondents could choose more than one response so columns may not total to 100%.
† These contraceptives were combined into a single response category in ICCP-2003.

In both ICCP-2003 and ICCP-2010, the most commonly used contraceptives were condoms and the oral contraceptive pill. Levels of use for these two methods increased over the seven-year period between the two surveys. Use of the contraceptive pill declined with age, which is a finding consistent with previous research (Centers for Disease Control and Prevention, 2010). Methods that may be considered less robust forms of contraception (e.g., withdrawal or rhythm method) decreased in use generally between the two surveys.

There are a number of interesting differences between the two surveys. Use of the contraceptive ring, contraceptive patch and injections or implanted capsules increased

from 3% in ICCP-2003 to 8% in ICCP-2010. The biggest increase for these methods was among the youngest age group (18–25): from 4% in 2003 to 12% in 2010. Use of the emergency contraceptive pill also increased in this age group from 5% in 2003 to 9% in 2010. The use of long-acting reversible contraceptives (LARCs) has increased overall, from 6% in 2003 to 11% in 2010. This trend is particularly evident in the older age groups. In ISSHR, LARC use among 18 to 24 year olds and 25 to 34 year olds was virtually non-existent at the most recent sexual intercourse occasion, compared with 9% of 35 to 44 year olds. The findings from all three surveys are important, because they suggest that the uptake of LARCs as a method of contraception is increasing across all age groups. These results support recent anecdotal evidence that although younger women living in Ireland are generally opting to use the contraceptive pill, they are asking their GP about alternative forms of contraception (Irish Medical News, 2009). They also support recent findings from the National Family Growth Surveys in the United States, which suggest that the uptake of IUDs increased from 2% in 2002 to 5.5% in the 2006–2008 period among women aged 15 to 44 (Centers for Disease Control and Prevention, 2010).

Several studies in Europe and elsewhere have recently reported on the usefulness and cost-effectiveness of LARCs in reducing unintended pregnancies (Mavranezouli, 2008; Ruddick, 2009). Recent research, however, suggests that there are a number of barriers preventing the uptake of LARCs, primarily cost or health care insurance coverage (Nearns, 2009). ICCP-2010 explored this issue in more detail in an Irish context (see Chapter 5).

The proportion of respondents reporting that they or their partner had been sterilised decreased between ICCP-2003 and ICCP-2010, from 8% to 6%. These findings are consistent with research that revealed a continued marked decrease in the number of laparoscopic tubal ligations and a marked increase in the number of Mirena coils being fitted in Ireland between 1999 and 2005 (Horgan et al., 2010).

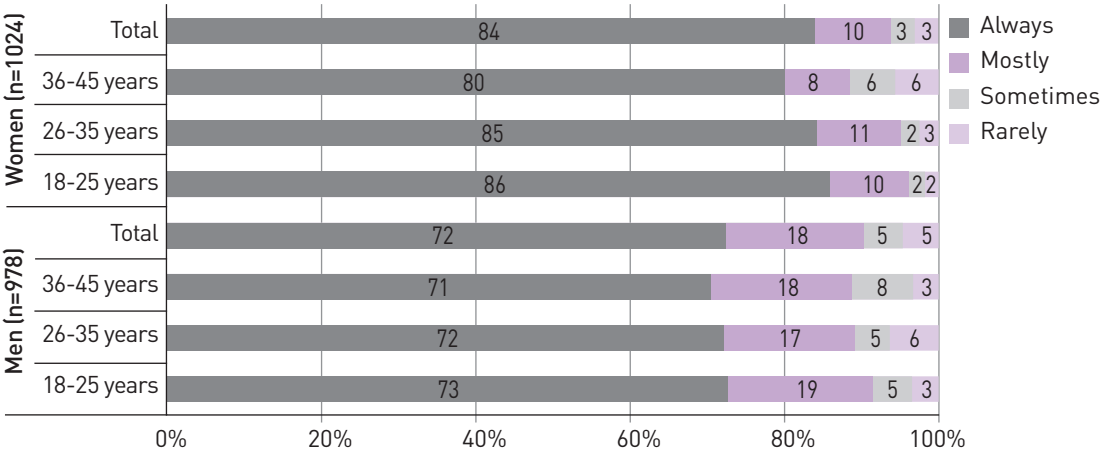
4.6 Consistency of using contraception

It is recognised that most pregnancies among contraceptive users are caused by inconsistent or incorrect use of contraception, rather than by a failure of the method itself (Glasier et al., 1999). In ICCP-2010, all adults who reported using one or more methods of contraception during the previous year were asked about their consistency of contraception use when having sexual intercourse during that year (see Figure 4.2); 78% of respondents (84% of women and 72% of men) reported that they always used a form of contraception each time they had sex. There was a trend across both men and women for decreased consistency of contraceptive use with increasing age.

At 78%, the proportion of men and women consistently using contraception has decreased from 83% in ICCP-2003. Comparing across ages groups, however, it is clear that the proportion of respondents in the youngest age group (18–25) who consistently used contraception every time they had sex has increased from 76% in ICCP-2003 to 79% in

ICCP-2010. The proportion of respondents in the two older age groups who consistently used contraception decreased across the seven-year period.

Figure 4.2 Frequency of contraceptive use when having heterosexual sex during the previous year, by gender and age group



4.7 Reasons for not always using contraception during the previous year

As noted above, one challenging area for policy makers and researchers is the failure of adults who are not trying to conceive to use contraception. All respondents who had never used contraception or who had not used contraception every time they had sex during the previous year were asked the reasons why they behaved in this way. Interviewers coded their reply into one or more response categories, although these categories were not read out to the respondents. The estimates for ICCP-2010 are compared with ICCP-2003 in Table 4.5. It is important to note that there are some minor differences between the two surveys in relation to response options.

Overall, 12% of respondents had not used contraception consistently during the previous year because either they or their partner had been pregnant (but was not pregnant at the time of the interview). The most common reason cited was 'took a chance' (20%), which implies that respondents knew that they should be using contraception; this category was not included in ICCP-2003. The two main reasons respondents gave for not using contraception in ICCP-2003 were that 'sex was not planned/not prepared/no contraception available' (48%) or that they had been 'drinking alcohol/taking drugs' at the time (21%). While these remain two of the three most common reasons given in ICCP-2010, the respective figures (15% and 16%) represent a marked decrease. In terms of 'sex was not planned/not prepared/no contraception available', this decrease applied across all age groups and was particularly noticeable amongst the younger respondents: the percentage of 18 to 25 year olds giving this as a reason dropped from 58% in ICCP-2003 to 19% in ICCP-2010.

Compared with ICCP-2003, there was a decrease in the number of respondents reporting that they could not get access to contraceptive services (from 2% to less than 1%). While lack of contraception use due to drinking alcohol or taking drugs was lower overall (16%, compared with 21% in ICCP-2003), over one-quarter (27%, down from 32% in ICCP-2003) of adults aged 18 to 25 still cited this as a reason for not consistently using contraception during the previous year. Indeed, this was the most common reason given by respondents in the 18–25 age group. There seemed to be a relatively high level of ambivalence towards pregnancy occurring among the older age groups (14% of 26 to 35 year olds and 22% of 36 to 45 year olds), but this reason was not reported in the 18–25 age group.

Table 4.5 Reasons for not always using contraception during the previous year, by age group (ICCP-2003 and ICCP-2010)

Reason	18–25 years % (w)		26–35 years % (w)		36–45 years % (w)		Total % (w)	
	ICCP-2003 (n=207)	ICCP-2010 (n=113)	ICCP-2003 (n=132)	ICCP-2010 (n=185)	ICCP-2003 (n=155)	ICCP-2010 (n=153)	ICCP-2003 (n=494)	ICCP-2010 (n=451)
Against religious beliefs to use contraception	0	0	4	0	5	1	3	1
Already pregnant†	NA	7	NA	14	NA	15	NA	12
Unlikely to conceive because of menopause	<1	<1	1	0	18	1	5	<1
I don't like/won't use contraception	3	8	5	7	8	5	5	6
Partner doesn't like/won't use contraception	0	3	1	1	2	3	1	2
Not my responsibility	3	0	0	1	1	0	1	<1
I/partner forgets to take contraceptive pill	5	4	5	1	1	3	4	2
Difficult to discuss contraception with partner	0	0	0	0	2	1	<1	<1
Drinking alcohol/ taking drugs	32	27	17	18	9	6	21	16
Didn't/don't care if pregnancy happens	0	0	0	14	5	22	1	13
Sex not planned/not prepared/no contraception	58	19	49	20	29	8	48	15

Reason	18–25 years % (w)		26–35 years % (w)		36–45 years % (w)		Total % (w)	
	ICCP-2003 (n=207)	ICCP-2010 (n=113)	ICCP-2003 (n=132)	ICCP-2010 (n=185)	ICCP-2003 (n=155)	ICCP-2010 (n=153)	ICCP-2003 (n=494)	ICCP-2010 (n=451)
Can't get contraceptive services	3	1	1	0	4	1	2	<1
Unlikely to conceive because possibly infertile/fertility problems	0	0	2	2	7	6	3	3
Took a chance	NA	22	NA	18	NA	22	NA	20
Had not heard of the morning after pill	NA	1	NA	0	NA	0	NA	0
Partner takes care of contraception	NA	3	NA	0	NA	1	NA	1
Other reason	11	7	14	12	19	7	14	9
Refused/no response	2	1	3	<1	5	1	3	1

Note: Respondents could choose more than one response so columns may not total to 100%.
% (w) = weighted percentages.
NA = response option was not included in ICCP-2003.
† Respondent is not currently pregnant or trying to conceive but at some point during the previous year was pregnant and therefore was not using contraception.

An interesting finding in ICCP-2003 was that 18% of women aged 36 to 45 reported that they did not always use contraception as they were unlikely to conceive because of the menopause. In both ICCP surveys, all respondents were aged under 46 and were unlikely to be post-menopausal or have a post-menopausal partner. In ICCP-2010, the percentage of women in this age group citing menopause as a reason for not always using contraception during the previous year was greatly reduced (1%). Although the reason for this change is not immediately apparent, it may be that women in this age group are more aware of the fact that they are not currently at the typical age for menopause. This may be related to national awareness campaigns that have promoted knowledge of women's fertility in this age group. Nevertheless, caution must be advised in interpreting these results. Women in ICCP-2010 reported using contraception more frequently in later life than was the case in ICCP-2003; although the results suggest that adults in this age group are using contraception less consistently than their ICCP-2003 counterparts. It is likely, therefore, that respondents chose to give reasons other than being menopausal for their non-consistent contraception use during the previous year.

5.0 Accessing contraception

5.1 Introduction

As discussed in Chapter 2, over a third of the population of Ireland has a general medical scheme (GMS) card that allows access to medical treatment and prescriptions for drugs and contraception. Condoms are not included under the medical card. This means that a large proportion of Irish adults have to pay to meet their contraceptive needs, which can be expensive (and particularly so for those on lower incomes). ISSHR explored the relationship between the cost of contraception and lack of use of condoms among those who were sexually active. It found that younger adults, those with lower levels of education and/or those with a manual occupation reported that the cost of condoms would prevent them from using them when having sex (McGee et al., 2008).

Cost is an important issue, particularly in relation to prescription contraceptives, including the hormonal methods and IUDs. By definition, prescription contraceptives have to be administered by a qualified health care professional. Research has shown that these methods are more effective than non-prescription methods (National Institute for Health and Clinical Excellence, 2005), but that they are generally more expensive because people are not only required to pay for the contraceptive product, but they also have to pay a consultation fee to be seen by their GP (Nearns, 2009). Whilst cost is frequently an issue for those on lower incomes, the change in the economic climate in Ireland in recent years has likely had a big impact on how people access services and use contraceptives. It is important to explore this issue in greater detail at a national level in order to guide sexual health policy formation.

It is important to recognise that cost is not the only barrier towards accessing contraceptive services or using contraception. For example, in the UK, where contraceptive services and supplies are provided free of charge, a high proportion of pregnancies (50%) are deemed unwanted or unintended despite 70% of women of childbearing age using some method of contraception (Kishen and Belfield, 2006). Elsewhere, in developing countries, research suggests that women, particularly those who are married, do not frequently cite cost as an obstacle to using contraception (Sedgh et al., 2007b). Clearly, there are other important issues besides cost that impact on whether people choose to use contraception consistently when pregnancy is not desired.

This chapter investigates these issues in more detail in an Irish context by:

- exploring where people living in Ireland source and access contraceptive advice and supplies;
- identifying the locations where people would prefer to access contraceptive supplies;
- describing barriers to accessing contraceptive services;
- examining how the cost of contraception may be a barrier to choosing specific contraceptive methods; and

- summarising how the cost of attending a GP prevents people who do not have a medical card from seeking medical treatment.

Most of the questions in this chapter were asked of respondents who had experienced heterosexual sex and had used contraceptive supplies or sought advice on contraceptives. Questions relating to the cost of using specific contraceptives were asked only of those who reported using those methods of contraception.

Accessing contraception: key findings

- Similar proportions of adults surveyed in ICCP-2010 (10%) and in ICCP-2003 (12%) had never sourced contraceptive supplies or advice.
- Nearly half of women (47%) reported that they would prefer to get their contraceptive supplies from a pharmacy (chemist shop), followed closely by from a GP (37%); men were more likely to choose a pharmacy (chemist shop) (64%) or commercial outlets such as a petrol station or supermarket (17%).
- More women and men in ICCP-2010 reported experiencing some level of difficulty accessing contraception (15% and 9% respectively) than in ICCP-2003 (4% of women and 6% of men), although the majority had no difficulty.
- Access/locality, embarrassment and cost were the three main reasons given for difficulty in accessing contraception.
- 10% of men and 7% of women aged 18 to 25 reported that the cost of condoms had prevented them from using condoms when they had had sex during the previous year.
- 1 in 11 women reported that the cost of the prescription for the contraceptive pill, patch or ring prevented her from refilling her prescription.
- Higher proportions of women who do not have access to a medical card failed to refill their contraceptive prescription (12%), compared with those with a full medical card (3%) or a GP-only medical card (4%).
- 18% of adults surveyed in ICCP-2010 reported that the cost of a GP consultation was a frequent barrier to them seeking medical attention.

5.2 Sourcing contraceptive supplies or advice

Respondents who had experienced heterosexual intercourse were asked about whether they had sought contraceptive supplies or advice from a range of services.

Table 5.1 shows the sources of contraceptive supplies or advice that respondents had ever used, by gender and age group. The results suggest that the majority of women had consulted with their GP for contraceptive supplies or advice (84%), with the second most common service being a pharmacy (chemist shop) (47%). For men, the most commonly used service was a pharmacy (chemist shop) (67%), followed by commercial outlets such

as supermarkets, petrol stations or vending machines (42–46%). These gender-specific trends have remained stable since ICCP-2003.

Table 5.1 Sources of contraceptive supplies/advice ever used, by gender and age group

Source	Men (n=1,321) % (w)				Women (n=1,421) % (w)			
	18–25 years (n=320)	26–35 years (n=550)	36–45 years (n=451)	Total	18–25 years (n=367)	26–35 years (n=619)	36–45 years (n=435)	Total
Never obtained supplies or sought advice	13	10	18	13	11	3	7	6
A GP	14	18	15	16	76	86	84	83
Practice nurse at a GP surgery†	6	8	6	7	36	34	31	34
Family planning or Well Woman/ Man clinic	5	8	9	8	21	27	31	27
Pharmacy (chemist shop)	70	69	63	67	50	48	44	47
Petrol station/ supermarket	53	53	30	46	23	18	15	18
Vending machines	37	46	40	42	6	11	10	9
Through the post via the Internet	7	8	4	6	6	4	3	4
Supplied by sexual partner/ family/friend††	1	<1	1	1	<1	1	0	<1
Any other service	1	1	1	1	1	2	1	2

Note: Respondents could choose more than one source so columns may not total to 100%.
% (w) = weighted percentages.
† This response option was available in ICCP-2010 only.
†† This response option was a fixed response category in ICCP-2003, but not in ICCP-2010, and information obtained from the 'other' category in ICCP-2010 was used to create this response category for 2010.

The proportion of men and women who had never sourced contraceptive supplies or advice decreased from 12% in ICCP-2003 (14% for men and 8% for women) to 10% in ICCP-2010 (13% for men and 6% for women).

5.3 Preference for sourcing contraceptive services

All respondents who had ever had heterosexual sex and who had ever sought contraceptive services (excluding those who were sterilised or infertile) were asked about their preferred source for obtaining contraceptive supplies (see Table 5.2).

Almost half of women surveyed reported that they would prefer to get their contraceptive supplies from a pharmacy (chemist shop) (47%), followed closely by from a GP (37%). The majority of women preferring to obtain contraception from a pharmacy (chemist shop) had used the contraceptive pill, ring or patch (46%) or condoms (52%) during the previous year. These preferences have changed slightly since ICCP-2003, when the main preferred service for women was a GP (50%), followed by a pharmacy (26%). In ICCP-2010, the majority of men chose a pharmacy (chemist shop) (64%) or commercial outlets such as a petrol station or supermarket (17%). This preference trend has remained stable since ICCP-2003.

Table 5.2 Preferred source of contraceptive supplies if all were available easily and locally, by gender and age group

Source	Men (n=1,151) % (w)				Women (n=1,326) % (w)			
	18–25 years (n=282)	26–35 years (n=501)	36–45 years (n=368)	Total	18–25 years (n=324)	26–35 years (n=593)	36–45 years (n=409)	Total
A GP	4	7	6	6	41	35	38	37
Practice nurse at GP surgery	0	0	<1	<1	4	2	2	2
Family planning or Well Woman/ Man clinic	1	1	1	1	6	6	8	7
Pharmacy (chemist shop)	64	62	67	64	44	50	45	47
Petrol station/ supermarket	18	19	15	17	5	5	4	5
Vending machines	13	8	8	9	<1	2	<1	1
Through the post via the Internet	<1	1	<1	1	1	<1	2	1
Other	0	<1	1	1	0	<1	1	1
No preference	1	2	1	2	0	1	1	<1

Note: % (w) = weighted percentages.

The finding of a preference to obtain contraception from a pharmacy is consistent with the existing literature. Research studies have reported that people, particularly women, prefer to get contraception from a pharmacist because it is faster and more convenient than obtaining a prescription from their doctor (Anderson and Blenkinsopp, 2006; Greene et al., 2006). Also, women reported that talking to a pharmacist about contraception can be very helpful and informative (Greene et al., 2006). Pharmacists in Ireland, like those in other countries, have an important role to play in preventing crisis pregnancies (Farris et al., 2010).

5.4 Difficulty in accessing contraception

Whilst it is encouraging that the findings of this study suggest that the majority of men and women recruited had sought contraceptive advice and/or supplies in their lifetime, previous research suggests that many factors can prevent or inhibit people from seeking contraceptive services. It is important to explore some of these factors in more detail.

In ICCP-2003, 4% of women and 6% of men reported that they experienced some difficulty in accessing contraception. As outlined in Table 5.3, it appears that more women (15%) and men (9%) are reporting some difficulty in accessing contraception in ICCP-2010.

Table 5.3 Difficulty in accessing contraception, by age group and gender

Difficulty level	18–25 years % (w)		26–35 years % (w)		36–45 years % (w)		Total % (w)	
	Men (n=273)	Women (n=290)	Men (n=497)	Women (n=569)	Men (n=354)	Women (n=377)	Men (n=1,124)	Women (n=1,236)
Very difficult	1	2	1	1	1	1	1	1
Quite difficult	2	3	1	3	1	2	1	3
Sometimes difficult	8	14	9	10	4	7	7	11
Not at all difficult	89	81	89	86	95	90	91	85
Don't know	0	0	1	1	<1	1	<1	1

Note: % (w) = weighted percentages.

Respondents who found it sometimes, quite or very difficult to get contraception (n=271) were asked to explain why this was the case for them (see Table 5.4). Respondents could give more than one reason, so percentages are of total respondents who answered the question. The three main reasons given for difficulty in accessing contraception were access/locality, embarrassment and cost. These issues will be discussed in more detail next.

Table 5.4 Reasons given by those respondents (9% of men and 15% of women) who thought it was difficult to obtain contraception, by age group

Barriers to accessing contraception	18–25 years (n=86) %	26–35 years (n=129) %	36–45 years (n=56) %	Total (n=271) %	
Do not know where to access contraceptive services	6	5	11	7	
Cannot access contraceptive services in locality	38	43	47	42	
Embarrassment	37	15	19	23	**
Cannot afford contraceptive services	24	24	22	24	
Inconvenience	4	18	14	13	**

Note: Respondents could choose more than one response so columns may not total to 100%.
*** p<0.01.*

5.4.1 Access/locality

As outlined in Table 5.4, for those who had some level of difficulty accessing contraception (15% of women and 9% of men), the issue that caused most difficulty was accessing services in the respondent's locality (42%). This is very similar to the results from ICCP-2003, when 45% of respondents cited the same reason for difficulty in accessing contraception. In ICCP-2010, there were no statistically significant differences between respondents living in rural (country/small towns) or urban (big towns/cities) areas or between age groups in relation to access or locality. A significantly higher proportion of older adults reported 'inconvenience' as a difficultly in accessing contraception, compared with younger adults ($p<0.01$).

5.4.2 Embarrassment

While only 11% of respondents had difficulty with access to contraception, it is interesting to note that despite the seven year gap between the surveys, a similar proportion of respondents mentioned embarrassment as a reason for difficulty in obtaining contraception (25% in ICCP-2003 and 23% in ICCP-2010). In ISSHR, 31% of men and 26% of women aged 18 to 64 reported embarrassment as a key barrier to obtaining contraceptive services. While there were no significant differences in relation to whether the respondent was located in an urban or rural location, significantly higher proportions of younger adults compared with older adults cited embarrassment as a reason for having difficulty in obtaining contraception.

The findings in relation to access and embarrassment in ICCP-2010 raise some important issues. For example, it may be that a person's feelings of embarrassment impact on whether they actually access contraceptive services. International research has demonstrated that young people in particular generally do not seek out services for sexual and reproductive care because they are embarrassed or too shy. Moreover,

young people often do not know where or how to find a hospital or clinic where they can obtain contraception or treatment for STIs in their locality (Boonstra, 2007). It may be that difficulties relating to access/locality may be intertwined with embarrassment. For example, respondents, particularly young respondents, may have access to only specific contraceptive services in their area (e.g., a family GP) and they may feel embarrassed about accessing those specific types of service due to concerns about privacy or confidentiality. It is important to acknowledge, however, that most young people do not experience embarrassment or problems with access to contraception in general.

5.4.3 Cost of contraception

The cost of visiting a health care professional for contraceptive needs, or obtaining a prescription for a contraceptive product, is often expensive. Recently, the Irish Government introduced a 50 cent levy per item prescribed by pharmacists to people with a full medical card. This change means that it may be even more difficult for people to access contraceptive products due to financial constraints. In ISSHR, 24% of men and 30% of women aged between 18 and 65 reported that cost was a barrier to accessing contraceptive services (McGee et al., 2008). There seems to be an increase in the proportion of adults reporting cost-related issues in relation to accessing contraception in ICCP-2010 (24%), compared with ICCP-2003 (17% overall). A major aim of the current survey is to explore whether the cost of different types of contraception is currently preventing sexually active adults from using them as a contraceptive method when having sex.

Cost of condoms preventing use

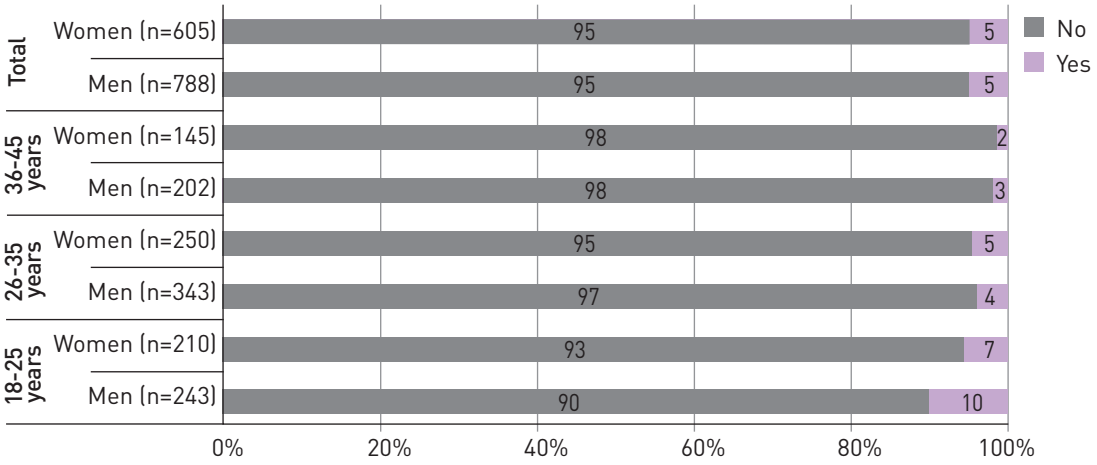
Recognising that the cost of condoms in Ireland was amongst the highest in Europe, the Irish Government introduced a measure in the 2008 Finance Bill to reduce the valued-added tax (VAT) on condoms from 21% to 13.5%. This reduced the price of a packet of twelve condoms from €13.20 to €12.40, and a packet of three condoms from €4.20 to €3.94 (CPA, 2008). Even with this price reduction, the cost of buying condoms in Ireland is still high when compared with other European countries, where condoms are often rated at the lowest possible VAT rate (5%). It is estimated, for example, that in Germany, the average price of a box of twelve condoms is around $5 or €3.50.[2] The issue of the cost of condoms is important, given that condoms are not currently covered under the medical card.

All respondents who had used condoms were asked whether the cost of condoms had prevented them from using that specific type of contraception when having sex during the previous year (see Figure 5.1). Of those respondents who had used condoms during the previous year (n=1,393), 5% of men and women indicated that they had had sex in that year without using condoms because of the cost of condoms. The cost of condoms seemed to be an issue for younger people, with 10% of young men and 7% of young women in the 18–25 age group reporting that they had had sex during the previous year without using condoms due to cost issues. There were no statistically significant

2 Condom prices around the world (11 September 2008); available online at: http://paradoxoff.com/condom-prices-around-the-world.html.

differences between respondents who did have and did not have a medical card in relation to this issue.

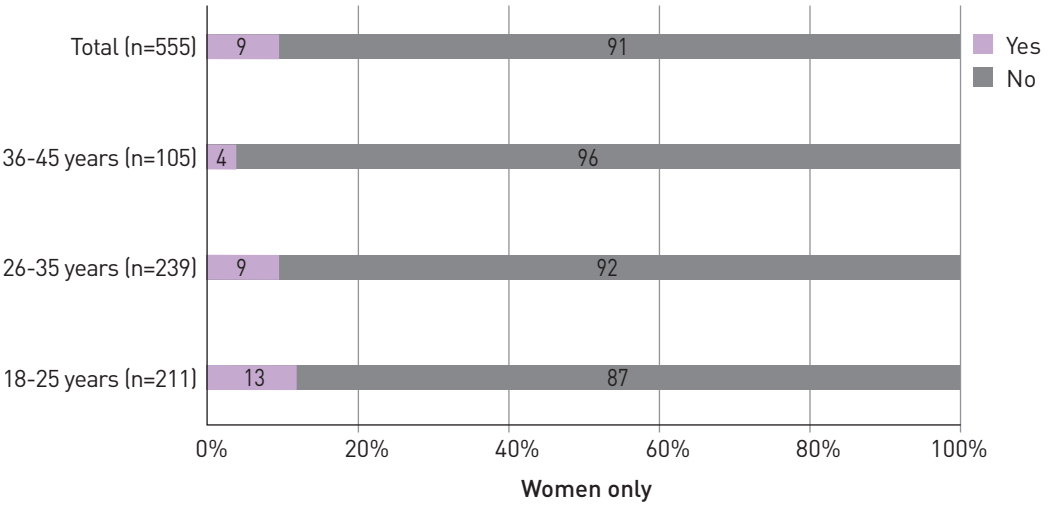
Figure 5.1 Has the cost of condoms prevented you from using them when you had sex in the last year? (by age group and gender)



Cost of contraceptive pill, ring or patch prescription preventing use

A delay in refilling a contraceptive prescription may result in a significant reduction of contraceptive efficacy and is a very common reason for failure of contraception (Trussell, 2007). In ICCP-2010, women who had used the contraceptive pill, patch or ring during the previous year (n=555) were asked if they had ever not refilled their prescription for their contraception because they could not afford it (see Figure 5.2). Overall, 1 in 11 women (9%) answered yes to this question; 1 in 8 women (13%) aged 18 to 25 reported that the cost of their contraceptive pill, ring or patch prescription prevented them from obtaining their contraceptive product. There was a statistically significant age group difference ($p<0.05$).

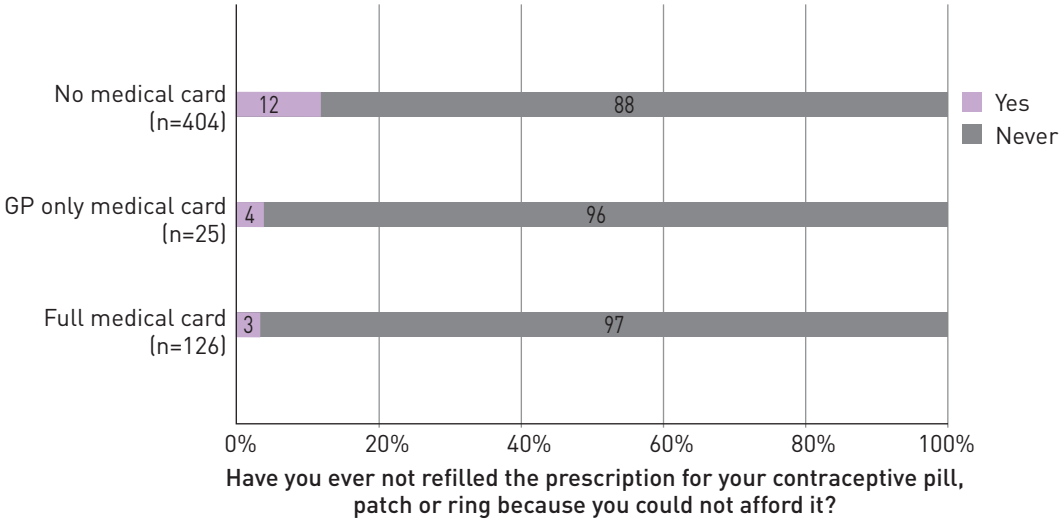
Figure 5.2 Have you ever not refilled your prescription for your contraceptive pill, patch or ring because you couldn't afford it? (by age group, women only)



The proportion of those women with a medical card refilling or not refilling their contraceptive prescription was also explored (see Figure 5.3).

Higher proportions of women who do not have access to a medical card failed to refill their contraceptive prescription (12%), compared with those with a full medical card (3%) or a GP-only medical card (4%). This difference in medical card ownership at the time of the survey was statistically significant across women who ever did and did not refill their prescription for their contraceptive pill, ring or patch because of cost issues ($p<0.05$).

Figure 5.3 Refilling contraceptive pill, patch or ring prescription by medical card status (women only)

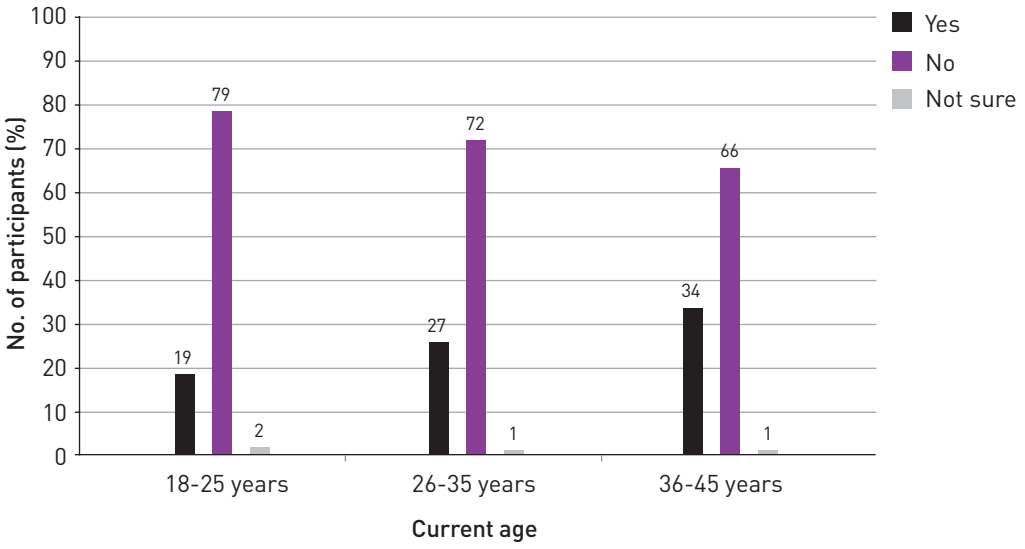


Cost of long-acting reversible contraception (LARC) preventing use/consideration of use

It is widely recognised that contraceptive methods that are not user-dependent, such as LARCs, are highly effective in preventing unintended pregnancies (Blumenthal et al., 2011; Mavranezouli, 2008). Indeed, the National Institute for Health and Clinical Excellence (2005) in the UK has advocated LARCs as the contraceptive method of choice. Despite this evidence, it is only in recent years that studies in Europe and the United States have seen an increase in the uptake of these types of contraception. For example, a national survey of obstetrician-gynaecologists in the United States revealed that while 95% agreed that the IUD is safe and effective, most would restrict IUD use for women who were not monogamous, not married, had a history of pelvic inflammatory disease or were nulliparous (i.e., had never given birth to a child) (Stanwood et al., 2002). Moreover, a recent UK study revealed that 61% of medical practitioners in general practice reported that they see too few patients requesting LARCs as a method of contraception to maintain the skills to fit these products for patients.

ICCP-2010 sought to explore whether women living in Ireland have considered using LARCs as a method of contraception and whether cost was a barrier to use. All women who reported being aware of LARCs (e.g., the coil/Mirena, IUD or IUS) but who had not used these methods during the previous year (n=1,210) were asked whether they had ever considered using these products as a method of contraception (see Figure 5.4). There was a statistically significant age difference, with higher proportions of older women having contemplated using LARCs as a method of contraception than younger women ($p<0.01$).

Figure 5.4 Was there ever a time when you considered using LARC as a method of contraception? (by age group, women only)



This study explored the cost of LARCs as a barrier to choosing this method of contraception. This may particularly be an issue in Ireland, where women without a medical card would have to pay a prescription fee for the device, as well as the doctor's consultation and fitting fee. Thus, the total cost for obtaining some LARCs in Ireland could be as much as €300.[3] It is important to note that cost is only one issue in relation to the provision of LARCs. Contraception in the UK has been available for free via the National Health Service since 1974, yet studies have suggested that even though women in the UK do not have to pay to get a prescription for a LARC, or to have it fitted or removed, the uptake of these devices has been relatively low, at approximately 17% (O'Sullivan et al., 2005). Clearly, there are issues besides cost that are associated with the low uptake of reliable long-term contraceptive methods.

In ICCP-2010, of the women who had considered using LARCs as a method of contraception (n=350), 27% reported that the cost of the prescription, including the cost of the consultation fee, prevented them from choosing these products as their method of contraception. There were no statistically significant age group differences. There were also no statistically significant differences between those who had a medical card and those who did not.

3 Wellwoman Centre (2011) List of services; available online at: www.wellwomancentre.ie/index.php?p=services.

Cost of 'morning after pill' (ECP) preventing use

Prior to 2011, people living in Ireland could obtain the ECP (emergency contraceptive pill) from a number of sources: (1) directly from a doctor; (2) from a pharmacist with a prescription from a doctor; (3) an emergency supply from a pharmacist in the Republic of Ireland without a prescription from a doctor (although the pharmacist may contact the doctor to have a prescription forwarded directly to the pharmacist after the supply); or (4) from a pharmacist without a prescription in other countries (including Northern Ireland). Thus, some people accessing the ECP would have to pay a consultation fee in addition to the cost of the ECP. At the time of the survey (mid-2010), the ECP was available for medical cardholders with a prescription from a doctor.

In ICCP-2010, 72 respondents reported having used the 'morning after pill' or ECP during the previous year. Of these respondents, one-fifth (20%) were covered by a full medical card. The cost of attending the doctor for the ECP would not be applicable for these respondents. Of the 8% of those using the ECP during the previous year who had a GP-only medical card, none reported that the cost of the ECP prevented them from using it during the previous year. The finding is not unexpected, given that the majority of ECP users obtain it directly from their GP (see Figure 9.7 in Chapter 9). Of the remaining respondents who did not have a medical card but had used the ECP during the previous year (n=51), 10% reported that the cost of the ECP had prevented them from using it after unprotected sex.

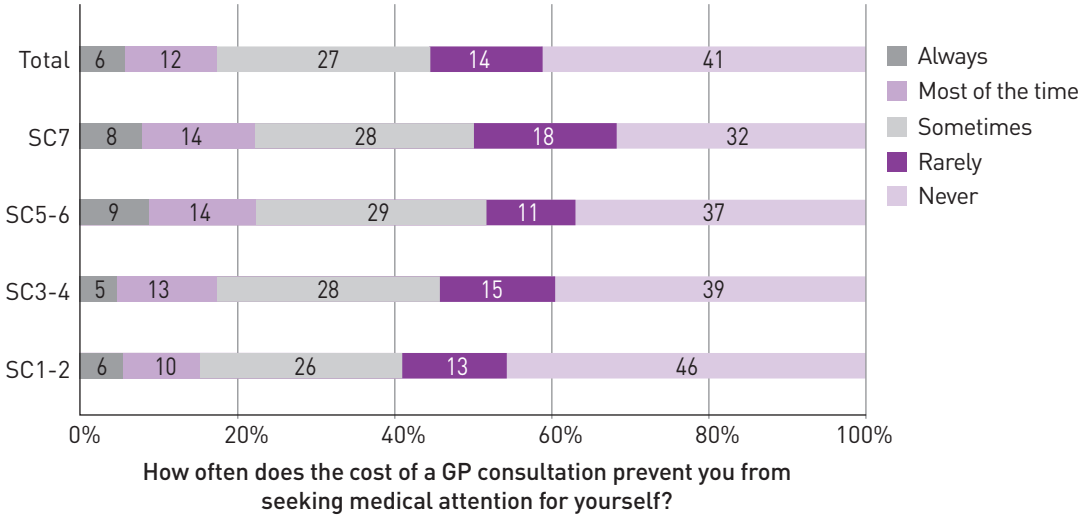
The ECP (Norlevo brand) was re-categorised in early 2011 as a non-prescription medicine in Ireland, meaning that this ECP is available from a pharmacy following a private consultation with a pharmacist. The Pharmaceutical Society of Ireland has issued guidance to pharmacists on the safe supply of non-prescription ECP (Norlevo brand) to patients and compliance with the guidelines is expected. This practice should make this form of contraception more readily available to patients, by increasing accessibility and reducing the cost. According to a survey by the Irish Pharmacy Union (2011) of over 200 pharmacists across the country, 85% of pharmacists were asked for the ECP without a prescription in the three months after the medication became available through pharmacies in February 2011. The average number of requests from patients per week was 2.4 in those pharmacies where a request had been made. The age of patients requesting the medication ranged from 16 to 40, with younger patients (aged 20 to 25) being the most likely to request the ECP.

5.5 Cost of medical care preventing people from seeking medical treatment

All respondents who did not have a medical card were asked how often the cost of a GP consultation prevented them from seeking medical attention for themselves. Overall, 18% of adults surveyed reported that the cost of a GP consultation was a frequent barrier to them seeking medical attention (see Figure 5.5). Differences across the social classes were statistically significant ($p<0.01$). Higher proportions of adults in the lower social

classes reported that the cost of a GP consultation regularly prevented them from seeking medical attention, compared with adults in the higher social classes.

Figure 5.5 Cost of GP consultation preventing respondent seeking medical treatment, among those without a medical card, by social class (n=2,225)



6.0 Pregnancy experiences and outcomes

6.1 Introduction

Experiencing a pregnancy is a life-changing event for most people. A pregnancy can have numerous outcomes, which depend on various biological and social factors. For example, many pregnancies do not reach full term due largely to biological reasons (e.g., a miscarriage, stillbirth or ectopic pregnancy). In other circumstances, the pregnant woman (and her partner) makes a decision about the outcome of the pregnancy and whether this will involve giving birth and parenting the child, giving birth and placing the child for adoption, or ending the pregnancy in an abortion. Understanding the prevalence of these different pregnancy outcomes over time can be very useful from a number of different perspectives, including helping to plan pregnancy-related services.

This chapter extends and builds upon pregnancy-related data obtained from two national surveys by:

- examining the proportion of adults living in Ireland who have experienced a pregnancy;
- exploring the outcomes of pregnancies experienced by adults living in Ireland;
- identifying trends in pregnancy outcomes between 2003 and 2010; and
- focusing on the experiences of women living in Ireland who have had an abortion.

This chapter focuses on all pregnancy outcomes (experiences of crisis pregnancies will be reported on in Chapter 7). Slight differences exist between ICCP-2010 and ICCP-2003 in relation to which respondents were asked about their pregnancy experiences (see Technical notes for details).

Pregnancy experiences and outcomes: key findings

- Fewer women but more men in ICCP-2010 had experienced a pregnancy (60% of women and 49% of men) compared with ICCP-2003 (61% of women and 45% of men).
- There was a decrease in the proportion of live births ever experienced by adults living in Ireland in ICCP-2010 (74%) compared with ICCP-2003 (82%).
- The proportion of pregnancies ever experienced by adults living in Ireland that ended in a miscarriage increased from 13% in ICCP-2003 to 18% in ICCP-2010.
- The proportion of all pregnancies that ended in a stillbirth or an adoption remained stable across the seven-year period at approximately 1% each.
- Of all pregnancies ever experienced in the lifetime of the adults surveyed, 4% had ended in abortion; this proportion has increased from 2% in ICCP-2003.
- 68 women had experienced an abortion; the majority had experienced one abortion only (84%), with 14% reporting two abortions, and just one woman (2%) reporting more than two abortions.
- Two-thirds of women who had experienced an abortion were living in the Republic of Ireland at that time – 94% of these women had their abortion in the UK.

- More adults seemed to be unsure (26%) about what outcome they would choose if an unplanned pregnancy were to happen to them at this time, compared with ICCP-2003 (22%).
- When asked to choose an outcome for their hypothetical unplanned pregnancy, 68% of adults would choose parenthood (down from 72% in ICCP-2003), 2% would select adoption (2% in ICCP-2003) and 4% would opt for an abortion (5% in ICCP-2003).

6.2 Overview of pregnancy experiences

Both ICCP surveys collected information about all pregnancies experienced by male and female respondents. By collecting data in this way, the surveys provide an estimate of the proportion of adults aged 18 to 45 living in Ireland at the time of the survey who have experienced the following pregnancy outcomes ever in their lifetime: a pregnancy (including at the time of the interview), a live birth, an adoption, a miscarriage, a stillbirth, an abortion or another type of pregnancy (e.g., ectopic). Comparing lifetime experiences of different pregnancy outcomes across the ICCP surveys is useful because it provides information on how common different pregnancy outcomes are within the general population of Ireland at two different time points. This information will be useful for planning services.

As outlined in Section 2.7.3, it is important to note that the sample recruited in ICCP-2010 is diverse in relation to nationality, particularly when compared with the sample recruited in ICCP-2003. This means that many people in ICCP-2010 may have experienced a pregnancy whilst living outside the Republic of Ireland, which may have an impact on pregnancy experience. For example, abortions may be more common in countries where the procedure is legalised.

Table 6.1 displays information relating to the lifetime pregnancy experiences and outcomes for all women and men. Results are displayed by age group, since fertility levels for each age group may differ. Overall, 52% of respondents had had sexual intercourse that had resulted in a pregnancy, with more women (60%) than men (49%) having experienced a pregnancy. These estimates have reduced slightly since ICCP-2003, when 54% of all respondents (61% of women and 45% of men) had experienced a pregnancy. In ISSHR, 63% of all women interviewed (aged 18 to 65) had experienced a pregnancy. As would be expected, the percentage of respondents experiencing a pregnancy, a live birth or a pregnancy loss (i.e., miscarriage or stillbirth) in ICCP-2010 increased with age cohort.

Approximately half of the men sampled who had experienced heterosexual intercourse (51%) had never experienced a pregnancy. The proportion of women who had never experienced a pregnancy was lower at 40%.

Table 6.1 Lifetime pregnancy experiences and outcomes for all respondents who had experienced heterosexual sex, by gender and age group (ICCP-2003 and ICCP-2010)

Pregnancy outcome	Men % (w)								Women % (w)							
	18–25 years		26–35 years		36–45 years		Total		18–25 years		26–35 years		36–45 years		Total	
	2003 n=327	2010 n=279	2003 n=418	2010 n=550	2003 n=484	2010 n=502	2003 n=1,229	2010 n=1,331	2003 n=398	2010 n=313	2003 n=651	2010 n=624	2003 n=763	2010 n=509	2003 n=1,812	2010 n=1,446
Never pregnant	92	88	51	56	25	22	55	51	77	82	36	41	10	15	39	40
Live birth	4	6	42	35	71	72	40	42	18	15	59	52	89	79	57	53
Adoption	0	0	<1	0	<1	1	<1	<1	0	0	0	1	1	0	<1	<1
Miscarriage	3	3	11	12	21	28	12	16	3	3	15	20	23	29	14	20
Stillbirth	0	0	1	1	1	2	1	1	0	<1	1	1	2	2	1	1
Abortion	1	1	5	3	3	6	3	4	4	4	4	5	2	4	3	5
Currently pregnant	2	4	5	7	3	4	4	6	4	1	5	6	2	2	4	4
Other	0	0	0	1	0	0	0	<1	0	0	<1	0	2	1	<1	1

Note: % (w) = weighted percentages. Respondents could choose more than one response so columns may not total to 100%.

6.3 Pregnancy outcomes among those who ever experienced a pregnancy

Analysis in this section focuses on those respondents who had ever experienced a pregnancy (i.e., those who never experienced a pregnancy in their lifetime were excluded from the analysis). These results outline what proportion of all pregnancies ever experienced by respondents aged 18 to 45 living in Ireland ended in a live birth, a miscarriage, a stillbirth, an adoption, an abortion or another outcome (e.g., ectopic). Since pregnancies that were in progress at the time of the survey did not yet have an outcome, these pregnancies were categorised separately.

In Table 6.2, the outcomes of all pregnancies reported in ICCP-2010 are compared with the findings of ICCP-2003. In ICCP-2010, 1,614 respondents had experienced a pregnancy. Three respondents were then excluded because they did not provide information on their pregnancy outcome. The total weighted number of pregnancies experienced by this sample was 3,962 (2,210 among women and 1,752 among men). In ICCP-2003, a total of 1,834 respondents in the comparable sample experienced a pregnancy. Five respondents were then excluded due to lack of information on the outcome of their pregnancies. The total weighted number of pregnancies experienced was 4,427 (2,633 among women and 1,794 among men).

Of all pregnancies reported in ICCP-2010, 74% ended in live births, 18% ended in miscarriages, 4% ended in abortions, 1% ended in stillbirths or adoptions and 3% were on-going at the time of the survey. Of the lifetime pregnancies reported by respondents in ICCP-2003, 82% ended in live births, 13% ended in miscarriages, 2% ended in abortions, less than 1% ended in stillbirths, less than 1% ended in adoptions and 3% were on-going.

Table 6.2 represents a breakdown of all pregnancies ever experienced by age and gender, for both surveys. Of all pregnancies reported by women in ICCP-2010, 75% ended in live births, 18% ended in miscarriages, 4% ended in abortions, less than 1% ended in stillbirths or adoptions and 2% were on-going at the time of the survey. Of all pregnancies reported by men in ICCP-2010, 73% ended in live births, 18% ended in miscarriages, 3% ended in abortions, less than 1% ended in stillbirths or adoptions and 4% were on-going. Comparisons to ICCP-2003 reveal some interesting trends, and will be discussed by outcome next.

Table 6.2 Outcomes of all pregnancies reported by respondents, by gender and age group (ICCP-2003 and ICCP-2010)

	Total number of men (ICCP-2003=595; ICCP-2010=695) % (w)								Total number of women (ICCP-2003=1,234; ICCP-2010=916) % (w)							
	18–25 years		26–35 years		36–45 years		Total		18–25 years		26–35 years		36–45 years		Total	
	2003 n=64	2010 n=49	2003 n=582	2010 n=511	2003 n=1,148	2010 n=1,192	2003 n=1,794	2010 n=1,752	2003 n=139	2010 n=96	2003 n=922	2010 n=842	2003 n=1,572	2010 n=1,272	2003 n=2,633	2010 n=2,210
Live birth	59	43	77	68	81	76	79	73	68	62	78	73	81	77	83	75
Adoption	0	0	1	0	<1	<1	<1	<1	0	0	0	<1	<1	0	<1	<1
Miscarriage	24	29	13	17	14	17	14	18	11	15	14	18	10	18	12	18
Stillbirth	0	0	1	<1	1	1	1	1	0	0	1	1	1	1	1	<1
Abortion	5	4	4	4	1	3	3	3	11	14	3	4	1	3	2	4
Currently pregnant	13	25	5	8	2	2	3	4	11	4	3	4	1	1	2	2
Other	0	0	0	0	0	<1	0	<1	0	0	<1	0	1	1	<1	<1

Note: For this table, the n under each survey year refers to the number of weighted pregnancies. Respondents could choose more than one response so columns may not total to 100%.

6.3.1 Parenthood

For men and women, the proportion of pregnancies ending in a live birth ever experienced by adults living in Ireland decreased from ICCP-2003 to ICCP-2010. Upon initial inspection, this finding is intriguing as CSO estimates suggest that the live birth rate in Ireland has increased over this seven-year period (from 61,529 in 2003 to 74,728 in 2009). It is important to note, however, that this study's findings refer to live births that may or may not have occurred in Ireland. Nevertheless, these results are a representation of the proportion of all pregnancies that end in a live birth among adults aged 18 to 45 who live in Ireland.

6.3.2 Adoption

Precise global and national estimates of domestic and inter-country adoptions are difficult to access. Over 43,500 domestic adoptions have taken place in Ireland since 1952 (when the Irish Adoption Board started to keep records of each adoption). The Irish Adoption Act 2010 was commenced in November 2010 to improve standards in domestic and inter-country adoption.[4] This Act was introduced against a backdrop of reports suggesting that the number of babies put forward for adoption in Ireland has reduced substantially in recent years. The results from this study indicate that the proportion of pregnancies ending in adoption has remained relatively stable and low (less than 1% of all pregnancies) across the last seven years.

6.3.3 Miscarriage/stillbirth

As outlined in Table 6.2, the proportion of pregnancies ending in a stillbirth reported by adults living in Ireland also remained stable from ICCP-2003 to ICCP-2010. In contrast, the proportion of pregnancies ending in a miscarriage increased. It is often hard to establish the global prevalence of miscarriages for comparison purposes. It is estimated that among those women who know they are pregnant, between 15% and 20% of pregnancies end in a miscarriage (Jones and Kost, 2007). Some reports, however, suggest that the actual rate of miscarriage is higher, even reaching about 30% (Stovall, 2002). Thus, the results from this study would appear to be comparable to global average estimates for miscarriage.

Despite this, it is not easy to explain the reason for the substantial increase from ICCP-2003 to ICCP-2010 in the proportion of men and women who are reporting that they have experienced this outcome. There are a number of factors that could be contributing to this finding. First, it could be that more people nowadays are having difficulty remaining pregnant once they conceive; however, the percentage of respondents reporting that they had fertility problems was very similar at 1% in both surveys. Second, as reported in Chapter 2, there was an increase in the proportion of respondents who were currently pregnant or trying to conceive in ICCP-2010 compared with ICCP-2003. It may be that those couples who are actively trying to conceive have an increased awareness of fertility cycles and now detect pregnancy at a very early stage. This group would be more likely

4 Adoption Act 2010 is available online at: www.irishstatutebook.ie/pdf/2010/en.act.2010.0021.PDF.

to be aware of a miscarriage occurring in the early stages of pregnancy. Third, national estimates from the CSO suggest that the characteristics of women giving birth in Ireland have changed in recent years. For example, the average age of women giving birth increased from 30.1 years in 1999 to 31.1 years in 2008 (ESRI, 2010). It is recognised that a higher maternal age is associated with increased risk of miscarriage (Usta and Nassar, 2008), which may help explain part of the increase in the proportion of pregnancies ending in miscarriage.

6.3.4 Abortion

The proportion of all pregnancies experienced by women that ended in an abortion increased from 2% in ICCP-2003 to 4% in ICCP-2010. For men, the proportion remained stable at 3%. The ICCP-2010 results are similar to the 2006 ISSHR findings, which revealed that 4% of women aged 18 to 64 who had been pregnant had experienced an abortion (Layte et al., 2006).

Again, it is important to note that these estimates do not refer to the proportion of Irish adults who have ever had an abortion; they refer to the proportion of adults aged 18 to 45 living in Ireland at the time of the ICCP surveys who have ever experienced an abortion. The demographic of the population of Ireland has changed considerably over the last number of years. This means that more women and men living in Ireland today have originated from countries where abortion is legal. As would be expected, research has shown that abortion levels are higher in such countries.

One important source of information relating to the proportion of Irish women who travel to Britain to have an abortion is the UK Department of Health. This source indicates that the abortion rate for women aged 15 to 44 giving Irish addresses at British clinics decreased from 7.5 abortions per 1,000 women in 2001, to 4.4 per 1,000 in 2010. This source of information is deemed to be accurate, given improvements in the telephone booking and data collection systems in Britain. Taken in context, these figures suggest that the rate of abortions would appear to be decreasing among Irish women.

Additional analysis was conducted in order to explore the apparent discrepancies between this study's findings and data obtained from the UK Department of Health. First, it is important to note some differences between ICCP-2003 and ICCP-2010. In ICCP-2003, the majority of the sample originated from the Republic of Ireland (90%), meaning that the majority of abortions that were reported in that survey are assumed to be as a result of Irish women travelling abroad (mainly to the UK) to have an abortion. In ICCP-2010, only 78% of the sample originated from the Republic of Ireland, meaning that a larger proportion of the sample originated from countries where abortion may be legal (e.g., Australia, UK, USA) or illegal but commonly occurring (e.g., Africa).

Moreover, anecdotal evidence suggests that in recent years post-abortion medical and counselling services in Ireland are seeing a significant growth in Irish women returning

from EU states such as the Netherlands, Spain and Belgium. It is unclear if these women lived abroad when they obtained abortions or travelled there for abortion services. This trend may be due to the high costs associated with having an abortion in the UK compared with other EU countries. Thus, many of the abortions reported in ICCP-2010 may have taken place outside Britain, and may not have involved women travelling from the Republic of Ireland to seek an abortion.

In an effort to untangle these issues, women who reported having an abortion were asked their country of residence at the time of the abortion and the country in which the abortion took place. This allowed for the isolation of a group of Irish women who were recruited in the 2010 survey and had ever travelled from the Republic of Ireland to Britain for an abortion. Next, the lifetime abortion estimates for this sub-sample of women in ICCP-2010 were re-analysed. As outlined in Table 6.3, when women who had an abortion while not living in the Republic of Ireland are excluded from the 2010 analysis, the lifetime prevalence for abortion among all women living in Ireland at the time of the survey remained stable between ICCP-2003 and ICCP-2010 at 2%. There was a decrease for all age groups except the 26–35 age group, which remained stable at 3% from 2003 to 2010.

Table 6.3 Lifetime occurrence of abortion among women, by age group (ICCP-2003 and ICCP-2010)

Survey	18–25 years %	26–35 years %	36–45 years %	Total %
ICCP-2003: all women (n=1,234)	11	3	1	2
ICCP-2010: all women (n=916)	14	4	3	4
ICCP-2010: women, excluding those who had an abortion while not living in the Republic of Ireland (n=895)	9	3	1	2

Experiences of abortion

Obtaining an understanding of experiences of abortion among women living in Ireland is an important issue for health care providers. This type of information can help inform the development of social policies and education programmes to reduce the need for this outcome. In ICCP-2010, all women who experienced an abortion (n=68) were asked additional questions about their experiences of abortion. In total, these women experienced 80 abortions. The majority of these women experienced one abortion only (84%), with 14% reporting two abortions, and the remainder (2%) reporting more than two abortions. Women having a repeat abortion may have difficulty in using contraception consistently, may lack the motivation to prevent unintended pregnancy, may use abortion as a method of family planning, or may be different from other women in more fundamental ways, such as an increased ability to become pregnant (Jones and Institute, 2006).

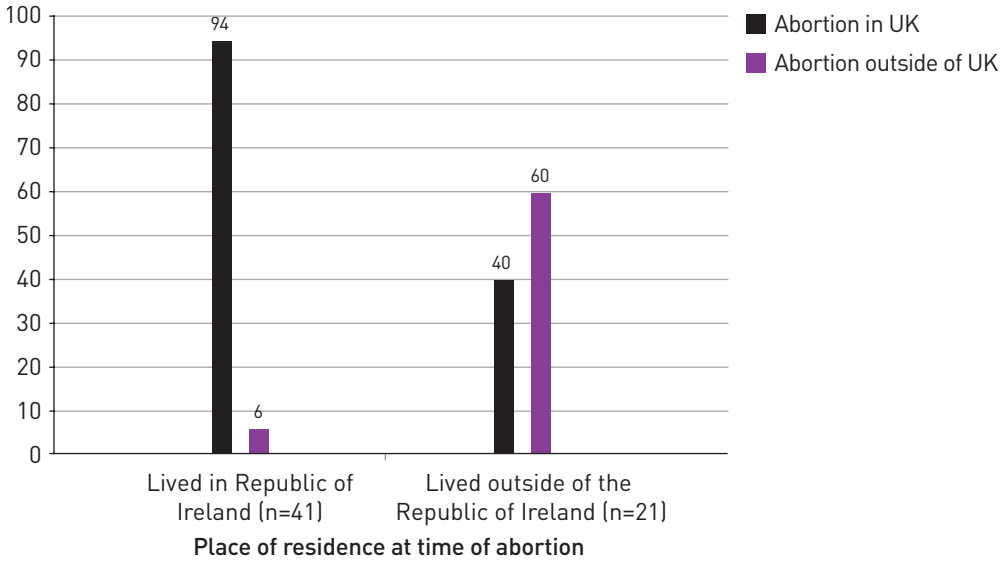
In the United States, about half of women having an abortion have had an abortion previously (Jones and Institute, 2006). In a study of 1,127 women seeking abortions in Ontario, Canada between August 1998 and May 1999, Fisher and colleagues reported that 68.2% were undergoing a first induced abortion, 23.1% a second abortion and 8.7% a third or subsequent abortion (Fisher et al., 2005). According to UK statistics (unpublished), the corresponding figures for the Republic of Ireland (2010) are: 82% undergoing a first induced abortion, 15% a second abortion and 3% a third or subsequent abortion (CPP, personal communication). Information on repeat abortions is important for service provision. Practitioners have an opportunity to counsel and educate women about contraception and related issues whilst providing post-abortion medical treatment (Palanivelu and Oswal, 2007).

Country of residence at time of most recent abortion

Women's experiences of their only (most recent if more than one) abortion are outlined below. Half of the abortions took place between 2001 and 2010 (50%); the remainder took place between 1991 and 2000 (41%) or prior to 1991 (9%).

Women were asked about their country of residence at the time of the abortion and the country in which the abortion took place. About two-thirds of those who experienced an abortion were living in the Republic of Ireland at that time. The majority (94%) of these women had the abortion in the UK. These results confirm that the UK is the main location to which women living in the Republic of Ireland travel to have an abortion. Of the remaining women who had an abortion but lived outside the Republic of Ireland at the time, the majority (60%) had the abortion in a country other than the UK.

Figure 6.1 Country where abortion took place, by of place of residence at time of abortion (women only)†



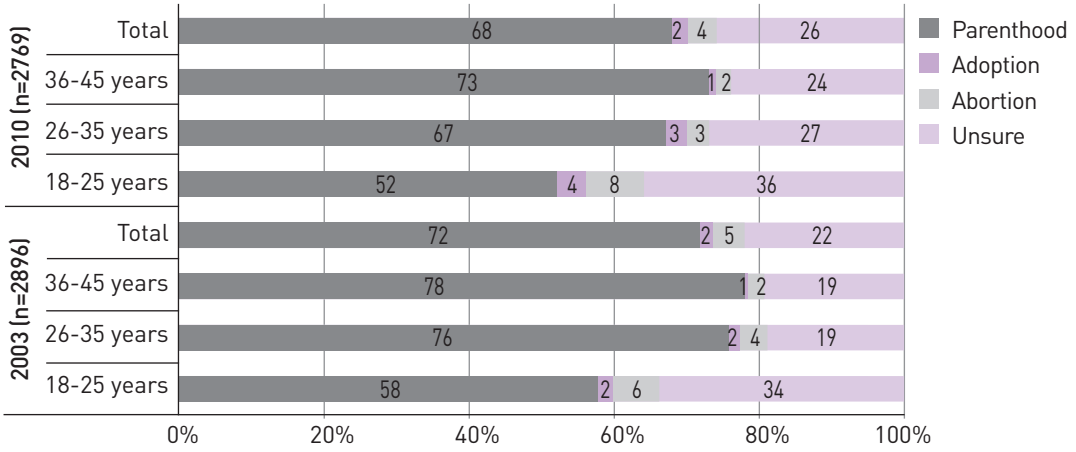
† Six women did not provide this information.

6.4 Future pregnancy outcomes

All respondents were asked to consider what pregnancy outcome they think they would be most likely to choose if they were to experience an unplanned or unwanted pregnancy at this time (even if it was unlikely that this would happen). Respondents who were sterilised, infertile (whether medically confirmed or not) or menopausal were not asked this question.

Although this question is hypothetical, information relating to perceived choices in the event of an unplanned pregnancy may provide an insight into national attitudes towards different pregnancy outcomes. As illustrated in Figure 6.2, the proportion in each age group choosing parenthood as the most likely outcome decreased from ICCP-2003 to ICCP-2010. Although the proportion of respondents choosing abortion decreased from 5% in ICCP-2003 to 4% in ICCP-2010, the proportion of young adults aged 18 to 25 choosing abortion as an outcome for an unplanned pregnancy increased from 6% to 8%. Overall, these results, which suggest that there is a degree of stability about people's thoughts on different pregnancy outcomes, are useful for service planning.

Figure 6.2 Most likely outcome of an unplanned or unwanted pregnancy at this time, by age group (ICCP-2003 and ICCP-2010)



7.0 Crisis pregnancy

7.1 Introduction

Unintended pregnancies are common among women of childbearing age from all backgrounds, regardless of age or socio-economic, racial, ethnic, religious or marital status (Blumenthal et al., 2011). Unintended pregnancy has long been acknowledged as an important global health, social and economic problem, which creates hardship for women and men and often impacts on the health and well-being of children (Gipson et al., 2008; Sonfield et al., 2011).

In Ireland, the term 'crisis pregnancy' was coined officially in 2001 to identify those pregnancies that are unintended and unplanned and that represent a personal trauma for the woman or couple involved. The term 'crisis' helps differentiate between such pregnancies and other pregnancies that, while not actually planned at the time, do not represent a crisis for the woman or couple involved (Rundle et al., 2004).

Research suggests that certain demographic and socio-economic characteristics influence the prevalence of crisis pregnancies. ICCP-2003 and ISSHR provided important data on the occurrence of crisis pregnancies in Ireland and key findings from these surveys will be discussed throughout this chapter. Given the vast demographic and economic changes that occurred in Ireland during the 2000s, it is important that the CPP continues to evaluate the occurrence of crisis pregnancies in Ireland. Moreover, it is important to understand current issues surrounding crisis pregnancy with a view to evaluating the relevance of the concept of crisis pregnancy in Ireland today. This information will be important for planning service provision and directing national policies.

This chapter explores experiences of crisis pregnancy among adults aged 18 to 45 and living in Ireland in detail by:

- establishing the proportion of adults who have experienced a crisis pregnancy;
- exploring trends in the outcomes of crisis pregnancies;
- examining the role of contraception at the time of conception of a crisis pregnancy;
- identifying adults' perception of risk of pregnancy;
- describing the emotional impact of a crisis pregnancy; and
- analysing the service needs of people experiencing a crisis pregnancy.

The early sections of this chapter cover the respondents' experiences of crisis pregnancies in general. Subsequent sections present findings from the detailed gender-specific 'crisis pregnancy' questionnaire, which was only used for those respondents who had experienced a crisis pregnancy that did not end in a miscarriage or a stillbirth. Slight differences exist between ICCP-2010 and ICCP-2003 in relation to which respondents were asked about their experiences of crisis pregnancy in general and also in relation

to respondents' detailed experiences of crisis pregnancy (as covered in the gender-specific crisis pregnancy questionnaire). The Technical notes may be consulted for this information.

Crisis pregnancy: key findings

- More women experienced a crisis pregnancy in ICCP-2010 (35%) than did in ICCP-2003 (28%); the proportion of men experiencing a crisis pregnancy has remained stable over the seven-year period (21% in 2010 and 22% in 2003).
- More pregnancies were considered crisis pregnancies (approximately 1 in every 8 pregnancies), compared with ICCP-2003 (approximately 1 in every 9 pregnancies).
- Similar to ICCP-2003, there was a trend for the proportion of pregnancies experienced as crisis pregnancies by women to decrease with age in ICCP-2010: 44% in the 18–25 age group (41% in 2003), 19% in the 26–35 age group (15% in 2003) and 11% in the 36–45 age group (7% in 2003).
- Of all the crisis pregnancies experienced by women, 62% ended in parenthood (72% in ICCP-2003), 14% ended in a miscarriage (8% in 2003), 1% ended in an adoption (0% in 2003), 21% ended in an abortion (15% in 2003) and 1% were on-going at the time of the interview (2% in 2003).
- Of all the crisis pregnancies experienced by men, 54% resulted in parenthood (59% in ICCP-2003), 20% ended in a miscarriage (15% in 2003), 1% ended in an adoption (0% in 2003), 22% ended in an abortion (24% in 2003) and 1% of men had a partner who was pregnant at the time of the interview (also 1% in 2003).
- The mean age at which women and men experienced their most recent crisis pregnancy was relatively stable over the seven-year period: for men, it was 24.8 years in ICCP-2010 (24.9 years in ICCP-2003) and for women 23.6 years in 2010 (23.5 years in 2003).
- For men and women, the two most common reasons for viewing the pregnancy as a crisis were that the pregnancy was not planned and that they were too young.
- A large proportion of men (54% in ICCP-2010 and 50% in ICCP-2003) and women (47% in 2010 and 39% in 2003) who did not use contraception did not think they were at risk of becoming pregnant on the occasion of the conception of their most recent or only crisis pregnancy. In particular, young men who did not use contraception did not perceive themselves as being at risk of experiencing a pregnancy.
- Use of alcohol or drugs at the time of conception of a crisis pregnancy decreased overall among men and women from ICCP-2003 to ICCP-2010, particularly among those in new or non-steady relationships.
- Crisis pregnancies are associated with psychological distress: one-quarter of women who felt down during their crisis pregnancy experienced thoughts of harming themselves or ending it all at some point during this time (n=26).

7.2 Proportion of respondents experiencing a crisis pregnancy

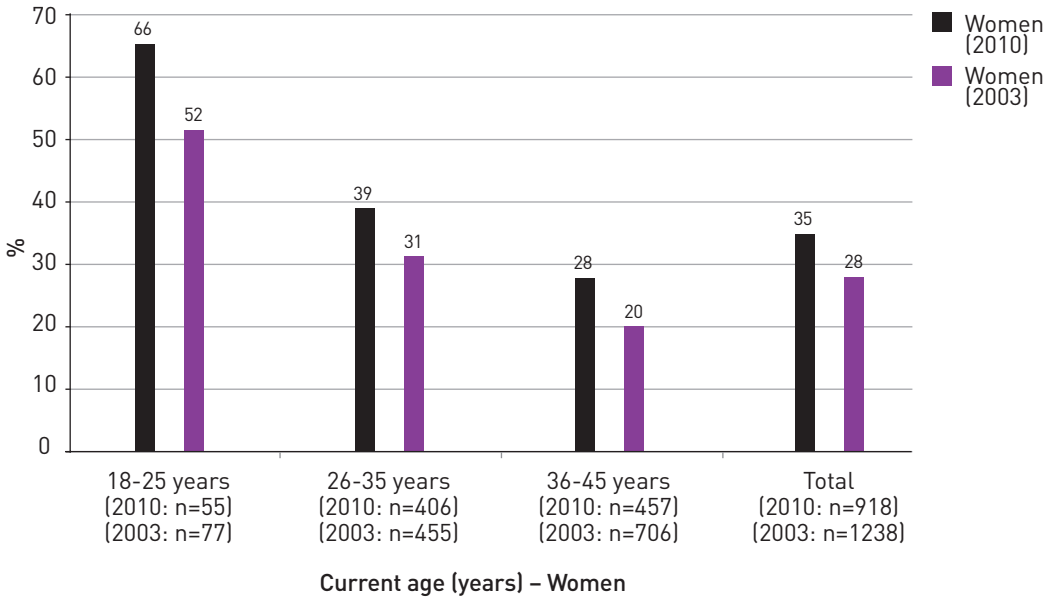
In 2008, approximately four in ten pregnancies (41%) worldwide were classified as unintended or unwanted pregnancies (Singh et al., 2010). ICCP-2010 provides a different estimate of crisis pregnancy within an Irish context. Specifically, all respondents who had ever experienced a pregnancy were asked 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 a 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 in circumstances. By collecting information in this way, this survey can provide an estimate of the lifetime occurrence of crisis pregnancy among adults aged 18 to 45 living in Ireland in 2010.

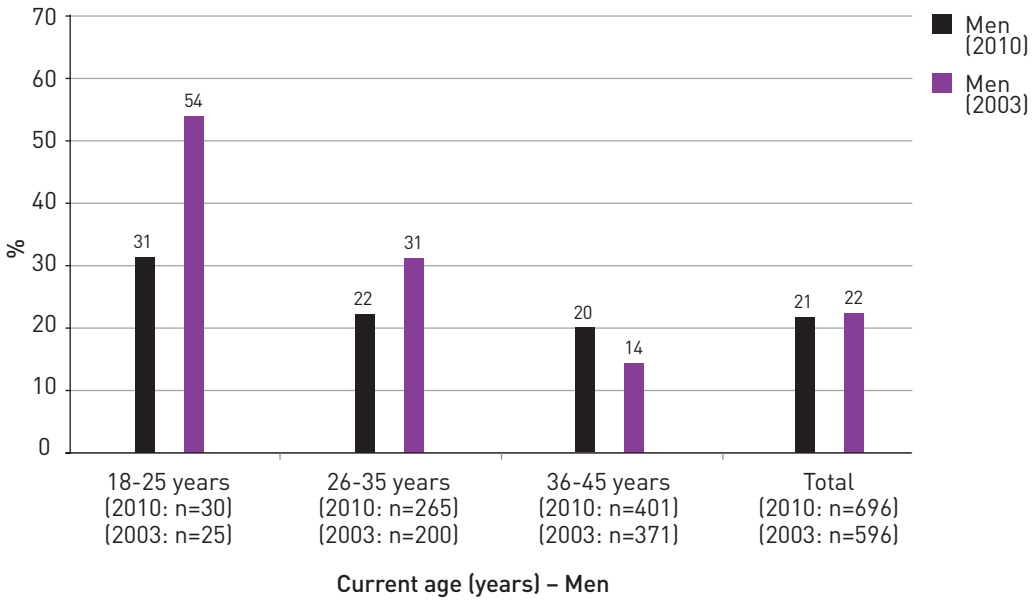
As outlined in Section 2.7.3, it is important to bear in mind that the sample recruited in ICCP-2010 is diverse in relation to nationality, particularly in comparison with the sample recruited in ICCP-2003. This means that more respondents in ICCP-2010 may have experienced a crisis pregnancy whilst living outside the Republic of Ireland, which may have an impact on the outcome of the crisis pregnancy (e.g., abortion may be more common in countries where such procedures are legalised). A history of crisis pregnancy experiences and outcomes was recorded for all adults who reported that they had experienced a crisis pregnancy. (See Technical notes for slight differences between ICCP-2003 and ICCP-2010.)

As outlined in Section 6.3, 1,834 respondents in ICCP-2003, and 1,614 respondents in ICCP-2010 experienced a pregnancy. The aim of this section is to explore what proportion of the respondents in the 2010 survey experienced a crisis pregnancy, and to compare these estimates to those obtained in 2003, to highlight any changes.

Figure 7.1 illustrates the percentage of crisis pregnancies experienced, by age group, for all those who had experienced pregnancy in ICCP-2010, compared with ICCP-2003. The results show that approximately one-fifth of men (21%) and one-third of women (35%) surveyed experienced a crisis pregnancy. These estimates have increased quite substantially for women (from 28%). The results for women are very comparable to the 2009 Pregnancy at Work Survey, which reported that 1 in 3 women aged 17 to 48 and who had given birth between July 2007 and June 2009 had experienced a crisis pregnancy (Russell et al., 2011).

Figure 7.1 Women and men who ever experienced a crisis pregnancy as a percentage of those experiencing pregnancy, by age group (ICCP-2003 and ICCP-2010)





In ICCP-2010, younger women were significantly more likely than older age groups ($p<0.001$) to have experienced a pregnancy as a crisis. There were significant education-level differences for women only, with women who have a pre-Leaving Certificate education being more likely to experience a crisis pregnancy ($p<0.001$). There were no significant differences across social class.

7.3 Percentage of crisis pregnancies among all pregnancies

In the previous section, the proportion of respondents who ever experienced a crisis pregnancy was explored. It is of interest to explore the proportion of crisis pregnancies among all pregnancies that have been experienced by respondents in the two ICCP surveys.

Approximately 1 in every 8 pregnancies, or 13% of all pregnancies, experienced by adults surveyed in ICCP-2010 could be considered a crisis pregnancy; this compares with 1 in every 9 pregnancies, or 11% of all pregnancies, in ICCP-2003.

In ICCP-2010, approximately 1 in every 7 pregnancies experienced by women, and approximately 1 in every 11 pregnancies experienced by men, were classified as crisis pregnancies (see Table 7.1). This compares to 1 in every 8 pregnancies for women and 1 in every 9 pregnancies for men, in ICCP-2003.

Table 7.1 Percentage of crisis pregnancies among all pregnancies, by gender (ICCP-2003 and ICCP-2010)

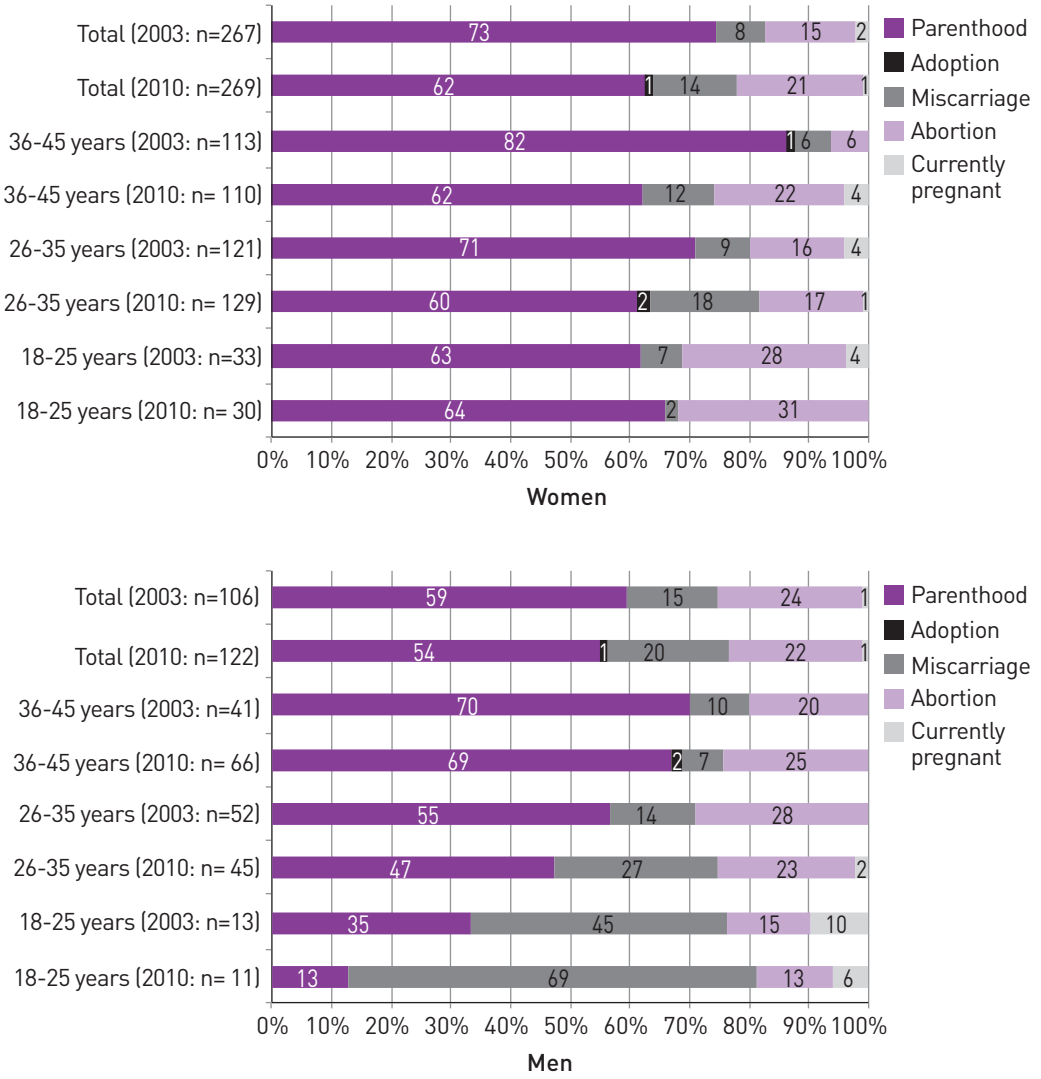
Survey	Women			Men		
	No. of pregnancies (weighted)	No. of crisis pregnancies (weighted)	% of crisis pregnancies among all pregnancies	No. of pregnancies (weighted)	No. of crisis pregnancies (weighted)	% of crisis pregnancies among all pregnancies
ICCP-2003	2,643	308	12%	1,794	188	11%
ICCP-2010	2,210	346	16%	1,752	157	9%

Similar to ICCP-2003, there was a trend in ICCP-2010 for the percentage of crisis pregnancies experienced to decrease with age. However, a higher proportion of pregnancies experienced by women in each age group in 2010 were viewed as crisis pregnancies: 44% of all pregnancies reported by 18 to 25 year olds were crisis pregnancies (41% in 2003), 19% of pregnancies reported by 26 to 35 year olds (15% in 2003) and 11% of pregnancies reported by 36 to 45 year olds (7% in 2003).

For men, a similar proportion of pregnancies were reported as crisis pregnancies among the 18–25 age group (33% in ICCP-2010 and 32% in ICCP-2003). The proportion of pregnancies experienced as crisis pregnancies in the 26–35 age group decreased from 15% in 2003 to 10% in 2010, whereas the proportion of pregnancies experienced as crisis pregnancies among men in the 36–45 age group increased slightly from 4% in 2003 to 7% in 2010.

Figure 7.2 displays outcomes of all crisis pregnancies experienced by women and men by age at interview. Due to small group numbers, caution is advised in interpreting the following results. In ICCP-2010, the outcomes of all crisis pregnancies for women were: parenthood (62%), a miscarriage (14%), an abortion (21%) and pregnancy on-going at the time of the interview (1%). For men, 54% of all crisis pregnancies ended in parenthood, 20% ended in a miscarriage, 22% ended in an abortion and 1% of men were experiencing a crisis pregnancy at the time of the interview. Corresponding results for ICCP-2003 are reported in Figure 7.2.

Figure 7.2 Outcomes of all crisis pregnancies for women and men, by age group (ICCP-2003 and ICCP-2010)



Note: Percentages are weighted and therefore may not total 100%.

For men, the results indicate a decrease in the proportion of live births as an outcome of crisis pregnancy across age groups. The proportion of crisis pregnancies ending in abortion was highest in the oldest age group (36 to 45 year olds), followed by the middle age group and then the youngest age group.

Among women, the proportion of crisis pregnancies ending in live births was similar across all age groups, but was highest for the youngest age group. This is in contrast to ICCP-2003, when the proportion of live births was highest for the 36–45 age group. The proportion of crisis pregnancies ending in abortion increased across all age groups. Most notably, the proportion of crisis pregnancies ending in abortion increased from 6% in ICCP-2003 to 22% in ICCP-2010 for women aged 36 to 45. Some caution is warranted when interpreting the abortion results. As discussed in Section 6.3.4, differences in the

nationalities of the respondents recruited mean that the experiences of abortion among adults recruited in ICCP-2003 are different to those recruited in ICCP-2010. As shown in Figure 6.1, approximately one-third of women recruited in 2010 who experienced an abortion did so while living outside the Republic of Ireland. These women did not travel from the Republic of Ireland to Britain or elsewhere for an abortion. In light of this demographic difference between the two surveys, additional analysis was conducted in relation to the outcomes of all crisis pregnancies, excluding those women who had an abortion while not living in the Republic of Ireland.

Table 7.2 explores the proportion of women who experienced an abortion as an outcome of a crisis pregnancy, by age, across the 2003 and 2010 surveys. The 2010 findings are shown for all women who had an abortion (Row 2) and also excluding women who had an abortion while not living in the Republic of Ireland (Row 3). The estimates for Row 1 and Row 2 correspond to the estimates reported in Figure 7.2. By excluding those women who had an abortion while not living in the Republic of Ireland from the analysis, the proportion of all crisis pregnancies ending in an abortion among women stabilised across the two surveys from 15% in 2003 to 13% in 2010. Nevertheless, the true representation of the proportion of all crisis pregnancies experienced by women currently living in Ireland that end in an abortion is 21%. This figure is important for planning pregnancy-related services in Ireland.

Table 7.2 Proportion of all crisis pregnancies ending in an abortion among women, by age group (ICCP-2003 and ICCP-2010)

Row	Survey	18–25 years %	26–35 years %	36–45 years %	Total %
1	ICCP-2003: all women	28	16	6	15
2	ICCP-2010: all women	31	17	22	21
3	ICCP-2010: women, excluding women who had an abortion while not living in the Republic of Ireland	22	14	7	13

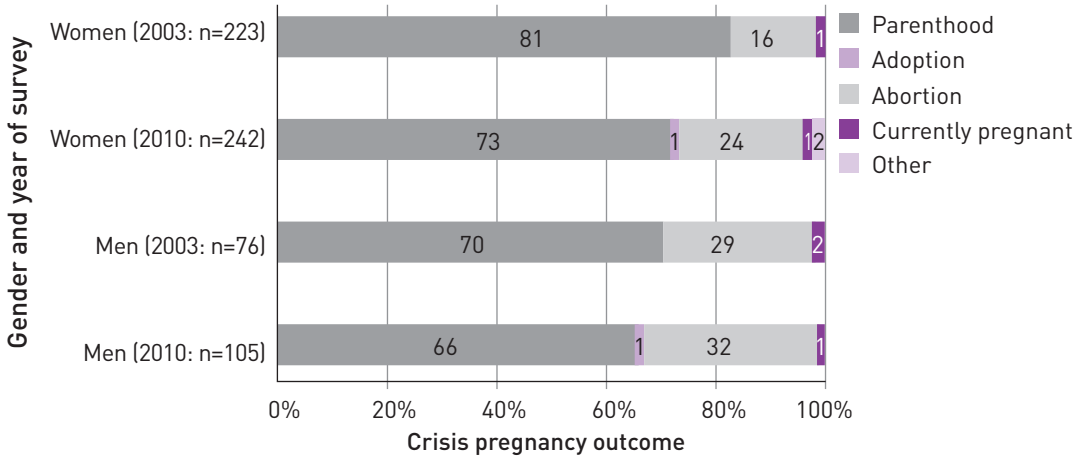
7.4 Detailed experiences of crisis pregnancy

All respondents who experienced a crisis pregnancy (except those due to a miscarriage or stillbirth) were asked to complete an additional questionnaire about their experiences of their only or most recent crisis pregnancy (n=355). Overall, 347 respondents (105 men and 242 women) provided details about their experiences of their only/most recent crisis pregnancy by completing an additional questionnaire. There were slight differences between ICCP-2010 and ICCP-2003 in terms of which respondents were asked to complete the additional crisis pregnancy questionnaire (see Technical notes). A comparable sample of 299 respondents (76 men and 223 women) who completed the additional crisis pregnancy questionnaire in ICCP-2003 is used for the analysis in this chapter.

7.4.1 Outcome of only or most recent crisis pregnancy

Figure 7.3 shows the outcomes of crisis pregnancies for men and women in both ICCP-2003 and ICCP-2010. A higher proportion of women in ICCP-2010 reported that their most recent crisis pregnancy had ended in an abortion (24%), compared with those in ICCP-2003 (16%). A lower proportion of women gave birth following a crisis pregnancy in ICCP-2010 (73%) than did in ICCP-2003 (81%). Interestingly, the proportion of men reporting that their most recent crisis pregnancy ended in an abortion remained relatively stable from ICCP-2003 (29%) to ICCP-2010 (32%), albeit that the proportion was still higher than that of women.

Figure 7.3 Outcome of most recent crisis pregnancy, by gender (ICCP-2003 and ICCP-2010)



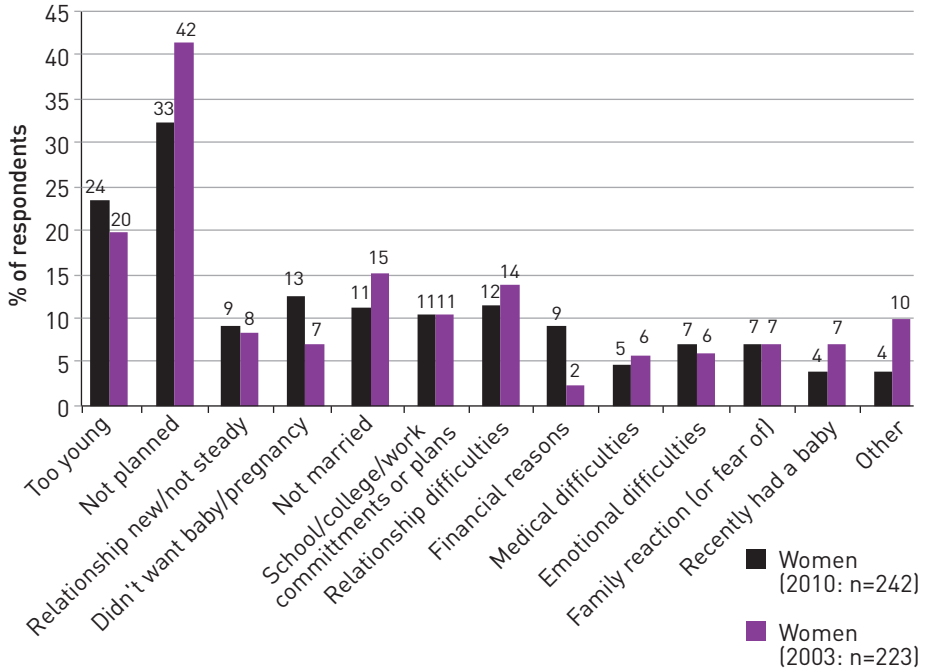
Note: Percentages are weighted and therefore may not total 100%.

For men, the most recent crisis pregnancy was experienced at a mean age of 24.8 years for men (95% CI=23.5–26.2), which remained stable since ICCP-2003 (mean age of 24.9 years; 95% CI=23.8–26.0). For women, the most recent crisis pregnancy was experienced at a mean age of 23.6 years (95% CI=22.8–24.4), which is a very slight increase since ICCP-2003 (mean age of 23.46 years; 95% CI=22.7–24.2).

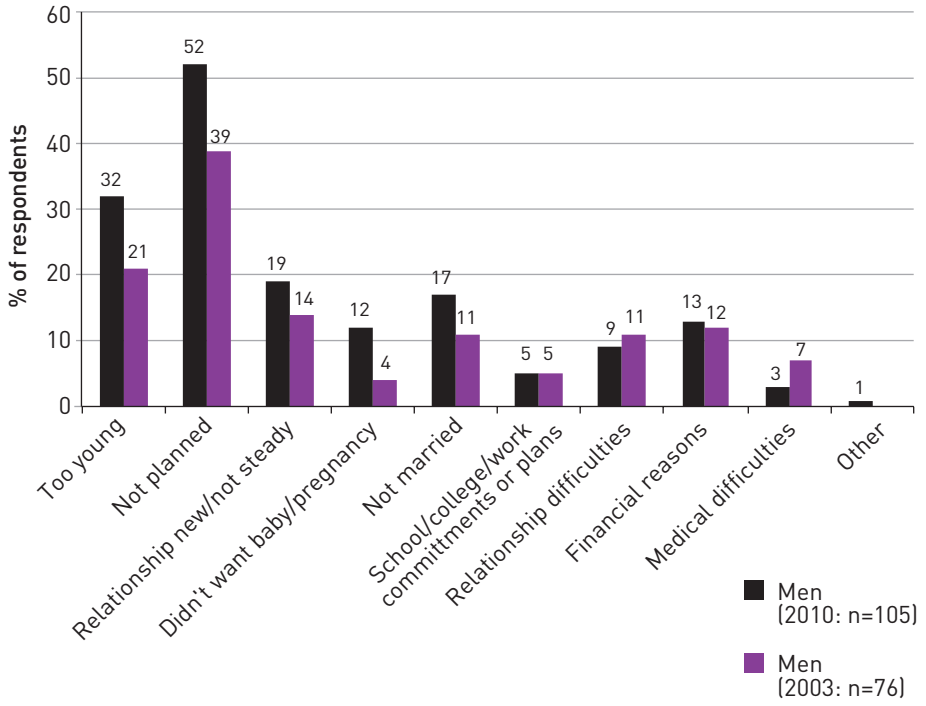
7.4.2 Describing why the pregnancy was viewed as a crisis pregnancy

Participants were asked to explain briefly why they would describe this pregnancy as a crisis pregnancy. Many participants gave a number of reasons, so percentages are of total numbers of participants responding. Women also gave a more diverse range of reasons and this has been outlined in the gender-specific graphs in Figure 7.4. For men and women in ICCP-2010, the pregnancy not being planned and being too young were the most common reasons why the pregnancy was viewed as a crisis. Financial reasons appeared to be more commonly cited in ICCP-2010 compared to ICCP-2003, for both men (13% in ICCP-2010 vs. 12% in ICCP-2003) and women (9% in ICCP-2010 vs. 2% in ICCP-2003). This result is like due to the unstable economic climate, and the higher rates of unemployment in Ireland in ICCP-2010 compared to ICCP-2003. Interestingly, whilst not being married was reported as a reason for viewing the pregnancy as a crisis in ICCP-2010, the proportion of women, but not men, citing this as a reason decreased from ICCP-2003.

Figure 7.4 Reasons why most recent crisis pregnancy viewed by crisis, by gender (2003 vs. 2010)



Reason why only most recent/only crisis pregnancy viewed as crisis – Women



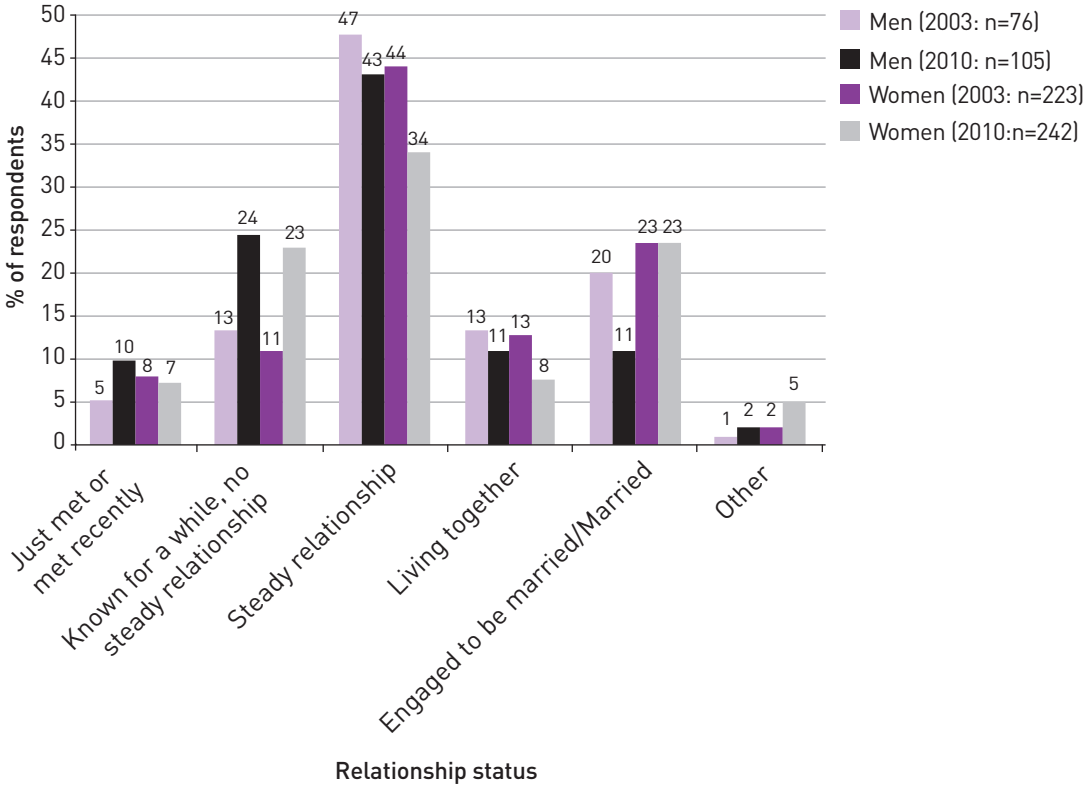
Reason why most recent/only crisis pregnancy viewed as crisis – Men

Note: Respondents could choose more than one response.

7.4.3 Relationship status at time of conception

Respondents were asked to describe their relationship with their sexual partner at the time of conception of their most recent crisis pregnancy (see Figure 7.5). For men, 34% did not have a steady relationship; 43% had a steady relationship; 22% were cohabiting, engaged to be married or married; and 2% had another type of relationship (including an extra-marital affair). For women, 30% did not have a steady relationship; 34% had a steady relationship; 31% were cohabiting, engaged to be married or married; and 5% had another type of relationship (including an extra-marital affair).

Figure 7.5 Relationship status at time of conception of most recent crisis pregnancy, by gender (ICCP-2003 and ICCP-2010)



7.4.4 Contraception use at time of conception

Respondents were asked whether any method of contraception or precaution had been used (by themselves or their partner) at the time of conception of their most recent crisis pregnancy. Almost half of the women surveyed in 2010 said that contraception had been used, compared with 35% in ICCP-2003. Interestingly, the proportion of men using contraception at the time of the conception of their most recent or only crisis pregnancy increased in ICCP - 2010 (39%, up from 35% in 2003). For women, approximately 38% of the 18–25 age group, 63% of the 26–35 age group and 40% of the 36–45 age group reported using contraception at the time of conception. For men, approximately 40%

of the 18–25 age group, 42% of the 26–35 age group and 31% of the 36–45 age group reported using contraception at the time of conception.

Respondents were asked who had made decisions about contraception on the occasion in question. As can be seen in Table 7.3, higher proportions of men and women in ICCP-2010 assigned responsibility for contraception use to the couple (i.e., the respondent and his or her sexual partner), compared with ICCP-2003.

Table 7.3 Decision making about contraception at time of conception, by gender (ICCP-2003 and ICCP-2010)

Who decided	ICCP-2003 % (w)		ICCP-2010 % (w)	
	Men (n=76)	Women (n=223)	Men (n=105)	Women (n=242)
My decision	8	11	1	18
Partner's decision	4	3	5	3
Joint decision	26	34	47	43
No one took responsibility	62	52	46	33
Refused/other	NA	NA	0	4

Note: % (w) = weighted percentages. NA = answer was not available.

Respondents who did not use contraception at the time of conception were asked to give reasons why. Of those women who did not use contraception, the main reasons given were that sex was not planned (32%), that they just took a chance (30%) or that alcohol/drugs were used at the time of conception (20%). These reasons were also frequently reported by men: taking a chance (43%), sex not planned (20%) and drinking alcohol/using drugs (18%).

Those respondents who had used contraception were asked why the contraception had failed. A substantial proportion (31% of women and 40% of men) did not know why their method of contraception failed. Problems with condom use (19% of women and 15% of men) and contraceptive pill failure (20% of women and 12% of men) were common. Other reasons given included thinking it was a safe period or taking the ECP too late. Similar reasons emerged in ICCP-2003.

Respondents who had used contraception were also asked which method was used at the time. As outlined in Table 7.4, condoms were the most commonly used contraceptive method for men in both surveys. For women, the contraceptive pill was the most commonly used method in ICCP-2003, whereas the condom was more commonly used in ICCP-2010. Natural methods, including the safe period and withdrawal, were also commonly used to prevent pregnancy at the time of conception.

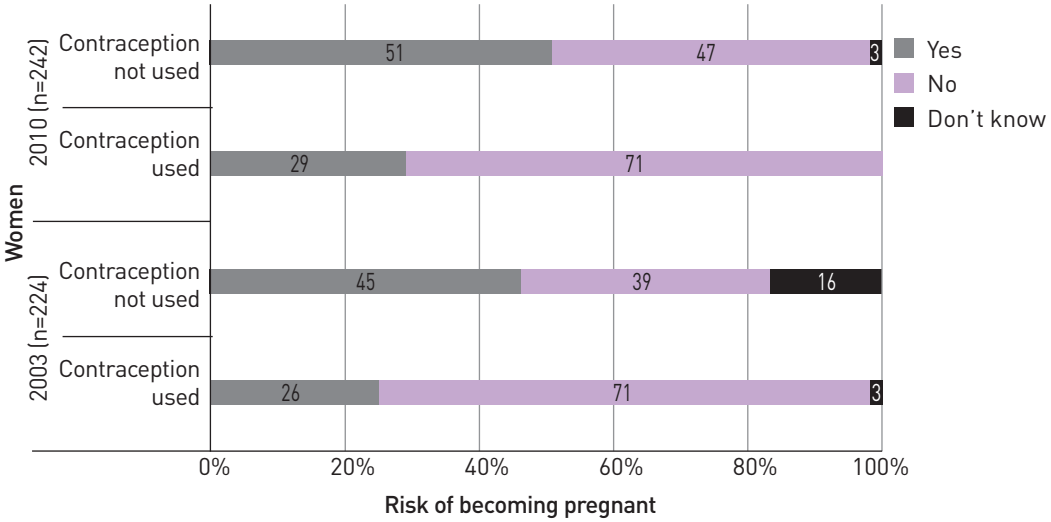
Table 7.4 Contraception and other precautions used at time of conception, by gender (ICCP-2003 and ICCP-2010)

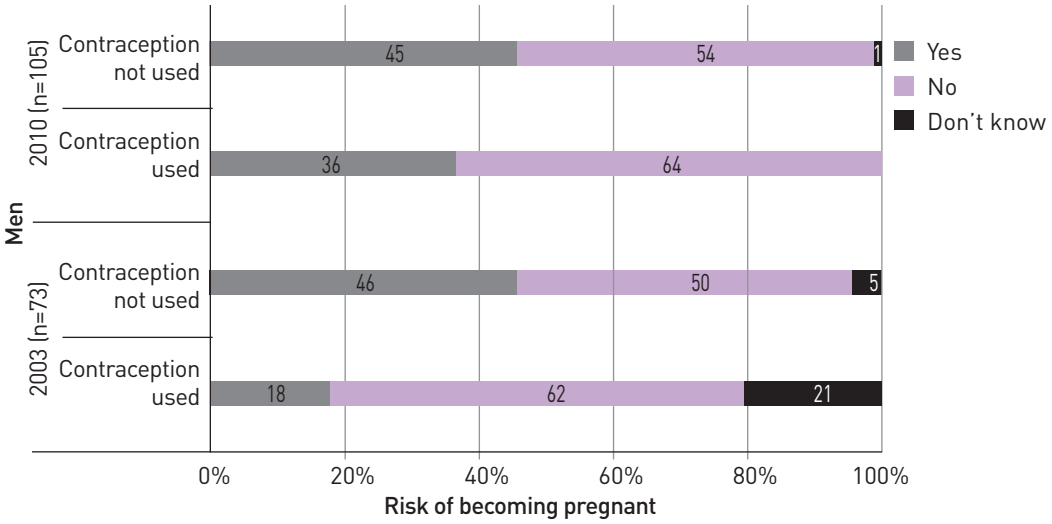
Contraception	ICCP-2003 % (w)		ICCP-2010 % (w)	
	Men (n=38)	Women (n=89)	Men (n=40)	Women (n=116)
Contraceptive pill	27	44	31	35
Condom	46	32	36	37
Safe period/rhythm method	15	8	15	7
Withdrawal	16	14	31	19
Other method	0	3	1	5
Don't know	0	0	7	1

Note. Question was asked only of respondents who used contraception at the time of conception of their most recent crisis pregnancy. Respondents could choose more than one response so columns may not total to 100%.
% (w) = weighted percentages.

All respondents who had experienced a crisis pregnancy were asked whether they thought they were taking a risk of becoming pregnant at the time of the sexual experience. Specific graphs for men and women are presented in Figure 7.6. Most notably, a large proportion of men (54% in ICCP-2010 and 50% in ICCP-2003) and women (47% in ICCP-2010 and 39% in ICCP-2003) who did not use contraception did not think they were at risk of becoming pregnant on that occasion. Focusing on the 2010 survey, there were significant age group differences ($p<0.05$) for men, with younger age groups less likely to perceive that they were at risk of becoming pregnant after not using contraception, compared with the oldest age group. No significant age differences emerged for women.

Figure 7.6 Women's and men's perceptions of risk of becoming pregnant, by use of contraception (ICCP-2003 and ICCP-2010)





7.4.5 Role of alcohol or drug use at time of conception

Analysis of the use of contraception and use of alcohol or drugs at the time of conception was conducted (see Tables 7.5 and 7.6). For women, the use of alcohol or drugs at the time of conception appears to have decreased from ICCP-2003 to ICCP-2010, particularly in recently established relationships. For those women who were not married but were in steady or cohabiting relationships, the role of alcohol or drugs slightly increased from ICCP-2003 to ICCP-2010. There was more stability in the use of alcohol/drugs at the time of conception of the crisis pregnancy for men; however, a lower proportion of men in newly established relationships reported using alcohol or drugs on this specific occasion.

Table 7.5 Women's use of alcohol or drugs at time of conception (ICCP-2003 and ICCP-2010)

Relationship status	ICCP-2003 Women (n=218) % (w)			ICCP-2010 Women (n=242) % (w)		
	Yes	No	Don't know	Yes	No	Don't know
Just met or met recently	90	10	0	50	50	0
Known for a while, no steady relationship	81	19	0	56	36	8
Steady relationship	28	72	0	32	65	3
Living together	15	85	0	22	78	0
Married or engaged	21	79	0	13	85	2
Extra-marital affair	50	50	0	0	100	0

Note: % (w) = weighted percentages.

Table 7.6 Men's use of alcohol or drugs at time of conception (ICCP-2003 and ICCP-2010)

Relationship status	ICCP-2003 Men (n=74) % (w)			ICCP-2010 Men (n=105) % (w)		
	Yes	No	Don't know	Yes	No	Don't know
Just met or met recently	100	0	0	80	20	0
Known for a while, no steady relationship	100	0	0	73	23	4
Steady relationship	47	53	0	50	48	2
Living together	60	40	0	54	46	0
Married or engaged	27	73	0	25	75	0
Extra-marital affair	100	0	0	100	0	0

Note: % (w) = weighted percentages.

7.4.6 Emotional impact of experiencing a crisis pregnancy

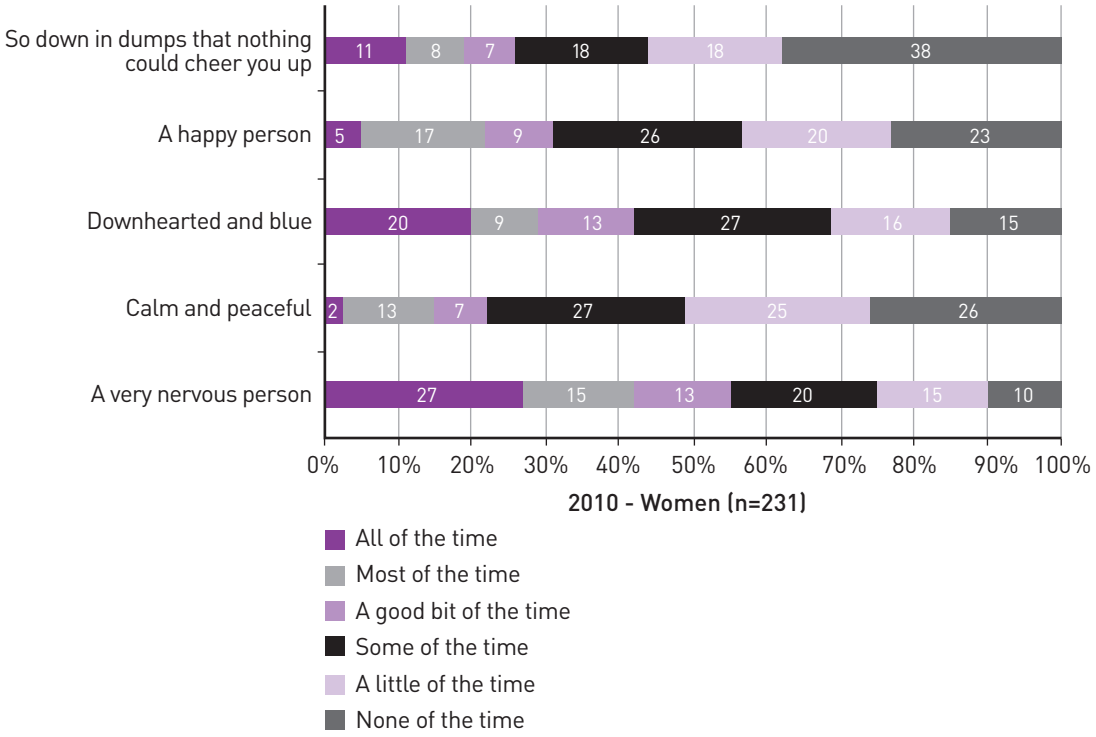
Respondents were asked to rate how much time they experienced a number of specific emotional states during the pregnancy. These questions were adapted from the Mental Health Inventory Index (MHI-5), which is a standardised scale containing the following questions:

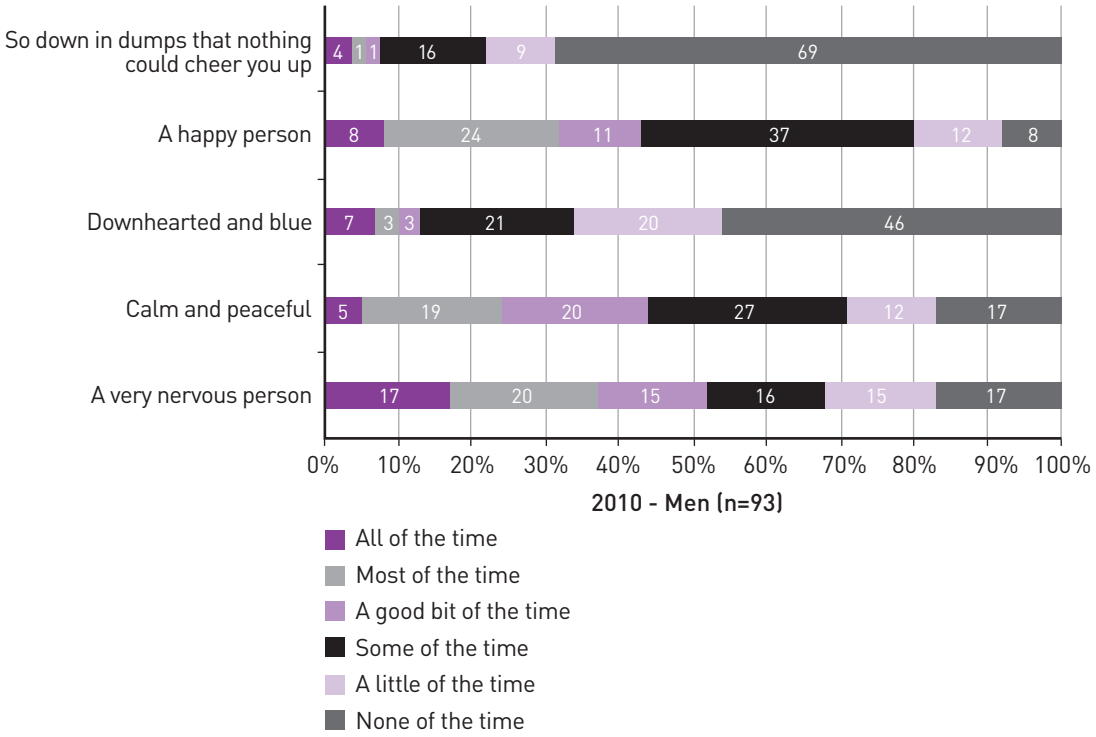
How much of the time during the last four weeks have you:

(1) Been a very nervous person?
(2) Felt calm and peaceful?
(3) Felt downhearted and blue?
(4) Been a happy person?
(5) Felt so down in the dumps that nothing could cheer you up?

The time frame for these questions was modified from 'during the last four weeks' to 'during the time you were pregnant' (with reference to the respondent's only or most recent crisis pregnancy). A six-point Likert scale ranging from 1 for none of the time to 6 for all of the time was used to score all items. Figure 7.7 outlines the percentage of men and women experiencing each emotional state during the time of the crisis pregnancy.

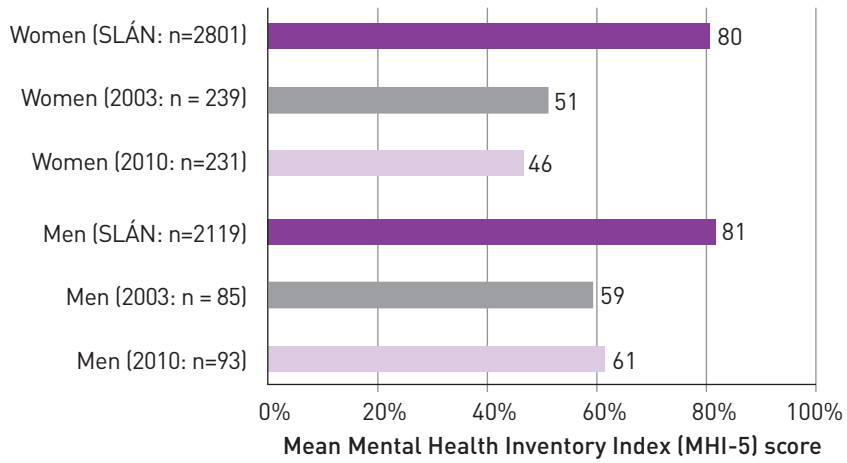
Figure 7.7 Men and women's experience of specific emotional states during most recent/only crisis pregnancy





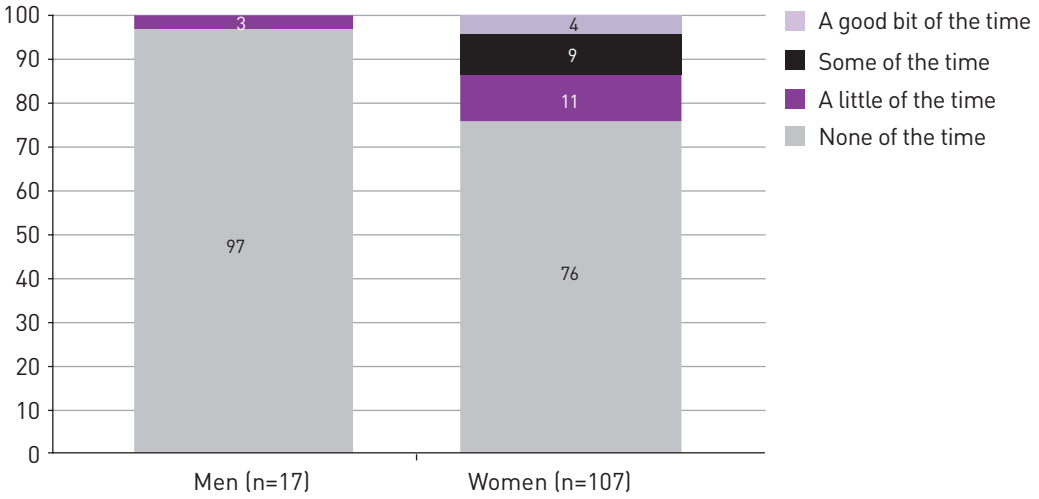
To provide an overall summary of emotional wellbeing during the crisis pregnancy, the scores from all five items were computed to a form a scale (MHI-5 scale score). Raw scores for the five emotional states range from 5 to 30. Scores were standardised by linear transformation to a scale ranging between 0 and 100, with higher scores indicating less psychological distress. In Figure 7.8, the mean MHI-5 scores of adults who experienced a crisis pregnancy in either ICCP-2003 or ICCP-2010 are compared with estimates from the general population (SLÁN 2007 survey). A number of important conclusions can be drawn. First, adults in the 2010 and 2003 surveys who experienced a crisis pregnancy had higher psychological distress at the time of that pregnancy than the general population (as indicated by the lower mean scores on the MHI-5). Focusing on ICCP-2010, it appears that men had lower psychological distress than women, particularly in ICCP-2010. Comparing across the two ICCP surveys, the psychological well-being of women experiencing a crisis pregnancy has decreased, whereas the psychological well-being of men whose partners were experiencing a crisis pregnancy has increased.

Figure 7.8 Comparison of mean MHI-5 scores of men and women experiencing a crisis pregnancy (ICCP-2003, ICCP-2010 and SLÁN 2007)



In ICCP-2010, a small number of respondents (n=124) reported that they had felt very nervous, downhearted and blue, or so down in the dumps that nothing could cheer them up, 'a good bit of the time', 'most of the time' or 'all of the time' during the crisis pregnancy. These respondents were asked if, during the time of the pregnancy, they had thoughts of harming themselves or ending it all (collectively labelled as 'suicidal ideation'). As illustrated in Figure 7.9, 24% of the women experienced suicidal thoughts at some point during the time of their crisis pregnancy (n=26), compared with 3% of men. It is important to note that the sub-groups differ in size and that this gender difference was not statistically signficant (p=0.054).

Figure 7.9 Suicidal ideation among respondents reporting psychological distress during a crisis pregnancy, by gender

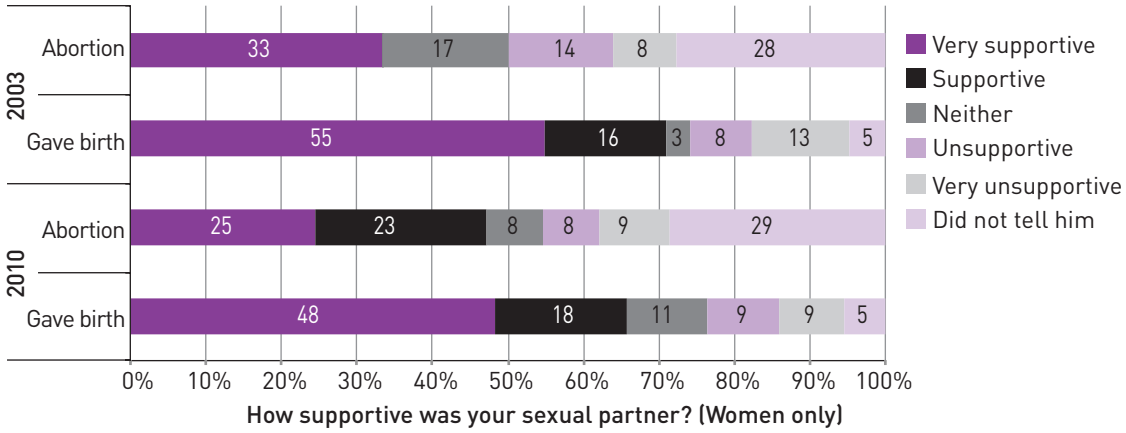


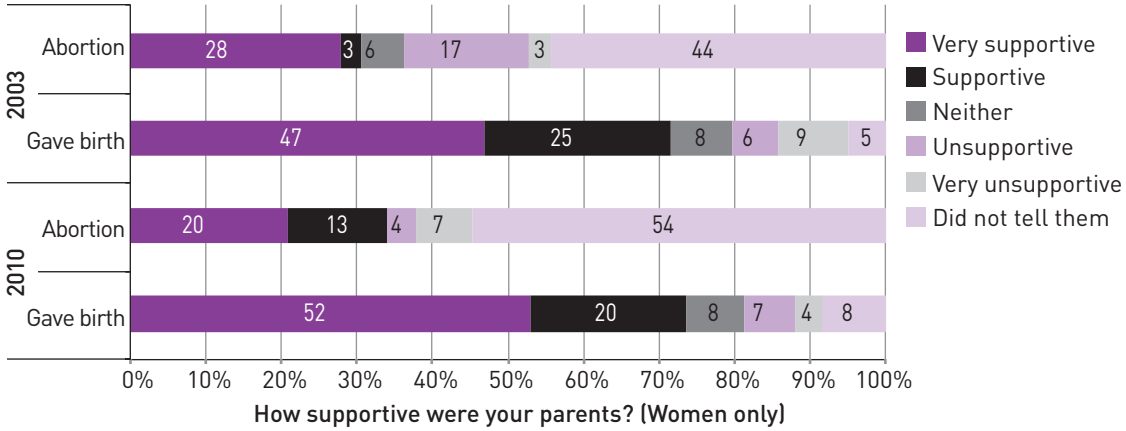
During the crisis pregnancy, did you have thoughts of harming yourself or ending it all?

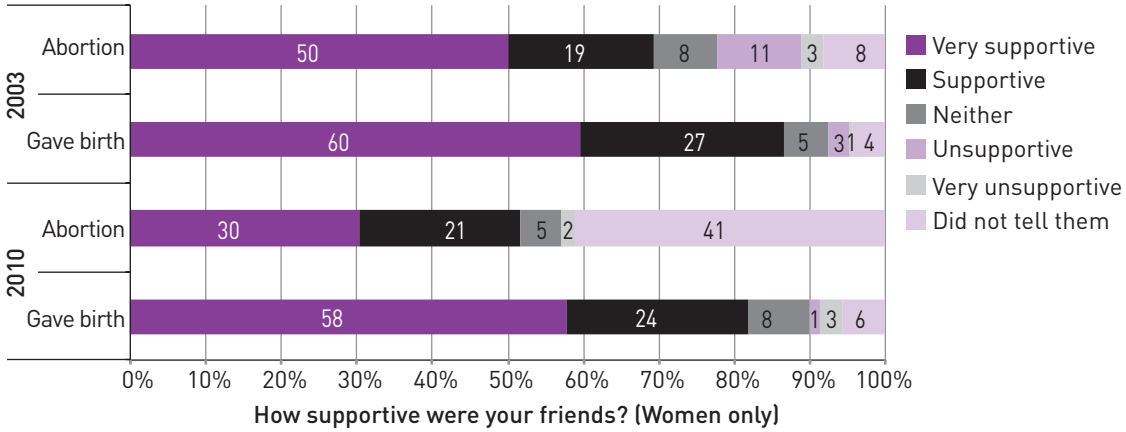
7.4.7 Support from sexual partner and family during a crisis pregnancy

In relation to personal support during the crisis pregnancy, women were asked how supportive key social supports were in their lives (see Figure 7.10). The level of support provided by the sexual partner was relatively similar in ICCP-2003 and ICCP-2010, regardless of the pregnancy outcome. It is noteworthy that approximately 1 in 4 women experiencing a crisis pregnancy that ended in abortion did not tell their sexual partner. Another interesting finding is that there appears to be an increasing trend in the proportion of women not disclosing that they have had an abortion to friends and family. For example, higher proportions of women reported that they did not tell their parents or friends about their abortion in ICCP-2010 than did in ICCP-2003.

Figure 7.10 Support provided to women experiencing crisis pregnancy by sexual partner, parents and friends, by pregnancy outcome (ICCP-2003 and ICCP-2010)







7.4.8 Use of crisis-pregnancy counselling services

Respondents were asked whether they were aware that crisis-pregnancy counselling services were available in Ireland. A similar proportion of men (84%) and women (83%) were aware of the availability of such services. In the main questionnaire, respondents who did not experience a crisis pregnancy were asked whether they had ever heard of crisis-pregnancy counselling. Of these respondents, higher proportions of women (79%) than men (63%) reported that they had heard of crisis-pregnancy counselling.

Of the respondents who had experienced a crisis pregnancy and completed the additional questionnaire (n=299), 23% of men and 23% of women had considered crisis-pregnancy counselling at the time of their most recent crisis pregnancy. Respondents who had considered crisis-pregnancy counselling were asked if they actually obtained counselling at that time. Approximately half of women (54%) and two-thirds of men (65%) had obtained crisis-pregnancy counselling. Of these respondents (n=45), 58% of men and 70% of women reported that they had had a good experience with the counselling service.

7.4.9 Additional support required during a crisis pregnancy

All respondents who experienced a crisis pregnancy were asked if there was anything that would have made the situation easier, if it had of been available to them at the time. Over half of women (57%) and over one-third of men (37%) suggested that additional support/ services would have made the situation easier for them. The top three items identified by men were money (34%), counselling or having someone to talk to (32%) and transport (15%). For women, the following three factors were most important: counselling or having someone to talk to (48%), family support (13%) and information on all options (13%).

7.4.10 Additional support required after a crisis pregnancy

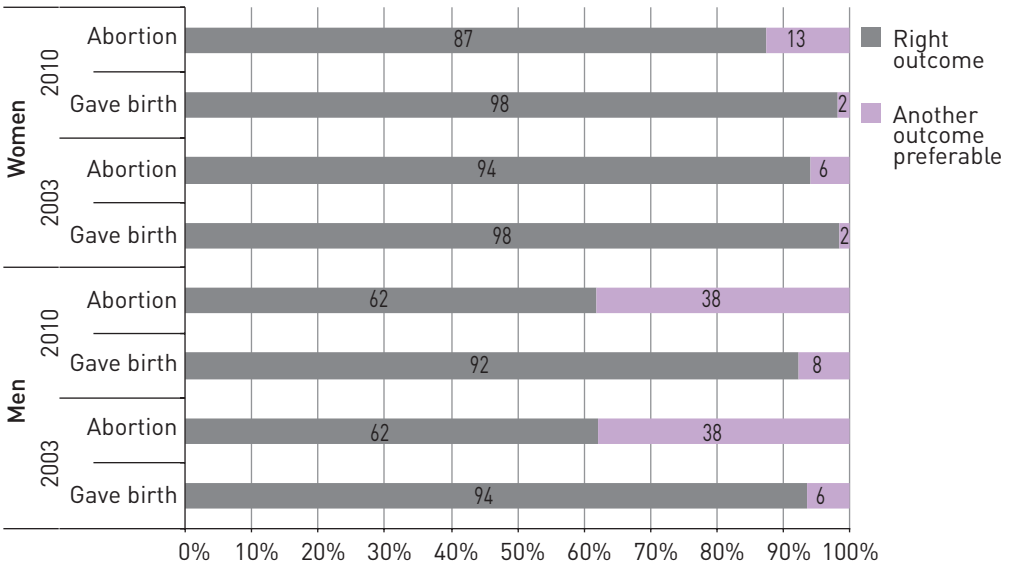
In relation to support services, women were asked about requirements for on-going support services after the crisis pregnancy. Approximately 1 in 5 (21%) women felt they needed on-going support or services after the crisis pregnancy. There was no significant difference in the proportion of women who felt they needed on-going support after having an abortion compared with those who gave birth. Those who felt they needed on-going support were asked which supports, from a pre-determined list, they needed. Six out of ten women who required support after the crisis pregnancy said that having counselling or advice was required. Almost 70% of women also said that they required support from family and friends, whereas nearly half (49%) required medical attention. These requirements were very similar to those reported by women surveyed in ICCP-2003.

7.4.11 Retrospective assessment of crisis pregnancy outcome

Respondents were asked how they felt at the time of the survey about the outcome of the crisis pregnancy in terms of whether it was the right thing to do or if they wished another outcome had been chosen (see Figure 7.11). The small number of men and women who had had a crisis pregnancy that ended in an adoption (n=3) are not included in the figure because no respondents in ICCP-2003 had a crisis pregnancy that ended in adoption;

all three respondents reported that the adoption had been the right outcome for them. For the remaining respondents, there were remarkably similar results for men across the 2003 and 2010 surveys, however, more women in ICCP-2010 thought that another outcome apart from abortion may have been preferable.

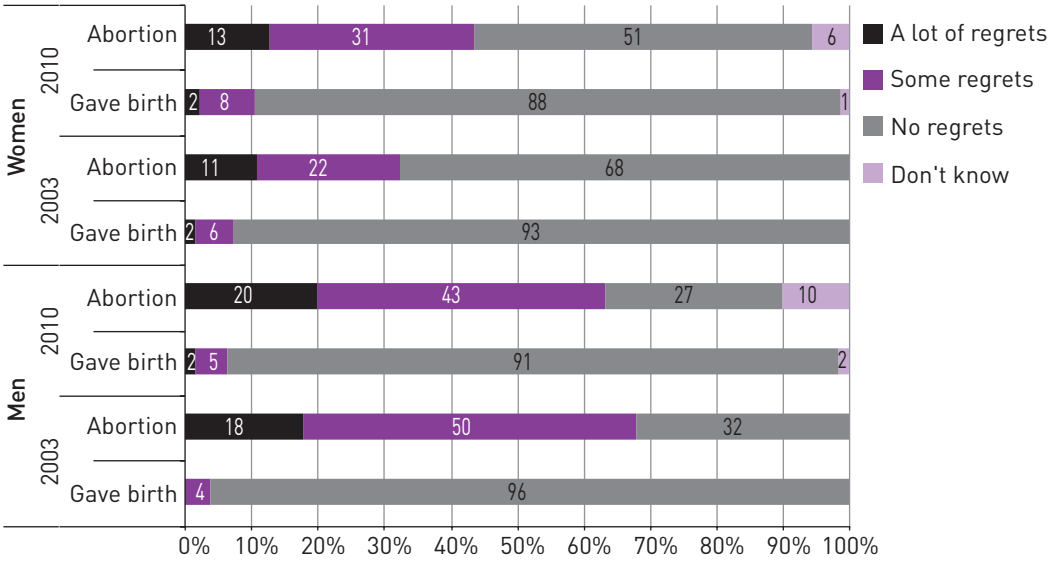
Figure 7.11 Outcome of pregnancy: retrospective assessment of whether outcome was the correct one, by gender and pregnancy outcome (ICCP-2003 and ICCP-2010)



7.4.12 Current level of regret about crisis pregnancy outcome

Respondents were asked whether they had any regrets at the time of the survey about the outcome that was chosen (see Figure 7.12). It is important to note that this question did not tease out the reasons for any regret. For example, it may be that a respondent's regret is that an outcome was necessary at that time (rather than that the wrong choice was made); or that if circumstances had been different, a different choice might have been made. Again, the small number of respondents who had experienced an adoption (n=3) are not included in the figure; all three reported that they had no regrets about the adoption. Across both surveys, more women reported having no regrets about an abortion (51% in ICCP-2010 and 68% in ICCP-2003) than men (27% in ICCP-2010 and 32% in ICCP-2003).

Figure 7.12 Current level of regret regarding outcome of pregnancy, by gender and pregnancy outcome (ICCP-2003 and ICCP-2010)



8.0 Experience of sex education

8.1 Introduction

Sex education is a lifelong process of acquiring knowledge and developing attitudes, beliefs and values about sexual identity, relationships and intimacy. This education is delivered consciously and unconsciously by parents, teachers, other adults, peers and the media. In Irish schools, Relationships and Sexuality Education (RSE) is a formal programme taught in the context of the Social, Personal and Health Education (SPHE) curriculum (Maycock et al., 2007). SPHE covers areas such as relationships at home and in school, self-esteem, communication skills, decision making and expressing feelings in an appropriate way. Parents have primary responsibility for how their children develop. Getting involved in sex education with their children at home is very important for reinforcing the messages their children receive in school (O'Higgins et al., 2007).

In 2006, ISSHR explored the sex education experiences of 18 to 64 year olds living in Ireland. The results revealed that 53% of men and 60% of women reporting having received sex education in their lifetime. There was a graduated relationship between the proportion of adults receiving sex education and age. This was likely due to the liberalising trend of the previous three or four decades, which provided an increasingly positive environment for sex education to be covered both in the home and at school (Layte et al., 2006).

The main aim of this chapter is to explore the current level of access to sex education at school, at home and from other sources. This chapter addresses this issue by:

- identifying the nature and source of the respondents' sex education;
- investigating the perceived helpfulness of any sex education in preparing for adult relationships;
- examining the relationship between receiving sex education and using contraception when having sex for the first time; and
- exploring the type of sex education respondents engage in with their children.

Most of the questions in ICCP-2010 that relate to sex education were asked of all respondents, with follow-up questions asked as appropriate. Only respondents who had children were asked about talking to their children about sex. Many of the questions relating to RSE were not asked in ICCP-2003, but comparisons to ISSHR are made, where appropriate.

Experience of sex education: key findings

- Nearly three out of four adults reported receiving sex education at some point in their lives (72%).
- 86% of adults in the youngest (18–25) age group reported receiving sex education, compared with 57% of adults in the oldest (36–45) age group.
- Adults who had received sex education were almost twice as likely to use contraception when having sex for the first time, compared with those who did not receive sex education.
- 'Sex and sexual intercourse' was the topic most commonly covered in sex education (60% of adults received education on this topic).
- 50% of adults received sex education in school only, 32% at home and in school, 8% at home only and 10% outside of the home or school environment.
- Where sex education is received is important – those who had received sex education at home and/or in school were over 1.5 times more likely to use contraception the first time they had heterosexual intercourse, compared with those who received sex education outside of the home or school environment.
- Adults who thought that their sex education was helpful in preparing them for adult relationships were nearly twice as likely to use contraception when having sex for the first time, compared with those who thought their sex education was unhelpful.
- Fewer parents (70%) reported that they or their partner had talked to their children aged 12 to 18 about sex, compared with ICCP-2003 (82%).

8.2 Experience of sex education

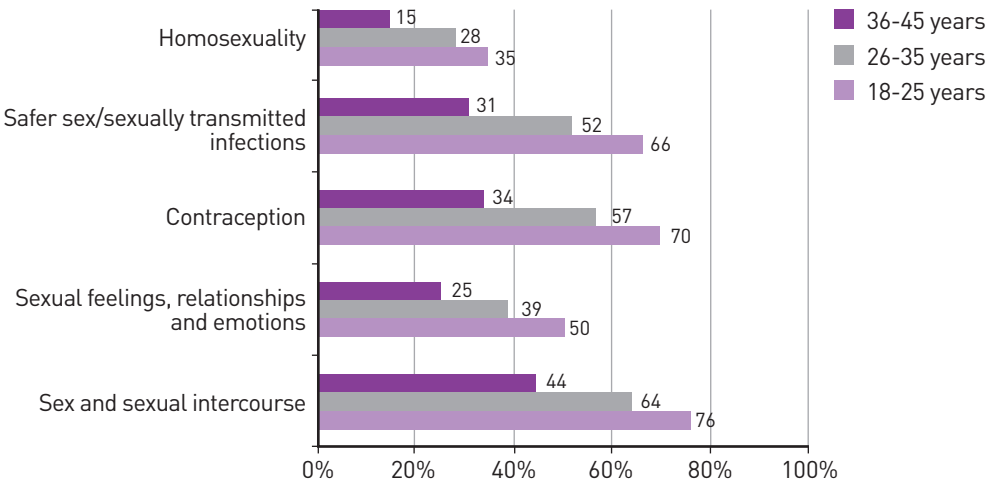
All respondents, regardless of their sexual history, were asked about their experiences of sex education. Almost three-quarters of adults surveyed (72%) reported that they had received sex education at some point in their lives. In terms of age, 86% of 18 to 25 year olds (87% of men and 86% of women), 76% of 26 to 35 year olds (73% of men and 80% of women) and 57% of 36 to 45 year olds (52% of men and 62% of women) received sex education. These estimates are very similar to those reported for similar age groups in ISSHR: 18 to 24 year olds (88% of men and 92% of women), 25 to 34 year olds (74% of men and 77% of women) and 35 to 45 year olds (48% of men and 60% of women) (Layte et al., 2006). In ICCP-2010, women, younger respondents and those with a Leaving Certificate or higher education were significantly more likely to have received sex education than their counterparts ($p<0.001$).

A binary logistic regression analysis was conducted to explore whether respondents who received sex education were more likely to use contraception on the occasion of their first heterosexual sexual experience, compared with those who did not receive sex education. The result revealed that those who received sex education were significantly more likely, in fact almost twice as likely (AOR=1.810; 95% CI=1.488–2.201), to use contraception when

having sex for the first time, compared with those who did not receive sex education, controlling for the effects of current age, gender, social class and educational attainment. This finding highlights the substantial role that RSE plays in making people aware of the importance of using contraception to protect against unwanted pregnancy and disease.

Respondents who had received sex education were asked whether they had received information in specific areas: sex and sexual intercourse; sexual feelings, relationships and emotions; contraception; safer sex and sexually transmitted infections; and homosexuality (see Figure 8.1). The topic 'sex and sexual intercourse' was the area where the majority of respondents received their sex education (60% overall). Similar to ISSHR, the most common topic of sex education received was basic biological information on sexual intercourse (Layte et al., 2006). In ICCP-2010, education about homosexuality was the area where respondents reported receiving the least information. Younger respondents were significantly more likely ($p<0.001$) to report receiving RSE in each specific topic, compared with older respondents.

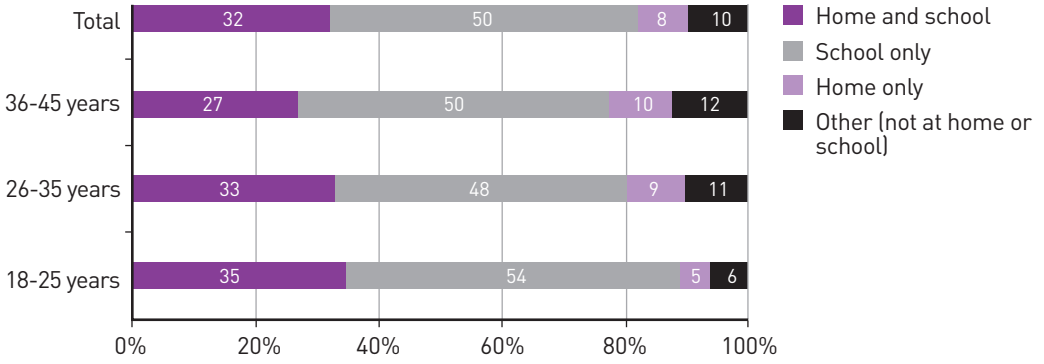
Figure 8.1 Topics covered in respondents' sex education (n=2,193)



8.3 Source of sex education

Respondents who received sex education while they were growing up were asked where they received this education. Respondents could respond with more than one option (e.g., at home and in school). Figure 8.2 illustrates where respondents in each age category received their sex education. In all age groups, the majority of respondents were educated about sex and relationships in school only. Approximately one-third of adults recruited had received sex education both at home and in school. Notably, 1 in 10 adults reported that they did not receive sex education at home or in school, but from another source (e.g., media or friends).

Figure 8.2 Source of sex education, by age group (n=2,193)

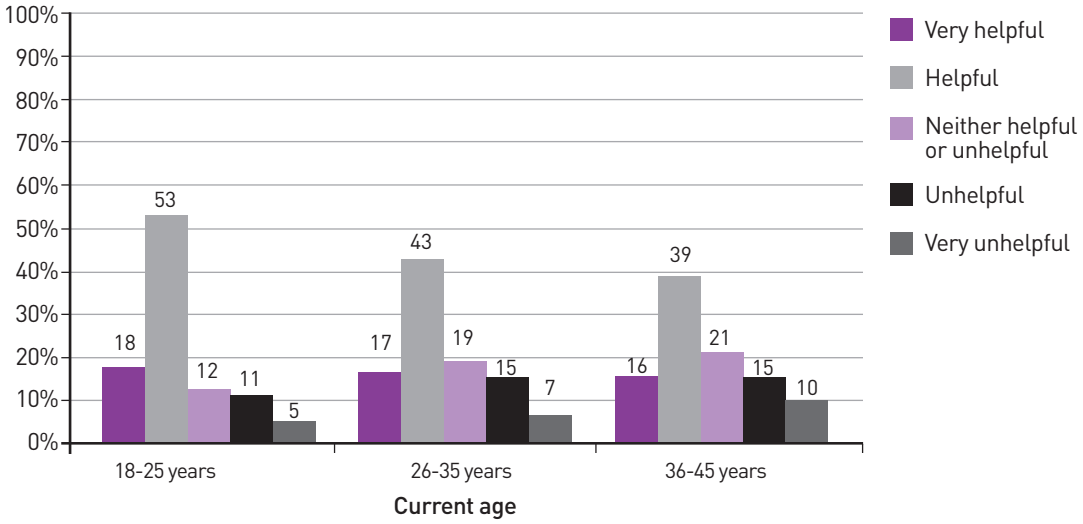


A binary logistic regression was used to explore whether the location where a respondent received sex education would help predict use of contraception on first heterosexual sexual occasion. The 'other, not at home or school' group was used as a reference category, with which all of the other sex education categories in Figure 8.2 were compared. The analysis controlled for gender, current age and social class. The results revealed that, compared with those who received sex education outside their home or school only, those who received sex education at home or in school were approximately 1.5 times more likely to use contraception the first time they had heterosexual intercourse (AOR=1.698; 95% CI=1.133–2.545). There were no other statistically significant differences in relation to RSE.

8.4 Helpfulness of sex education in preparing for adult relationships

All respondents who received sex education were asked whether they thought it was helpful in helping to prepare them for adult relationships (see Figure 8.3). Higher proportions of respondents in the 18–25 age group reported that their sex education was very helpful or helpful (71%), compared with those aged 26 to 35 (60%) or 36 to 45 (55%). The age group differences were statistically significant ($p<0.001$). Higher proportions of men and women in ICCP-2010 reported that their sex education was helpful than in ISSHR: 18–24 age group (65% of women and 58% of men), 25–34 age group (51% of women and 48% of men) and 35–45 age group (46% of women and 45% of men) (Layte et al., 2006).

Figure 8.3 Helpfulness of respondents' sex education in preparing them for adult relationships, by age group (n=2,193)



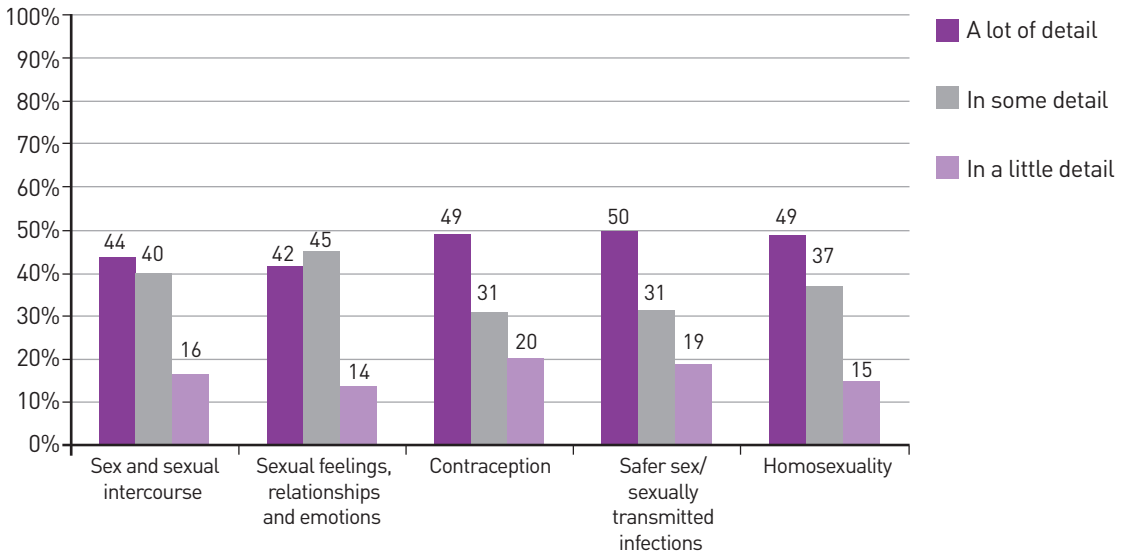
The helpfulness scale was re-categorised into a binary variable to compare respondents who considered their sex education to be helpful or very helpful in preparing them for adult relationships, with those respondents who did not consider their sex education to be helpful. A binary logistic regression analysis was then conducted to explore whether respondents who found the sex education they received to be very helpful or helpful were more likely to use contraception on the occasion of their first heterosexual sexual experience, compared with those who did not perceive their sex education to be helpful.

The results revealed that those who thought the sex education they had received was helpful in preparing them for adult relationships were nearly two times more likely (AOR=1.788; 95% CI=1.413–2.262) to use contraception when having sex for the first time, compared with those who received sex education that was unhelpful, controlling for the effects of current age, gender, social class and educational attainment.

8.5 Talking to children about sex

Just 70% of respondents with children aged between 12 and 18 years reported that they or their partner had talked to them about sex; this represented a decrease from 82% in ICCP-2003. Respondents who did speak to their children about sex were asked whether they had covered five main topics: sex and sexual intercourse (87% had covered this); sexual feelings, relationships and emotions (85%); contraception (78%); safer sex and sexually transmitted infections (74%); and homosexuality (73%). The level of detail given by the parent to the child on each topic is presented in Figure 8.4.

Figure 8.4 Level of detail of sex education covered by respondents, by topic (n=283)



Topics covered in relationship and sexual education (RSE) by respondents with their children (n = 283)

9.0 Knowledge and attitudes about contraception, fertility and sexually transmitted infections

9.1 Introduction

The correct and consistent use of contraception is highly effective in preventing pregnancy and sexually transmitted infections (STIs) (Frost et al., 2007). Whilst this public health message is clear, the use of contraception by sexually active people is a complex issue. Many factors influence a couple's decision on whether to use contraception; these include attitudes towards contraception and pregnancy, knowledge about different contraceptive methods and fertility, relationship status, communication difficulties and accessibility and affordability of contraceptive services or products (Frost and Darroch, 2008). Understanding these issues as they currently exist within an Irish context is critical for directing campaigns to encourage consistent use of contraception among the sexually active.

ICCP-2010 provides a unique opportunity to explore the current picture of how adults living in Ireland view different types of contraception and to examine any issues they have in relation to using and accessing these methods. It also provides an opportunity to explore issues relating to STIs and HIV, including knowledge of and levels of testing for these infections.

This chapter extends the knowledge obtained from ICCP-2003 and ISSHR by:

- describing attitudes towards contraception use among adults aged 18 to 45 who are living in Ireland;
- assessing knowledge of fertility periods in the menstrual cycle;
- determining levels of knowledge about the effectiveness of the emergency contraceptive pill (ECP);
- exploring issues around using and accessing the ECP;
- assessing levels of knowledge of HIV; and
- examining levels of testing and diagnoses of HIV and STIs.

The majority of questions discussed in this chapter were asked of respondents who had never had sex, or who had experienced heterosexual sex, or whose sexual history was unknown (n=2,959). However, questions relating to HIV/STIs were asked of all adults who had ever experienced sexual intercourse, including those who had had same sex experiences.

Knowledge and attitudes about contraception, fertility and STIs: key findings

- 42% of adults believe that the contraceptive pill has dangerous side effects; a decrease from 50% in ICCP-2003.
- The proportion of adults who believe that taking a break from long-term use of the contraceptive pill is a good idea remained stable across the seven-year period (67% in ICCP-2003; 68% in ICCP-2010). Six out of ten adults living in Ireland have concerns about how safe it is to use the contraceptive pill over a long time period.
- 24% of adults feel that when a woman who is not in a relationship carries condoms she gives the impression that she is 'easy' or looking for sex. This finding is consistent with the 23% of adults who agreed with the same statement in ICCP-2003.
- Fewer adults (50%) correctly identified the most fertile time within a monthly cycle (i.e., when a woman is most likely to become pregnant), compared with 54% in ICCP-2003.
- More adults (41%) were aware of the 72-hour time limit for taking the ECP, compared with ICCP-2003 (39%). Women, younger adults, those with a post-Leaving Certificate education and those in higher social classes were more likely to identify the 72-hour window for effective use of the ECP.
- The ECP had been used by more adults during the previous year in ICCP-2010 (4%) than in ICCP-2003 (2%). Among young adults (18 to 25 years), use of the ECP during the previous year increased from 5% in ICCP-2003 to 9% in ICCP-2010.
- Consistent use of contraception was higher among those adults who did not use the ECP (83% in ICCP-2003; 79% in ICCP-2010) compared with those who did use the ECP (54% in ICCP-2003; 50% in ICCP-2010).
- Over half of the adults who had used the ECP during the previous year had obtained it directly from a GP or a Well Woman clinic (54% for women and 56% for men).
- 36% of respondents (26% of men and 45% of women) had been tested for HIV in their lifetime. Less than 1% of adults tested had been diagnosed with HIV.
- 20% of men and 32% of women had been screened for an STI other than HIV. Of those tested for an STI, 14% of respondents were diagnosed with an STI.

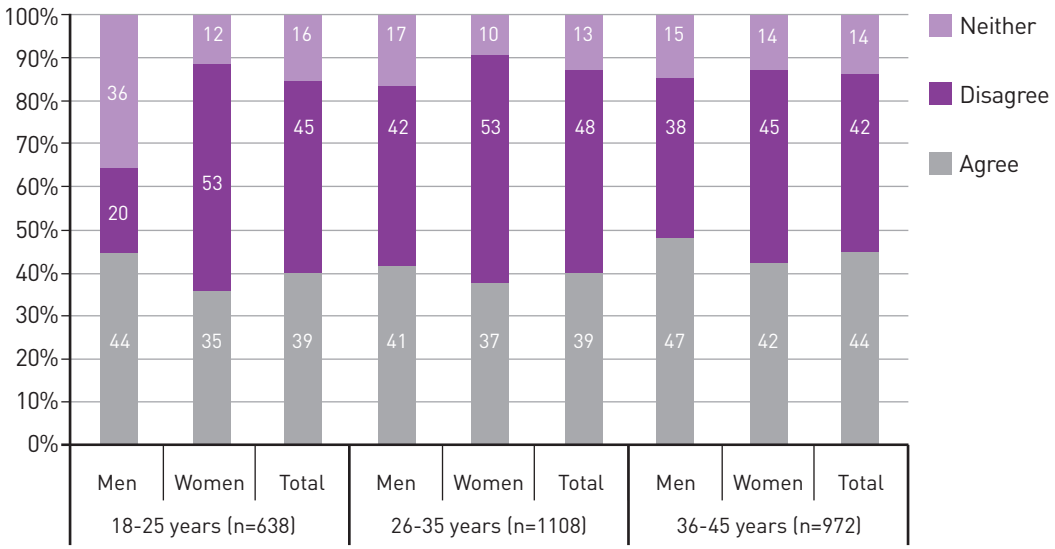
9.2 Knowledge and attitudes about contraception and fertility

Adults were asked for their views on five statements relating to contraception use. There were significant gender differences in views across all five statements and significant age differences in views across four of the statements; thus, results are presented by age and gender, where appropriate.

9.2.1 Perceived side effects of the contraceptive pill

In total, 42% of respondents agreed with the statement that 'the contraceptive pill has dangerous side effects' (see Figure 9.1); a slight decrease from ICCP-2003, when 50% of respondents agreed with this statement. Although a higher proportion of adults in the oldest age group (36–45 years) agreed with the statement compared with those in the two younger age groups, age group differences were not statistically significant (p>0.05).

Figure 9.1 Agreement with statement 'The contraceptive pill has dangerous side effects', by age group and gender



Comparisons with ICCP-2003 reveal that the proportion of adults in each age group agreeing with this statement has decreased; the figures in ICCP-2003 were: 49% (18–25 years), 70% (26–35 years) and 80% (36–45 years). This result suggests that over the seven-year period, a greater awareness of the health consequences of the contraceptive pill has filtered into the general public.

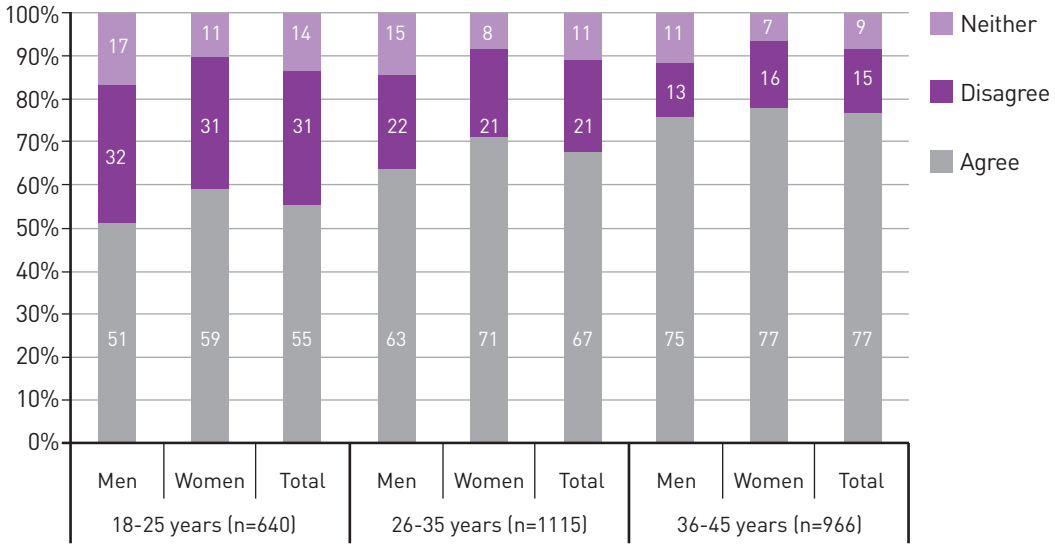
9.2.2 Taking a break from use of the contraceptive pill

The second statement related to taking a break from the long-term use of the contraceptive pill. In the past, particularly in the 1970s and 1980s, feminist health groups criticised the use of oral contraceptives by pointing out their health risks and advocating the use of barrier contraceptive methods that do not interfere with complex bodily functions (Hardon, 1992; Murphy, 1993). In 1995, the UK Committee on Safety Medicines issued a warning that the use of oral contraceptive pills was associated with an increased risk of health problems. This had a negative impact on health, with many women choosing to switch to alternative contraceptive types or to cease using contraception altogether (Furedi, 1999). Research demonstrated that both prescribers and pill users in Ireland were influenced by the UK warning because prescriptions for oral contraception decreased in Ireland following the warning being issued in the UK (Williams et al., 1998).

Since then, copious empirical literature has suggested that there is no medical need to refrain from using the contraceptive pill for long periods of time (Anderson et al., 2006; Gold and Duffy, 2009; Hannaford et al., 2010).

Overall, 68% of adults thought that taking a break from the long-term use of the contraceptive pill is a good idea. As illustrated in Figure 9.2, this belief was more common in the older age groups (77% of 36 to 45 year olds and 67% of 26 to 35 year olds) compared with younger respondents (55% of 18 to 25 year olds). In ICCP-2003, 67% of adults overall agreed with this statement, suggesting that attitudes towards the long-term use of the contraceptive pill among adults living in Ireland have remained remarkably stable over the seven-year period.

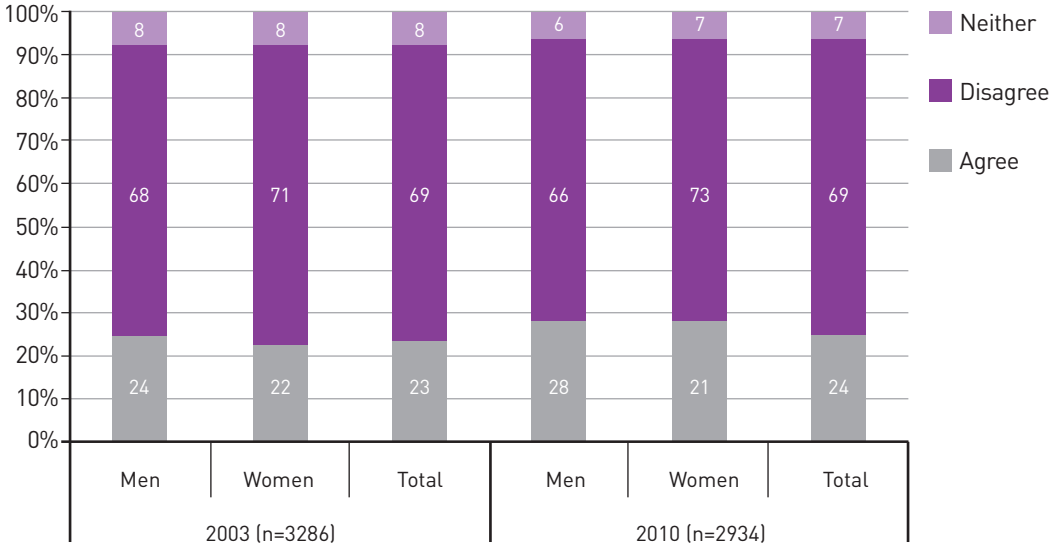
Figure 9.2 Agreement with statement 'Taking a break from the long-term use of the contraceptive pill is a good idea', by age group and gender



9.2.3 Carrying condoms while not in a relationship

Respondents were asked about their opinions or attitudes in relation to condom use. In ICCP-2003, 24% of men and 22% of women surveyed agreed with the statement that 'If a woman carries condoms while not in a relationship, it gives the message that she is looking for sex or is easy'. Results from ICCP-2010 in relation to this issue are presented in Figure 9.3. Attitudes towards carrying condoms as a precautionary measure for unprepared sex have remained very consistent over the seven-year period. Whilst the majority of respondents disagree with this statement, almost one-quarter of adults living in Ireland agree.

Figure 9.3 Agreement with statement 'If a woman carries condoms while not in a relationship, it gives the message that she is looking for sex or is easy', by gender (ICCP-2003 and ICCP-2010)



9.2.4 Talking to a sexual partner about contraception

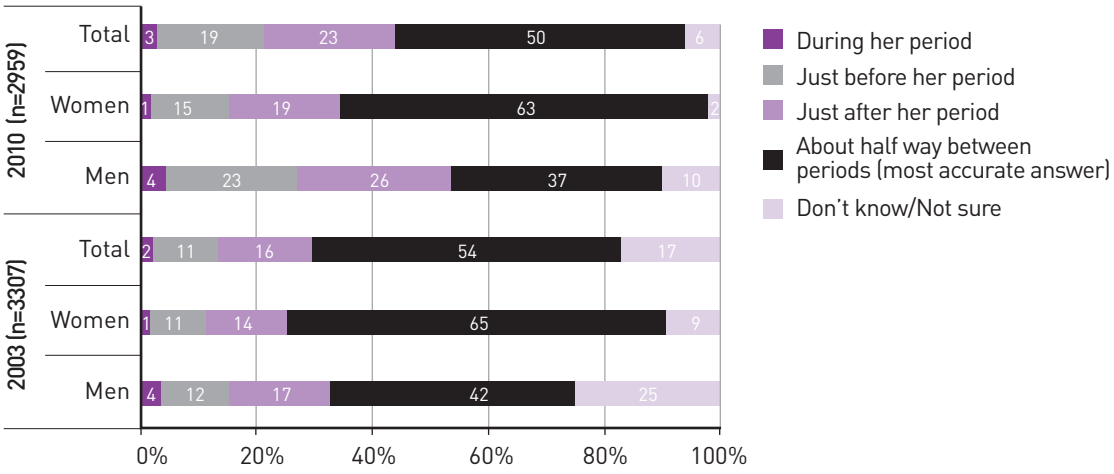
A very important aspect of contraceptive practice is how it is negotiated between sexual partners. Respondents were asked their opinion on whether they would find it difficult to talk to a sexual partner about contraception. A comparison of the 2003 and 2010 surveys reveals that the majority of adults do not find it difficult to talk to their partners about contraception, although the proportion of adults agreeing that they would find it difficult to talk to a partner increased from 6% in ICCP-2003 to 8% in ICCP-2010.

9.2.5 Knowledge about menstrual cycle

Knowledge about fertility is a precursor to effective contraceptive practice. When contraception such as condoms or prescription contraceptives (e.g., the pill, patch, LARCs) are not an option, as was the case in Ireland before the change in legislation on contraception in 1979, knowledge of cycles of fertility provides the only contraception available. It is interesting, therefore, to examine how levels of knowledge about a woman's fertility may have changed in Ireland since the greater availability of contraception.

In both ICCP-2003 and ICCP-2010, an important question concerning female fertility was asked of respondents: 'Thinking about the female menstrual cycle/period, at what time of the month do you think a woman is most likely to become pregnant?' (see Figure 9.4). When this question was asked in ISSHR, 43% of adults aged 18 to 64 correctly identified the time in a woman's monthly cycle when she is mostly likely to get pregnant (Layte et al., 2006). This implies that the majority of men and women living in Ireland in 2006 (57%) could not correctly identify the most fertile time within a woman's monthly cycle. Comparing across the two ICCP surveys revealed that the proportion of adults correctly identifying the most fertile period for a woman was higher in 2003 (54%) than in 2010 (50%).

Figure 9.4 Knowledge about the time during her menstrual cycle when a woman is most likely to become pregnant, by gender (ICCP-2003 and ICCP-2010)

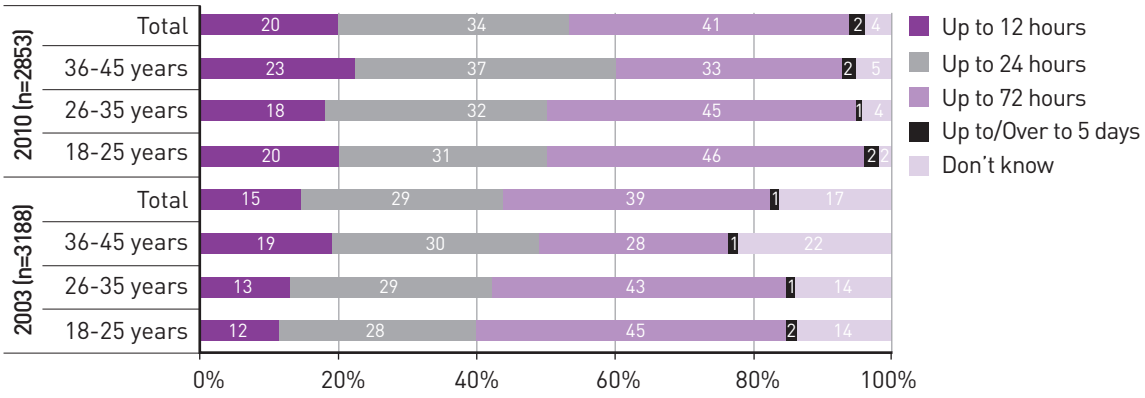


This trend is consistent with the findings from ISSHR, which suggest that, in more recent years, a higher proportion of adults are less knowledgeable about fertility-related issues. This is an interesting trend, given that it appears that more people nowadays are trying to conceive and, therefore, it would make sense that more people would have a better knowledge of fertility. To explore this issue in more detail, the knowledge of fertility among those who were pregnant or trying to conceive was compared with the knowledge of fertility among those who were not actively trying to conceive. A significantly higher proportion of those who were pregnant or trying to conceive correctly identified the most accurate answer for a woman's most fertile period (60%), compared with those who were not (50%) ($p<0.001$).

9.3 Knowledge of, use of and access to the emergency contraceptive pill (ECP)

The vast majority of respondents (95%) had heard of the ECP or 'morning after' pill. This finding is similar to that reported in ICCP-2003 (96%). As a follow-up, respondents who had heard of the ECP were asked how long after sexual intercourse it can be effectively used. There were five possible response options, as illustrated in Figure 9.5. There was a slight increase in the proportion of respondents correctly identifying the 72-hour time limit for taking the ECP, from 39% in ICCP-2003 to 41% in ICCP-2010.

Figure 9.5 Knowledge about how long after sexual intercourse the ECP can be effectively used, by age group (ICCP-2003 and ICCP-2010)



A binary logistic regression analysis was conducted to explore the factors associated with identifying the 72-hour limit for taking the ECP, compared with not knowing this information. Several predictor variables were included in the model (see Table 9.1). The results of this model suggest that men were significantly less likely than women (62% less likely) to identify the correct time period for using the ECP. Compared with those in the oldest age group, younger adults were approximately 1.5 times more likely to know that the ECP can be used up to 72 hours after unprotected sex.

Respondents with a pre-Leaving Certificate education were 50% less likely than those with a post-Leaving Certificate education to identify the correct time period, whereas those with a Leaving Certificate education were around 20% less likely to know the 72-hour time frame than those with a post-Leaving Certificate education. In short, those with the highest levels of education were the most knowledgeable about how the ECP should be used effectively. Similarly, knowledge of the 72-hour time limit was highest among those in social classes 1 and 2; those in the lower social classes were between 20% and 35% less likely to identify the correct time frame.

Interestingly, receiving sex education was not significantly associated with knowledge of the ECP time limit. This is somewhat concerning because it would seem appropriate that knowledge about contraception, including emergency contraception, should be provided during the course of sex education, be it at home or in school. In recent years, the topics and content of sex education in Irish schools, particularly in post-primary schools, has been an important area for research and discussion (Maycock et al., 2007).

Table 9.1 Weighted adjusted odds ratio (AOR) and 95% confidence intervals (CI) for identifying correctly the 72-hour time limit for using the ECP after unprotected sex (compared with those who did not know this information), by selected predictors

Socio-demographic characteristics	AOR	95% CI
Sex		
Men	0.377***	0.321–0.442
Women (reference group)	1.000	
Current age		
18–25 years	1.736***	1.391–2.168
26–35 years	1.520***	1.258–1.837
36–45 years (reference group)	1.000	
Education level		
Pre-Leaving Certificate	0.488***	0.382–0.625
Leaving Certificate	0.819*	0.680–0.987
Post-Leaving Certificate (reference group)	1.000	
Social class		
SC 1–2 (reference group)	1.000	
SC 3–4	0.799*	0.660–0.966
SC 5–6	0.743*	0.557–0.992
SC 7 (unknown/never worked)	0.657**	0.515–0.838
Any sex education received		
Yes	1.103	0.914–1.331
No (reference group)	1.000	

*Note: *** p<0.001; ** p<0.01; * p<0.05.*

All respondents who had had sex during the previous year, who had heard of the ECP and who were not pregnant or trying to conceive were asked about their use (or their partner's use) of the ECP during the previous year (see Table 9.2).

Table 9.2 Use of the ECP during the previous year, by age group (ICCP-2003 and ICCP-2010)

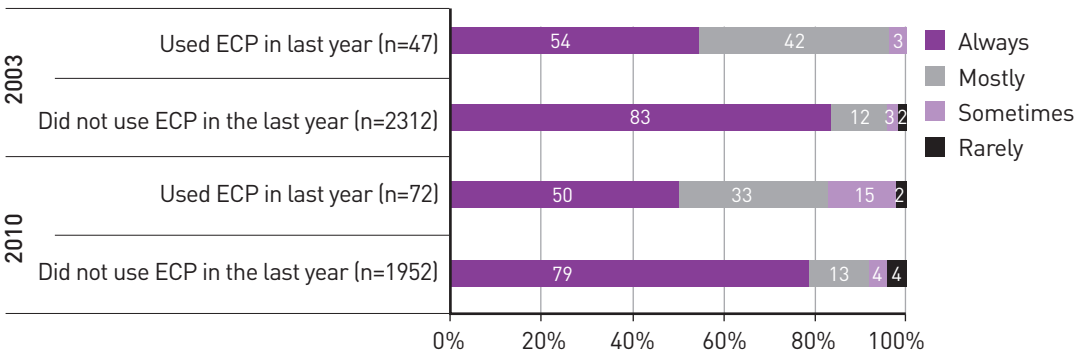
	ICCP-2003 (n=2,629) % (w)				ICCP-2010 (n=2,246) % (w)			
	18–25 years (n=645)	26–35 years (n=865)	36–45 years (n=1,119)	Total	18–25 years (n=535)	26–35 years (n=889)	36–45 years (n=822)	Total
Yes	5	2	1	2	9	3	1	4
No	95	98	99	97	91	97	99	96

Note: In ICCP-2010, this question was asked only of those who had had sex during the previous year, but who weren't pregnant or trying to conceive, and who had heard of the ECP. Comparable estimates were calculated for ICCP-2003. % (w) = weighted percentages.

The proportion of respondents using the ECP increased from 2% in ICCP-2003 to 4% in ICCP-2010. Of particular interest is that the proportion of young adults aged 18 to 25 using the ECP during the previous year increased from 5% in 2003 to 9% in 2010. These findings may be interpreted in a number of ways. First, it may be that stigma and embarrassment surrounding use of the ECP has decreased in recent years, meaning that people may be more likely to report using it. Second, it may be that due to increased awareness of the ECP through advertising campaigns, more people are seeking out the ECP when they need it. Third, it could be that more people are using the ECP because they are not consistently using a regular or primary contraceptive method when they have sex. To explore this issue in more detail, the consistency of contraceptive use of people who had used the ECP during the previous year was explored.

Figure 9.6 compares the consistency of contraceptive use among respondents who had used the ECP during the year before the survey. As might be expected, a higher consistency of using contraception was found among respondents who had not used the ECP (83% in ICCP-2003; 79% in ICCP-2010) compared with those had used the ECP (54% in ICCP-2003; 50% in ICCP-2010). Focusing on those respondents who had used the ECP during the previous year, it can be seen that the levels of inconsistent use seem to be higher for ICCP-2010 than for ICCP-2003 respondents, with 17% of ECP users in 2010 reporting that they rarely or only sometimes use contraception, compared with 3% in 2003. This analysis tentatively suggests that people may be using the ECP more frequently nowadays to compensate for lack of consistent use of regular contraceptive methods.

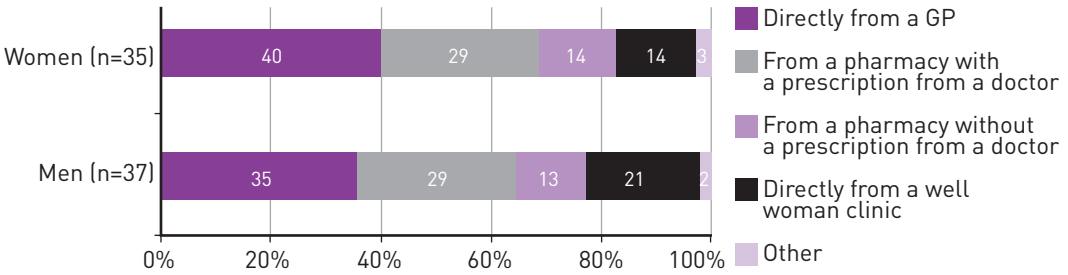
Figure 9.6 Consistency of contraceptive use among those who had used the ECP during the previous year (ICCP-2003 and ICCP-2010)



As discussed in Chapter 5, the ECP (Norlevo brand) was re-categorised as a non-prescription medicine in Ireland. The long-term impact of this change in licensing arrangements has yet to be seen. Research in the UK, however, has suggested that making the ECP available over the counter in pharmacies has not resulted in an increase in its use or a decrease in the use of other contraceptives (Marston et al., 2005). As previously outlined in Section 5.4.3, the ECP was available from a number of different sources at the time of the 2010 survey (mid-2010). Figure 9.7 shows that over half of the

adults who had used the ECP during the previous year had obtained it directly from a GP or a Well Woman clinic (54% for women and 56% for men); 29% of men and women obtained the ECP from a pharmacist with a prescription from a doctor; with a smaller proportion obtaining it from a pharmacist without a prescription.

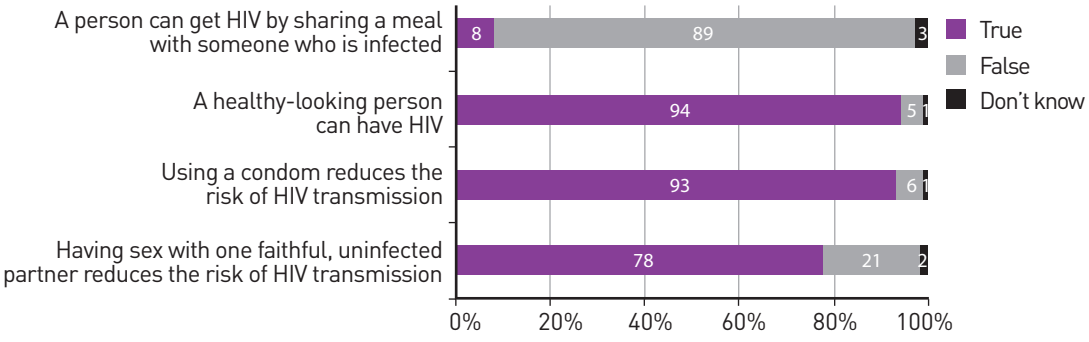
Figure 9.7 On the most recent occasion of use, where was the ECP obtained? (by gender)



9.4 Knowledge of HIV

Unprotected sex carries an increased risk of exposure to STIs and HIV. Many national studies have demonstrated that knowledge surrounding HIV is generally high, although certain misconceptions still exist (Layte et al., 2006). Four key statements were used in this survey to assess the knowledge of adults living in Ireland about HIV (see Figure 9.8). The results suggest that, in general, many adults have accurate information on the key issues about HIV and how contraception can help prevent the spread of the virus. One noteworthy finding is that just over one-fifth of adults (23%) were not aware that 'having sex with one faithful, uninfected partner reduces the risk of HIV transmission'.

Figure 9.8 Knowledge of HIV-related issues (n=3,002)



9.5 Sexually transmitted infections (STIs) and HIV

9.5.1 Screening for HIV

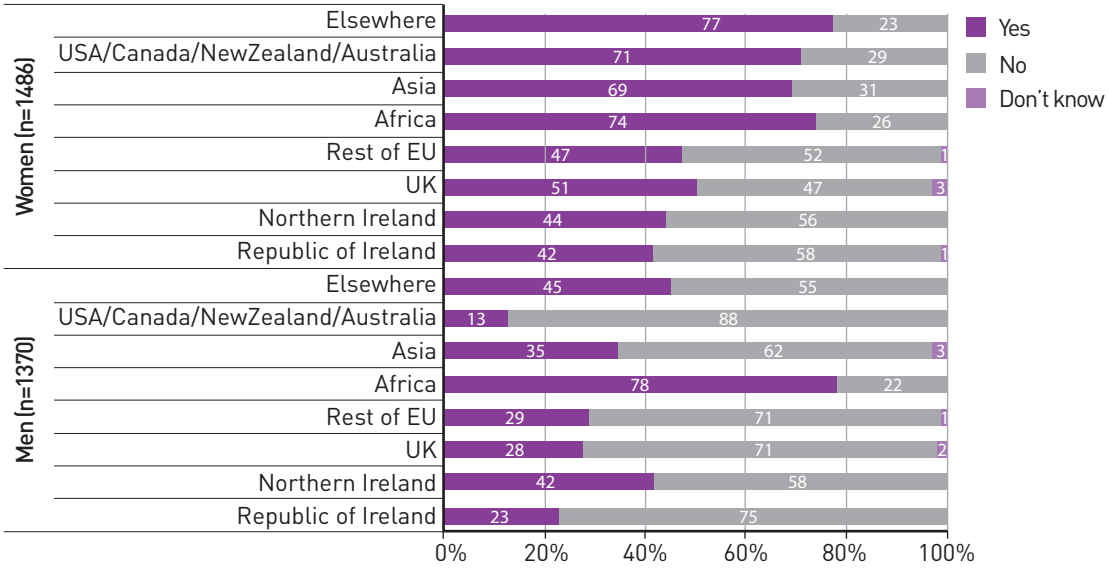
The epidemiology of HIV in Ireland is complex and, due to the voluntary nature of the reporting system, it is likely that the number of case reports is underestimated. In 2010, the Health Protection Surveillance Centre reported that there were 331 new diagnoses of HIV in Ireland. The reported incidence of new HIV diagnoses in Ireland in 2010 was 7.8 per 100,000 of the population (11.3 per 100,000 men and 4.2 per 100,000 women).

Unlike previous knowledge, attitudes and behaviours surveys in Ireland, ICCP-2010 was the first study to ask adults about whether they had been screened and/or diagnosed with HIV or an STI. It is important to note, however, that the location (country) where the HIV test took place was not recorded and, therefore, these estimates do not represent the proportion of HIV tests being conducted in Ireland. Nevertheless, nationally representative data in relation to how many adults living in Ireland have ever sought testing for an STI or HIV, and have ever been diagnosed with an STI or HIV, is important for service planning.

In ICCP-2010, 36% of respondents (26% of men and 45% of women) reported that they had been tested for HIV in their lifetime (n=1,043). It is noteworthy that many women may have been tested for HIV as part of the Voluntary Antenatal Testing in Ireland campaign.

Additional analysis was conducted to explore the levels of HIV testing among those respondents who were born in the Republic of Ireland, compared with those who originated from other countries (see Figure 9.9). The rationale for this analysis was to explore whether the level of testing among those who originated in the Republic of Ireland, which has no national policy in relation to HIV testing, is different to those who originate from other countries that may have different approaches to HIV testing. Again, it is important to note that the study collected information on whether a respondent was tested for HIV, but not the country in which the test took place. It is also important to bear in mind that some of these specific country groups contain small numbers of respondents. One of the most notable findings from this analysis is that the proportion of men and women who were born in the Republic of Ireland and who have been tested for HIV is lower than the proportion of adults from other European countries, including Northern Ireland and Britain.

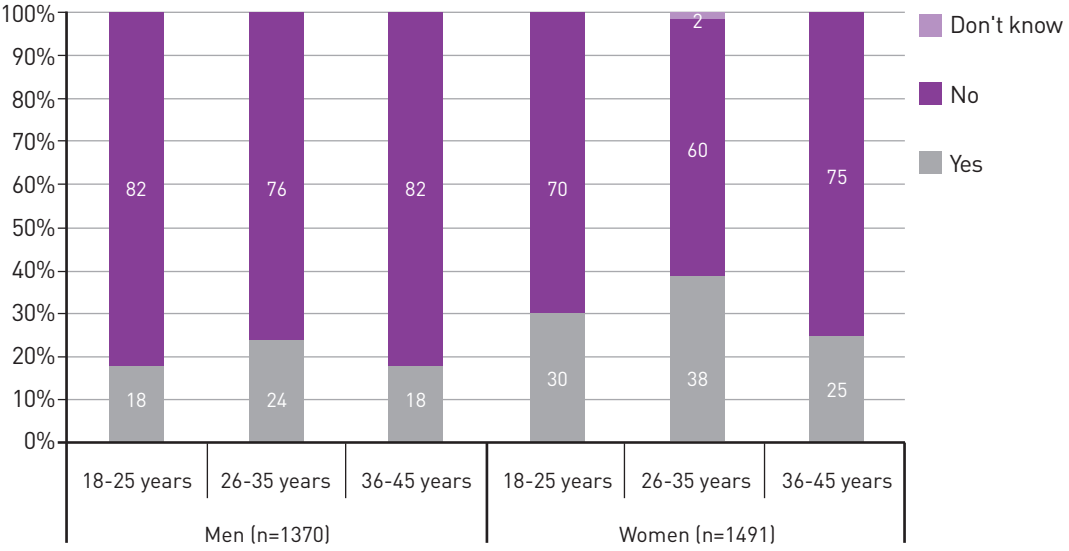
Figure 9.9 Breakdown of HIV testing, by gender and country of birth



9.5.2 Screening for an STI other than HIV

Respondents were also asked whether they had been screened for an STI other than HIV. Overall, 20% of men and 32% of women had been screened for an STI. A breakdown of testing estimates by age and gender is provided in Figure 9.10. The highest proportion of testing for STIs among men and women was in the 26–35 age group, with 24% of men and 38% of women having been tested for an STI. Similar to the HIV testing, it may be that women have routine STI testing during the antenatal period.

Figure 9.10 Breakdown of testing for an STI other than HIV, by gender and age group



9.5.3 Diagnoses of an STI and/or HIV

All respondents who had ever been tested for an STI or for HIV were asked if they were ever diagnosed or told they had an STI or HIV. Of those tested for an STI other than HIV (n=768), 14% of respondents were diagnosed with an infection, with 14% of 18 to 25 year olds, 14% of 26 to 35 year olds and 15% of 36 to 45 year olds being diagnosed. These age differences were not statistically significant ($p>.05$).

The relationship between early sexual history and experiences and an STI diagnosis was then explored. This type of analysis permits the identification of potential risk factors for being diagnosed with an STI. Specific variables of interest include age when first had sex and use of contraception when first had sex. It is important to bear in mind, however, that information relating to the timing of the STI diagnosis was not collected from the respondent, and the data relates to liftetime occurrence. Higher proportions of adults who had sex for the first time before the age of 17 had been diagnosed with an STI (24%), compared with those who waited until after the age of 17 to have sex (11%) ($p<0.01$). Fewer adults who used contraception the first time they had sex were diagnosed with an STI in their lifetime (12%), when compared with those who did not use contraception (23%). Of the 1,043 respondents who had been tested for HIV, a small minority (1%) of adults reported that they had been diagnosed with HIV. Similar analysis exploring the relationship between HIV diagnosis and early sexual experiences could not be conducted for HIV due to the low number of respondents with this diagnosis (n=5).

10.0 Attitudes towards abortion

10.1 Introduction

The issue of abortion in the Republic of Ireland has a longstanding history. Between 1861 and 1992, abortion was entirely illegal in the State. Many women living in Ireland availed of abortion services in Britain following the reform of the abortion law there in 1967. In 1992, a major controversy (commonly referred to as the 'X Case') erupted in Ireland over whether a suicidal minor who was a victim of statutory rape and who became pregnant, could leave Ireland for an abortion that is lawful in another country. This case subsequently established the right of Irish women to an abortion if a pregnant woman's life is at risk because of the pregnancy, including the risk of suicide (Clements and Ingham, 2007). Since 1992, women residing in the Republic of Ireland are legally entitled to travel to other countries to obtain an abortion.

In 2010, a landmark decision was made by the European Court of Human Rights in relation to another case (known as 'Ms C'). The court declared that this woman's rights were violated because there was no procedure to enable her to establish whether she qualified for a lawful termination of pregnancy in accordance with Irish law, even though she feared that her pregnancy would cause the recurrence of cancer. The Court stipulated that Ireland had failed to implement properly the constitutional right to abortion where a woman's life is at risk. In response to this decision, the Irish Government has established an expert group of medical and legal professionals to examine whether changes to abortion legislation in Ireland are needed to ensure that Ireland complies with the European Convention on Human Rights. Thus, accessing changes in public attitudes in relation to complex issues surrounding a woman's right to an abortion is an important issue in the Republic of Ireland, particularly in light of potential future changes to abortion legislation.

One important issue related to the restriction on access to abortion is the illegal sourcing and use of abortifacients (Coles and Koenigs, 2007; Rosing and Archbald, 2000; Sedgh et al., 2007a). Given the sensitive nature of this topic, data sources are limited and accurate information on the occurrence of induced abortion is very difficult to obtain (Sedgh et al., 2007a). Anecdotal evidence has emerged from different Irish sources to suggest that abortifacients are being sourced and used by women living in Ireland. ICCP-2010 provided a unique opportunity to explore this issue in some detail, with the view to providing nationally representative data on adult's knowledge and use of abortifacients in Ireland.

This chapter investigates these issues in more detail by:

- exploring the general public's attitudes towards abortion and identifying any changes since ICCP-2003; and
- examining respondents' knowledge about and use of abortifacients in Ireland.

Attitudinal and knowledge questions relating to abortion and abortifacients in this chapter were asked of all respondents, with follow-up questions being asked as appropriate.

Attitudes towards abortion: key findings

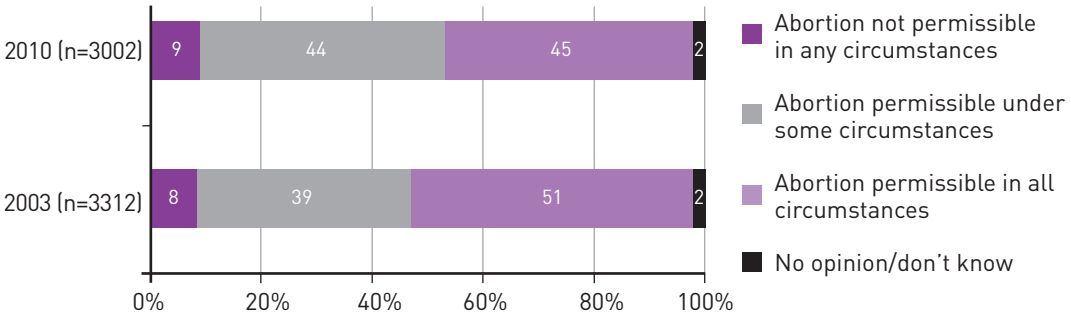
- Approximately 1 in 11 adults (9%) believe that abortion is not permissible in any circumstance. This finding has remained stable since ICCP-2003.
- Fewer adults (45%) are of the opinion that abortion is permissible in all circumstances than were in ICCP-2003 (51%).
- More adults believe that abortion is permissible under certain circumstances (44%), compared with ICCP-2003 (39%); however, attitudes regarding the specific circumstances in which abortion is permissible remained very stable over the seven-year period.
- The most common circumstances when an abortion is deemed permissible is when the pregnancy seriously endangers a woman's life (95%) or health (89%), or when the pregnancy is the result of rape (88%) or incest (86%).
- Less support was evident for an abortion if the child has a serious abnormality (44%), if the couple are not married or in a stable relationship (14%) or if the couple cannot afford another child (11%)
- In relation to abortifacients, 13% of respondents were aware of herbs or medications that can be taken to induce an abortion. When they were questioned about the legality of using abortifacients in Ireland, 75% thought the practice was illegal, 6% thought it was legal and 19% were unsure.
- Of the 13% of adults, men and women, who were aware of abortifacients (n=371), seven adults reported they or their partner had used these types of medication or herbs in Ireland.

10.2 Attitudes towards abortion

The attitudinal questions asked in ICCP-2010 in relation to abortion were very similar to those asked in ICCP-2003. These 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).

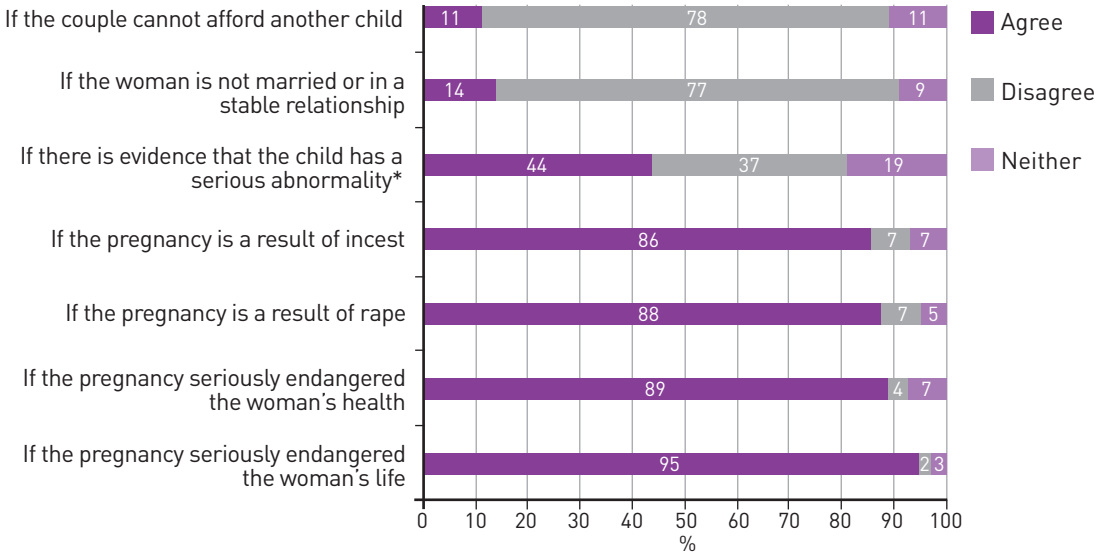
Adults were asked their opinion about whether a woman should have a right to an abortion. Four specific response options were available to respondents, as outlined in Figure 10.1. For those respondents who thought that a woman should have the choice to have an abortion in certain circumstances, or for those who did not have an opinion, a list of possible circumstances were outlined. Results from ICCP-2003 provide a baseline against which any change in attitudes towards abortion in Ireland can be monitored. The proportion of adults reporting that an abortion was not permissible in any circumstances remained stable across the seven-year period.

Figure 10.1 Respondents' views on whether a woman should have the choice to have an abortion (ICCP-2003 and ICCP-2010)



Respondents were asked whether they agreed or disagreed that a woman should have a choice to have an abortion in each circumstance (see Figure 10.2). A comparison with ICCP-2003 reveals that attitudes towards abortion in specific circumstances remained very stable over the intervening seven years. In ICCP-2010, 11% of respondents agreed that an abortion should be permitted if the couple cannot afford another child, compared with 9% of respondents in ICCP-2003. In ICCP-2010, 14% of respondents agreed that an abortion should be allowed if the couple is not married, compared with 12% in ICCP-2003. When the pregnancy resulted from a rape, 88% of respondents in ICCP-2010 agreed that an abortion would be permissible (compared with 87% in ICCP-2003). When the pregnancy resulted from incest, 86% of ICCP-2010 respondents agreed that an abortion would be permissible (compared with 85% in ICCP-2003). The proportion of adults agreeing that a woman should be allowed to have an abortion if her life is in danger has also remained stable across the seven-year period (95% in ICCP-2003; 96% in ICCP-2010). Finally, slightly more adults in ICCP-2010 agreed that an abortion should be permitted if the woman's health is in serious danger (89%), compared with ICCP-2003 (87%). The statement regarding the permissibility of abortion when 'the child has a serious abnormality' has no direct comparison in ICCP-2003, but 44% of adults agreed with this statement in the 2010 survey.

Figure 10.2 Respondents' views on circumstances in which a woman should have the choice to have an abortion (n=3,002)



** The term seriously deformed was used in 2003; 44% agreed that abortion is permissible in this circumstance.*

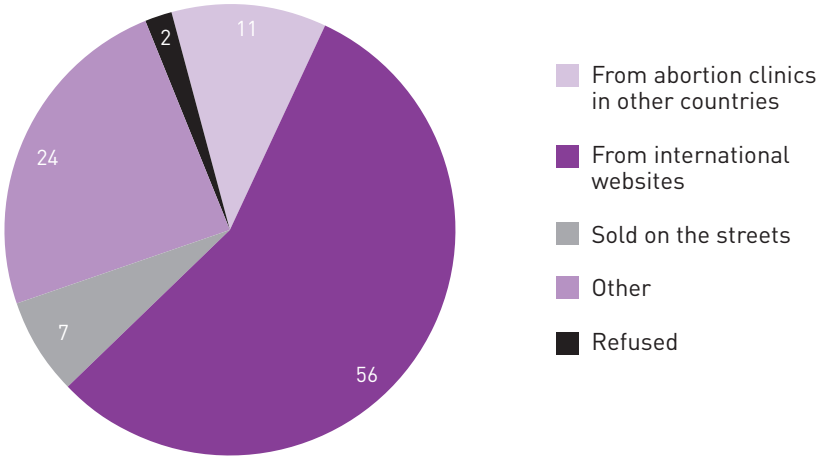
10.3 Knowledge of abortifacients

Anecdotal reports from services in the Republic of Ireland and Northern Ireland suggest that the knowledge and use of abortifacients or abortion pills increased towards the end of the last decade (Caldwell, 2009; Ryan, 2011); however, little empirical Irish data exists relating to the general public's knowledge and use of abortifacients. All ICCP-2010 respondents were asked whether they had heard of any medications or herbs that can be taken at home and used to induce abortion. If required, it was explained to respondents that these medications are often sold under names such as 'abortion pills', 'abortion tablets', RU486 or mifepristone (Mifegyne or Mifeprex). Of those who answered the question (n=2,974), 13% (n=391) had heard of these types of medication or herb. Significantly higher proportions of women (16%) than men (10%) had knowledge of these medications or herbs. There were no significant age differences, with approximately 11% of 18 to 25 year olds, 14% of 26 to 35 year olds and 12% of 36 to 45 year olds being aware of medications available to induce abortion at home.

Respondents who were aware of these medications or herbs (n=391) were asked two additional questions relating to abortifacients. First, their opinion was sought on whether the use of these medications to induce an abortion at home is legal or illegal in Ireland. The majority of respondents (75%) were aware that this practice was illegal, with only 6% indicating that they thought it was legal to use these types of medication or herb. Interestingly, the remaining respondents (19%) indicated that they did not know whether using abortifacients in Ireland was legal or illegal.

Second, respondents were asked if they knew where these herbs or medications could be obtained for use in Ireland (see Figure 10.3). Approximately one-quarter (24%) said yes, with the remainder reporting no (73%) or not sure (3%). Respondents who did report knowledge on where such medications or herbs can be sourced for use in Ireland were asked for more specific information. It is important to note that these results are based on a small number of respondents (n=106). Over half (56%) of respondents who answered this question reported that such medications and herbs could be sourced from international websites for use in Ireland. Approximately 1 in 10 respondents (11%) reported that medication could be obtained from abortion clinics in other countries, whereas 7% thought that these supplies were available for sale on the black market on the street. The 'other' category included information relating to obtaining supplies from homeopathies, pharmacies and other commercial outlets.

Figure 10.3 Locations where abortifacients can be sourced for use in Ireland (n=109)



All respondents who had ever had heterosexual intercourse and had heard of abortifacients (n=371) were asked if they or their partner had ever used such medications or herbs in Ireland. A small minority (n=7) reported that they had used these substances in Ireland.

11.0 Pregnancy experiences of Polish and Nigerian women living in Ireland

11.1 Introduction

Previous chapters in this report have explored in detail the topic of sexual health and pregnancy among adults living in Ireland. The results reveal that while knowledge and use of contraception is common among adults living in Ireland, the issue of crisis pregnancy remains prevalent, particularly among women. As outlined in Section 2.2.2, a secondary aim of the 2010 survey was to recruit a sample of women who were not born in Ireland but who moved to Ireland after early adolescence and to assess their knowledge, attitudes and behaviours in relation to sexual health and pregnancy. An opportunistic sample of Polish and Nigerian women aged 18 to 34 years (n=261) who were living in Ireland at the end of 2010 was recruited (referred to as the 'supplement sample'). All of these women had moved to live in Ireland after the age of 13 years. This lower age limit was chosen because it was important to obtain the viewpoints of women who had received their primary education outside the Irish system, to explore whether their knowledge, attitudes and behaviours would be different to women living in Ireland. The upper age limit was chosen to focus on women of childbearing age.

As described in Section 2.3.2, a separate, shortened questionnaire was administered to the supplement sample. Prior to generating this questionnaire, the project team consulted a number of not-for-profit organisations that work on a regular basis with non-Irish nationals. Draft versions of the questionnaire were discussed with these organisations to ensure that the content and language used would be relevant and easily understood by women who had spent their early years living outside the Republic of Ireland. Subsequently, the project team consulted with a number of Polish and Nigerian interviewers who had been conducting interviews for the national sample. Following their input, a number of minor revisions were made to the questionnaire, which was then piloted using a small sample of Polish and Nigerian women (n=10). Once the project team was satisfied that the questionnaire had been well received by the targeted group of women, recruitment and interviewing of the supplement sample began.

The main aim of the questionnaire was to seek information on:

- knowledge and use of contraception, including natural or traditional methods; and
- experiences of pregnancy and crisis pregnancy.

This chapter analyses data from the supplement sample to explore these areas. Direct comparisons to the national sample are limited due to the opportunistic nature of the supplement sample; however, efforts will be made to highlight tentatively the similarities and differences between the two samples.

Pregnancy experiences of Polish and Nigerian women living in Ireland: key findings

- Similar to the national sample, knowledge of contraceptive methods was high among Polish and Nigerian women: 84% of Nigerian women and 90% of Polish women were aware that there are products or methods that men and women could or do use to avoid pregnancy.
- The majority (94%) of Polish and Nigerian women surveyed had used some type of contraception during the previous year.
- Over two-thirds (68%) of the women had children: 88% of Nigerian women and 60% of Polish women.
- Crisis pregnancy was common among the Polish and Nigerian women in this sample, with over one-fifth (23%) of women reporting that they had experienced a pregnancy when they did not want to be pregnant.
- Differences between Polish and Nigerian women were evident in relation to what happened after they discovered they were pregnant with an unwanted pregnancy. None of the Polish women in this sample reported attempting to stop the pregnancy. Just over one-third (34%) of Nigerian women in this sample who had experienced a crisis pregnancy ended the unwanted pregnancy.
- Similar to the national sample, the main reasons given by Polish and Nigerian women for viewing the pregnancy as a crisis was that the pregnancy was not planned or that the woman felt she was too young at the time.

11.2 Overview of the supplement sample

The majority of women comprising the supplement sample were in the 26–35 age group (76%), had moved to Ireland between the ages of 18 and 25 (53%), were married or cohabiting with their partner in Ireland (64%), were employed (53%) and had a third-level education (52%). Half the sample had a full medical card (50%). Table 11.1 presents these characteristics by country of origin.

Table 11.1 Demographic characteristics of the supplement sample, by country of origin

Demographic characteristics	Polish (n=131)		Nigerian (n=130)†	
	n	%	n	%
Current age				
18–25 years	26	20	37	29
26–35 years	105	80	93	71
Age when moved to Ireland				
17 years or younger	3	2	42	32
18–25 years	89	68	50	39
26–35 years	39	30	38	29
Marital status				
Single	23	18	52	40
Cohabiting	36	28	12	9
Married and living with partner in Ireland	66	50	52	40
Married but not living with partner in Ireland	1	<1	8	6
Previously married	5	4	5	4
Educational level				
Primary	2	2	6	5
Secondary	55	42	61	47
Third	63	48	50	39
Other	11	8	13	10
Employment				
Full time	69	53	13	10
Part time	29	22	29	22
Unemployed	33	25	88	68
Medical card				
Yes, full	46	35	84	65
Yes, GP-only	12	9	18	14
No	73	56	28	21

† Marital status data is missing for one case (N=129).

Significant differences exist between the Polish and Nigerian women in relation to the age when they first moved to Ireland and their marital, employment and medical card status ($p<0.01$).

11.3 Knowledge of contraception

All respondents were asked if they had heard of any ways or methods that a man or a woman can use to delay or avoid pregnancy. The majority of respondents (84% of Nigerian women and 90% of Polish women) were aware that there were things or products that men and women could do or use to avoid pregnancy (n=223). Women who were not aware of any contraceptive methods (n=38) were not asked additional questions in relation to contraception. Women who were aware of contraceptive methods were asked to give additional information on these methods (see Table 11.2).

Table 11.2 Knowledge of supplement sample about ways or methods that can be used to avoid pregnancy, by country of origin

Method of contraception	Polish (n=116)	Nigerian (n=107)	Total (n=223)	
	%	%	%	
Conventional methods				
Contraceptive pill	92	69	81	**
Condom/Durex	85	66	76	**
Contraceptive ring (NuvaRing)	7	10	9	
Contraceptive patch (Ortha Evra)	20	25	22	
Coil (Mirena)	32	36	34	
Cap/diaphragm	3	3	3	
Gels, sprays, pessaries	7	3	5	
Injections (Depo Provera) or implanted contraceptive capsules (Implanon)	27	50	38	**
Vasectomy/tubal ligation	3	6	5	
Natural methods				
Safe period/rhythm method	53	14	35	**
Withdrawal	8	8	8	
Abstinence	9	10	9	
Other/traditional methods				
Concoction (herbs, etc.)	0	2	1	
Drinking salted water	0	4	2	*
Fizzy drinks	0	2	1	
Abortion	3	1	2	

Note: Respondents could choose more than one response so columns may not total to 100%.
*Significant nationality differences: *p<0.05; **p<0.001.*

The majority of Polish and Nigerian women were aware of conventional contraceptive methods, such as the contraceptive pill (81%) and condoms (76%), although more Polish women than Nigerian women were aware of these specific methods. Higher proportions of Polish women reported the safe period or rhythm method as a practice to avoid or delay pregnancy. More Nigerian women reported long-term contraceptive methods, such as contraceptive injections or capsules, compared with their Polish counterparts.

11.4 Sexual history

All women were asked if they had ever had sex. One woman refused to answer this question. Similar to the national sample, the majority of the women in the supplement sample had experienced sex (95% of Nigerian women and 97% of Polish women). A small proportion of women in this sample had never had sex (4%), which is also in line with the national sample (5%). A slightly higher proportion of respondents in the supplement sample were pregnant or trying to conceive (13%), compared with respondents in the national sample (11%).

All respondents were asked about their experience of sex during the previous year. Two women failed to provide information in relation to this issue. A breakdown of the sexual history of the remaining respondents (n=258) is presented in Table 11.3. Women who did not experience sex were not asked any additional questions in this section.

Table 11.3 Current sexual status of supplement sample, by country of origin

Current status	Nigerian (n=127)	Polish (n=131)	Total (n=258)
	%	%	%
Never had sex	4	3	4
Did not have sex during the previous year	10	2	6
Currently pregnant	6	9	7
Had sex during the previous year, not currently trying to conceive	75	80	77
Had sex during the previous year, currently trying to conceive	6	6	6

11.5 Contraceptive use

All women who had ever had sex (n=250) were asked if they had ever used a condom when having sex. The vast majority (84%) of these women had used a condom while having sex at some point in their lifetime.

Women in this sample who had sex during the previous year and who were not pregnant or actively trying to conceive (n=198) were asked a number of questions in relation to their contraceptive use during the previous year. The majority (n=189) provided information on their contraceptive use, as presented in Table 11.4. Most (94%) of these women had used some method of contraception. The proportion of women in the supplement sample who had not used any contraception during the previous year (6%) was the same as that for all adults recruited in the national sample (6%).

The most commonly used forms of contraception during the previous year were: condoms only (41%), the contraceptive pill only (21%) or a combination of condoms and the contraceptive pill (16%). Whilst the format of questions in the questionnaire for the supplement sample does not allow direct comparisons in relation to contraceptive use, similarities between this sample and the national sample include a high proportion of respondents reporting that they use condoms and/or the contraceptive pill. Use of LARCs (e.g., coil, implant, capsules, injections) was common, but lower than other forms of contraception.

Table 11.4 Contraceptive methods used by women in the supplement sample who had had sex during the previous year, by country of origin

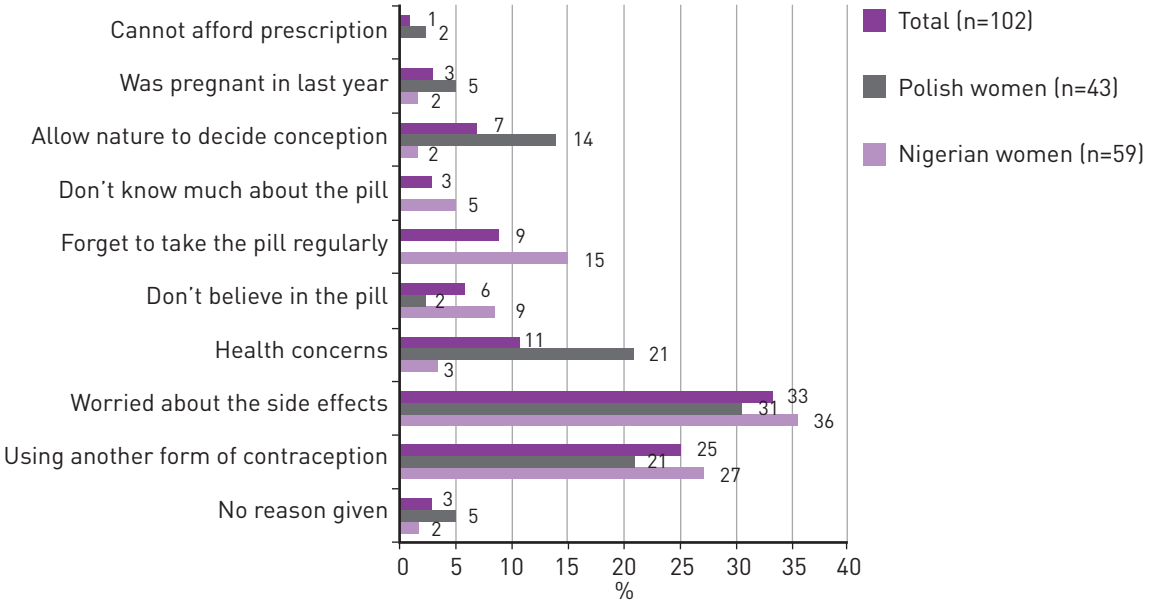
Contraceptive use	Polish (n=99)	Nigerian (n=90)	Total (n=189)
	%	%	%
Condoms only	34	48	41
Condoms and contraceptive pill	23	8	16
Contraceptive pill only	26	16	21
Contraceptive ring/patch	5	2	4
Implant/capsule/injections	0	9	4
Coil	2	4	3
Condoms and contraceptive ring/patch	0	2	1
Condoms and rhythm method	0	1	1
Natural methods only†	2	3	3
Traditional methods only††	0	1	1
No method used	7	6	6

† Includes methods such as withdrawal, safe period, rhythm method.
†† Includes methods such as herbs, concoctions, lemon juice, fizzy drinks, salted water.

Additional questions were asked in relation to condom and contraceptive pill use to elicit information about the reasons why women either choose to use or choose not to use these specific types of contraception. First, women who reported using condoms as a method of contraception during the previous year (n=116) were asked to describe their main reason for using this method when they had sex. Seven in ten women reported that their main reason for using a condom while having sex was to prevent a pregnancy; nearly one-quarter said they wanted to protect against HIV or other infections and against pregnancy; and 6% said that primarily they wanted to protect against HIV or other infections.

Second, all women who had had sex during the previous year and who had heard of the contraceptive pill but did not report using it during the previous year (n=102) were asked about their reasons for not using this type of contraception as protection against pregnancy (see Figure 11.1). Concern about the side effects of the contraceptive pill (e.g., weight gain or mood swings/irritability) appeared to the most common reason for not using the pill (33%), and approximately one-quarter of the women reported using another form of contraception during the previous year. Other reasons given for not using the contraceptive pill included having health concerns about using the pill (e.g., a history of breast cancer in the family) or forgetting to take the pill regularly thereby rendering it ineffective.

Figure 11.1 Reasons why sexually active women in the supplement sample who were not trying to conceive did not use the contraceptive pill as a method of contraception during the previous year, by country of origin

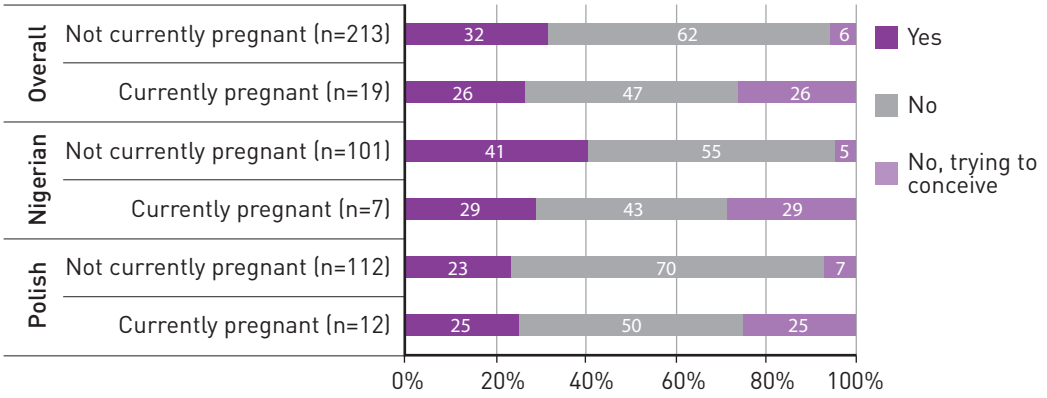


11.6 Experiences of pregnancy

The next section of the questionnaire asked women who had ever had sex (n=251) about their experiences of pregnancy. At the time of the survey, 7% of women were pregnant (9% of Polish women and 6% of Nigerian women). Over two-thirds (68%) of the women in this sample had children, with a higher proportion of Nigerian women (88%) reporting that they had children than Polish women (60%). Approximately 1 in 5 women (22%) had experienced a miscarriage or a stillbirth. The estimates for miscarriage and stillbirth in this sample are very similar to those experienced by women aged 18 to 45 in the national sample (miscarriage 20%, stillbirth less than 1%). Nearly seven out of ten women surveyed in the supplementary sample reported that they would like to have a child or more children in the future.

Women were asked about their attitudes towards becoming pregnant. Those women who were pregnant at the time of the interview were asked whether they had been worried about becoming pregnant before they got pregnant. The other women were asked if they had been worried about becoming pregnant during the previous year. As can be seen in Figure 11.2, almost one-third of women who were not pregnant at the time of the interview had been worried that they would become pregnant when they had had sex during the previous year. More Nigerian women (41%) had this type of concern than Polish women (23%). Approximately one-quarter of women (26%) who were pregnant at the time of the interview reported that before they became pregnant they had worried that they would become pregnant.

Figure 11.2 Concern during the previous year about becoming pregnant among the supplement sample, by country of origin



In the last year, were you worried that you might become pregnant when you had sex?

11.7 Experiences of crisis pregnancy

An important aim in recruiting the supplement sample was to obtain information about the experiences of non-Irish national women in relation to crisis pregnancy. As outlined earlier in this chapter (and in Chapter 2), the questionnaire administered to the supplement sample was different to the questionnaire administered to the national sample. Whilst it was important to gain an understanding of the experiences of crisis pregnancy among this sample, it was considered appropriate[5] to revise the definition of crisis pregnancy to make it more applicable to the experiences of this sample.

Specifically, all women who had ever had sex (n=251) were asked if there was ever a time in their lives when they had been pregnant but they did not want to be. Over one-fifth (23%) of women said that they had been pregnant when they did not want to be. Assuming this estimate to be a marker for a 'crisis pregnancy', a lower proportion of women in the non-Irish national sample experienced a crisis pregnancy than women in the national sample (35%). A significantly higher proportion of Nigerian women (42%) reported having been pregnant when they did not want to be, compared with Polish women (6%) ($p<0.001$).

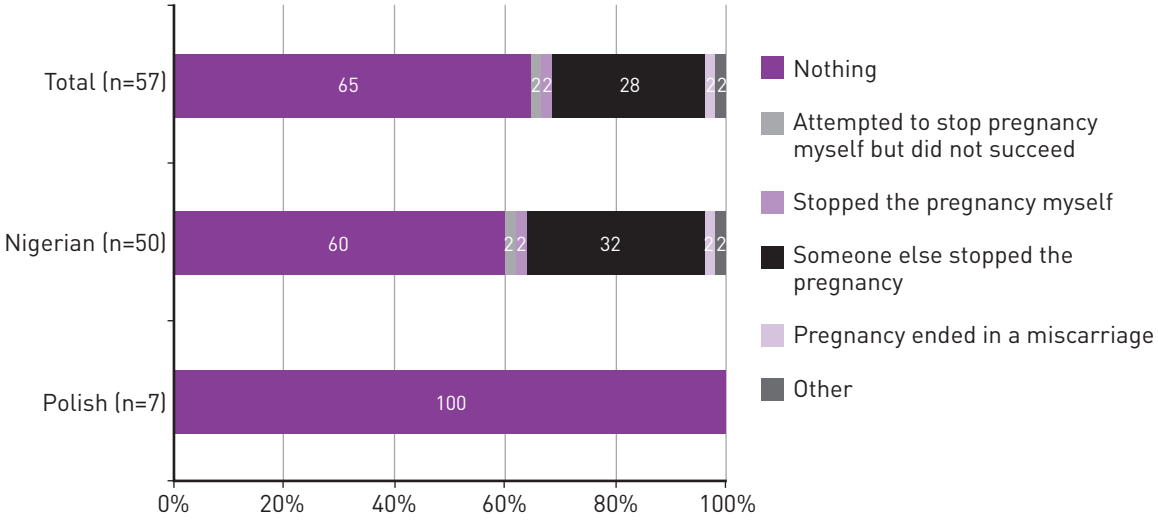
All women who had experienced an unwanted pregnancy (n=58) were asked to describe what they did when they found out that they were pregnant. The interviewers listened to the respondent's answer and then coded it into a pre-defined list of options. These options were created using information gathered from a number of sources, including previous research and information sourced from organisations who deal with issues of importance to non-Irish nationals. In line with advice received from various sources during the questionnaire development phase, the term 'abortion' was not used in this section of the survey. This was because the term 'abortion' often refers specifically to a legal procedure carried out by an authorised medical professional, but may not cover attempts to have

5 Following consultations with the Advisory Group for ICCP-2010, Polish and Nigerian interviewers, and charities/organisations that work with non-Irish national women.

an abortion by illegal methods. Six different response options were devised to cover all potential outcomes when a women finds herself pregnant but does not want to be.

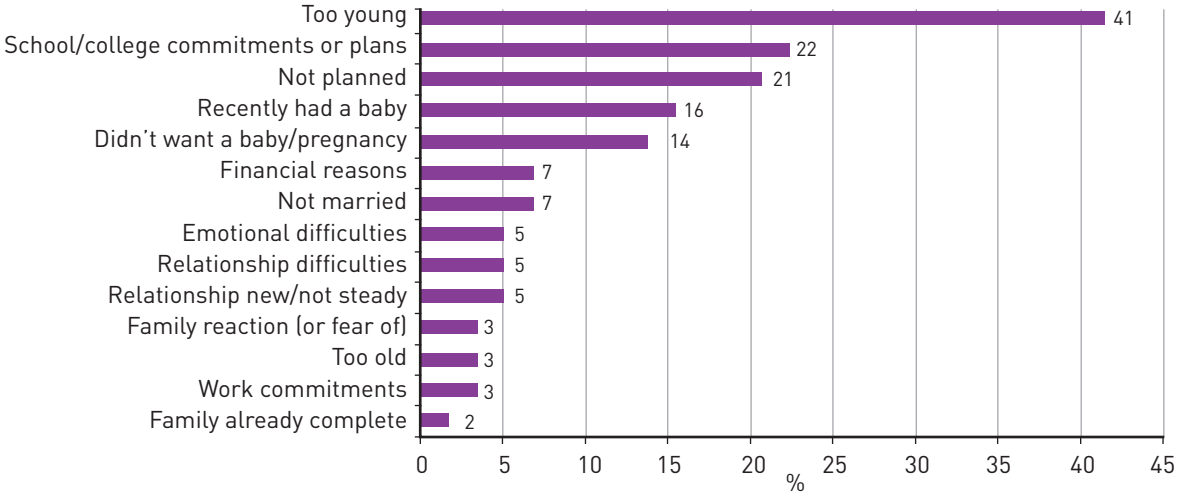
As can be seen in Figure 11.3, there were differences between Polish and Nigerian women in relation to what happened after they discovered they were pregnant with an unwanted pregnancy. None of the Polish women in this sample reported attempting to stop the pregnancy. It is likely that these women continued on with the pregnancy and gave birth. In contrast, nearly one-third (32%) of Nigerian women ended an unwanted pregnancy by having an abortion. Moreover, another small proportion of Nigerian women attempted to stop the pregnancy themselves, but were unsuccessful in doing so.

Figure 11.3 Response of supplement sample to an unwanted pregnancy, by country of origin



All women who had experienced an unwanted pregnancy were asked to describe why this was the case for them at that time. As illustrated in Figure 11.4, the three main reasons given to explain why the pregnancy was unwanted were: being too young, having school or college commitments or plans, and the pregnancy not being planned. These three reasons were among the main reasons reported by women who were recruited for the national sample in this study (see Section 7.4.2).

Figure 11.4 Reasons given by supplement sample on why pregnancy was unwanted (n=57)



Note: Respondents could choose more than one response.

11.8 Knowledge of abortifacients

The final section of the questionnaire assessed women's knowledge of abortifacients. These questions were similar to the questions asked of the national sample. Specifically, all women were asked if they had heard of any herbs or medications that can be taken at home and used to end a pregnancy. One in five women (20%) said that they were aware of these types of medication. Upon closer inspection, however, references to the morning after pill were excluded from the analysis, resulting in a smaller proportion (12%; n=6). This is similar to the national sample, where 13% of adults were aware of abortifacients (see Section 10.3). Within the supplement sample, a number of sources for these types of herb and medication were reported, including international websites, the streets, and from people bringing them to Ireland from other countries.

11.9 Conclusion

This chapter provided important quantitative data on the contraceptive needs and pregnancy experiences of women living in Ireland in 2010 who have specific cultural and ethnic backgrounds because they grew up in other countries. The results suggest that the concept of crisis pregnancy is prevalent among Nigerian and Polish women living in Ireland. This information, along with research findings from other studies, will help pregnancy-related services in Ireland to plan for dealing with the experiences of all women in Irish society.

12.0 Conclusion

12.1 Introduction

Conducting ICCP-2010 provided a unique opportunity to replicate a major national survey (ICCP-2003) after a seven-year period, using a robust methodological design, which included landline and mobile telephone recruitment. This successful survey, with its large sample size (n=3,002) and high response rate (69%), builds on existing Irish research in the areas of pregnancy and sexual health, as will be discussed in this chapter.

12.2 Positive changes in sexual health and pregnancy profiles, 2003–2010

Several findings from this survey provide evidence of positive changes in the areas of sexual health and pregnancy in Ireland over the seven years from 2003 to 2010. Some of the most important findings relate to young adults (aged 18 to 25). The results show that a sizeable proportion of young men and women in this age group have not had sex and suggests that they may be waiting until they are older to have sex for the first time; this proportion has remained stable over the period (13% in ICCP-2003 and 15% in ICCP-2010). Of those respondents surveyed in 2010 who had experienced sex, higher proportions of younger adults (18 to 25 years), compared with older adults (26 to 45 years), used contraception the first time they had sex. Adults who had received some sex education were almost twice as likely to use contraception the first time they had sex, compared with those who had not received sex education. These results indicate that sex education plays an important role in determining contraception use on the occasion of first sexual intercourse.

The proportion of adults, particularly young adults aged 18 to 25, reporting that the sex education they received was helpful in preparing them for adult relationships has increased since the ISSHR in 2006. While this is an important finding, the data also reveal that fewer parents in ICCP-2010 (70%), compared with ICCP-2003 (82%), reported that they or their partner had talked to their children aged between 12 and 18 about sex. It would be very useful to have more information on what issues parents address with their children in relation to sex education, how their education could be complementary to that delivered in school, and what their needs are in terms of educational materials to help them engage most effectively with their children on the topics of sex and relationships. These findings have important implications for future policies on sex education, particularly the need to ensure that such education takes place in the home and in school in complementary ways.

More young adults aged 18 to 25 surveyed in 2010 reported consistently using contraception every time they had sex, compared with ICCP-2003. Use of the contraceptive pill, ring, patch and injections increased for all adults over the seven-year period, and was especially prevalent among the youngest age group (18–25). The proportion of young adults in this age group who relied on less robust methods of contraception (e.g., withdrawal, safe period) had decreased since ICCP-2003, whereas

the proportion choosing to abstain from sex as a method of avoiding pregnancy remained stable. The results also reveal that higher proportions of people surveyed in 2010, particularly young adults aged 18 to 25, had used the emergency contraceptive pill (ECP) during the previous year, compared with ICCP-2003. Collectively, these findings are encouraging because it is widely recognised that consistent use of reliable forms of contraception should reduce the likelihood of a couple experiencing a crisis pregnancy. Continued high levels of condom usage among young adults from ICCP-2003 (55%) to ICCP-2010 (61%) is a very promising finding, as many other contraceptives do not protect individuals against STIs.

Generally, the aforementioned findings are positive and reassuring. They suggest that sex education and national contraception campaigns, mostly aimed at younger people in terms of messages and visual images, may be reaching their target audience.

12.3 Areas of challenge for on-going improvement of sexual health profiles

Analysis of the ICCP-2010 data, as well as comparisons with ICCP-2003, reveal a number of important areas that require additional work. Of interest are the findings relating to a potentially vulnerable group of young adults – those who are not waiting until adulthood to have sex, but who are instead initiating sex before the legal age of consent in Ireland (i.e., before 17 years of age). The proportion of young people who experienced sex for the first time before the age of 17 increased for women over the seven-year period between the surveys (i.e., from 21% in ICCP-2003 to 26% in ICCP-2010 for those currently aged 18 to 25), while remaining stable, albeit at a slightly lower level, for men in the same age group (39% in ICCP-2003 to 37% in ICCP-2010). This finding may signal more 'harmonisation' of the experiences of same-aged men and women. However, additional research is necessary to examine the patterns of partner age at first sexual experience to explore whether more same-age sexual relations are developing.

Overall, the findings for young adults are positive, given that a large proportion of them are waiting to have sex at an older age; nevertheless, it is important to consider that young women are potentially at increased risk for experiencing adverse outcomes as a result of initiating sex at an early age. A continued focus on young women is needed to ensure that any possible converging of the ages of first sex of young men and women does not mean that the proportion of young women having early sex rises to the level currently reported for young men.

Information given by adults recalling their experiences of the first time they had sex can be useful in helping to identify those people who are at risk for experiencing first sex before the legal age of consent. Adult respondents in this survey who were men, younger in age, had a pre-Leaving Certificate education and were in lower social classes were significantly more likely to have experienced sex for the first time before the age of 17. These characteristics remain the same from ICCP-2003.

ICCP-2010 provides strong evidence that positive developments and improvements have occurred in relation to consistent contraception use among young people every time they had sex; however, consistent use of contraception among adults aged 26 to 45 had decreased over the seven-year period from ICCP-2003. Moreover, complete non-use of contraception during the previous year among people who were sexually active and at risk of pregnancy but not actively trying to conceive was more prevalent among older adults (aged 26 to 45) than among younger adults (aged 18 to 25). The reason most often given for not using contraception was 'took a chance' (20%). The next most common reasons showed marked decreases from ICCP-2003: 'drinking alcohol/taking drugs' at the time (16% in 2010, down from 21% in 2003) and 'sex was not planned/not prepared/ no contraception available' (15% in 2010, down from 48% in 2003). In terms of the latter, the decrease was particularly noticeable amongst 18 to 25 year olds, with the percentage citing this reason falling sharply from 58% in 2003 to 19% in 2010.

In relation to crisis pregnancies, there was an increase in the proportion of women reporting lifetime prevalence of a crisis pregnancy (from 28% in ICCP-2003 to 35% in ICCP-2010), with more stability among men (22% in ICCP-2003 and 21% in ICCP-2010). The increase for women spans all age groups, which provides strong evidence that crisis pregnancy remains an important issue for women living in Ireland, regardless of age. The pregnancy 'not being planned' or the respondent 'being too young' at the time the pregnancy occurred were the two main reasons given for describing a pregnancy as a crisis. These reasons had not changed over the seven-year period; however, financial reasons were reported more often in ICCP-2010 than in ICCP-2003. Given the rising unemployment rate and increased economic instability in Ireland, this finding is not surprising. ICCP-2010 data also highlight the important negative emotional impact that a crisis pregnancy can have on a woman's mental health. Almost one-quarter of those women who reported psychological distress during the time of the crisis pregnancy had had thoughts of self-harming or 'ending it all'. Collectively, these findings suggest that, despite many social as well as economic changes in Irish society in the recent past, crisis pregnancy is an area of grave concern with the potential to cause great distress to those affected.

Another notable finding in ICCP-2010 is the relatively high level of ambivalence towards pregnancy among older adults (aged 26 to 45), which was not evident among the younger group. Of those who did not use contraception consistently every time they had sex, 1 in 7 adults aged 26 to 35 and 1 in 5 adults aged 36 to 45 reported that they 'did not care if pregnancy happened'. It is important to note, however, that adults in this age range are still fertile and risk pregnancy if they are having unprotected sexual intercourse. Thus, there appears to be a slight discrepancy between the rather high levels of ambivalence towards pregnancy among this age group, and the rise in the level of crisis pregnancy experienced by women over their lifetime. It is likely that there are many reasons for this apparent discrepancy, which are difficult to explore in this survey given that factors relating to ambivalence towards pregnancy were not explored in detail. This is an important area for future research, particularly research of a qualitative nature.

The proportion of adults expressing difficulty in accessing contraception had been low in ICCP-2003 (4% of women and 6% of men) and it is noteworthy that there was an increase in the numbers reporting difficulty in ICCP-2010 (15% of women and 9% of men). Locality, cost and embarrassment were all reported as barriers to access. The rise in the level of difficulty is somewhat surprising, given that it might be expected that access to contraception in Ireland would have become easier in recent years. Difficulty in accessing contraception remains an important issue. It may be that more readily available access to affordable contraception would increase the use of contraception.

In conclusion, ICCP-2010 is the third national study in Ireland in the area of sexual health and pregnancy. The results, in combination with the other surveys (ICCP-2003 and ISSHR), provide a wealth of information on important trends in sexual behaviour, contraceptive use and pregnancy outcomes among adults living in Ireland. This evidence-based information will be valuable for developing national policies for the provision of sexual health and pregnancy-related services over the coming years.

13.0 Recommendations from the HSE Crisis Pregnancy Programme

Since 2002, the Crisis Pregnancy Programme (former Agency) has led an evidence-based approach to strategy formulation, implementation and evaluation. To date two national strategies on crisis pregnancy prevention have been implemented, in partnership with a broad range of statutory and non-statutory bodies and organisations. This survey, the 2010 Irish Contraception and Crisis Pregnancy Study (ICCP 2010), was commissioned to provide nationally representative survey data that, taken together with other measures, will enable the Programme to assess and evaluate the impact of its work. The ICCP 2010 survey has also provided crucial data to inform the Programme's third national strategy (2012-2016) on crisis pregnancy prevention.

The findings from this survey provide a robust snapshot of behavioural and attitudinal shifts over a seven-year period from 2003 to 2010. The findings from the report, when compared to findings from the first Irish Contraception and Crisis Pregnancy Study (ICCP 2003) and also the Irish Study of Sexual Health and Relationships 2006 (ISSHR), provide a sound evidence base for the recommendations presented below.

It is a challenge to change risky sexual behaviours and prevent the negative sexual health outcomes that arise from these. This report builds on a substantial evidence base established by the Programme to address why couples have unprotected sexual intercourse when they do not want to become pregnant or contract an STI. The findings from this report help us to understand better these reasons, to gauge over time their relative importance, to identify changes in the patterns of those most at risk of negative sexual health outcomes and to provide an indication of where our collective efforts are having an impact and where they are not.

The recommendations follow the sequence of the chapters outlining the results of ICCP 2010, as well as comparisons to ICCP 2003 and ISSHR 2006, as indicated.

13.1 First sexual experiences

Chapter three demonstrates very positive trends in relation to the age of first sex in Ireland and contraceptive use. Findings highlight at-risk groups, potential trends into the future and suggest where our prevention efforts need to be more clearly focused.

Findings show that a larger proportion of 18-25 year olds in 2010 have not yet had sex compared to 2003, suggesting increasing numbers of young men and women living in Ireland today are waiting until they are older to have sex for the first time. In addition, over the two time-periods, the average age of first sex among 18–25 year old men or women has remained relatively stable. The median age of first sexual intercourse for young men (18-25 years) is the same as it was in 2003, at 17 years, and for women the age of first sex increased to 18 years, from 17 in 2003. In addition to these positive findings, increasing numbers of young people are using contraception the first time they have sex now compared to previous surveys. Overall, 90% of adults aged between 18 and 25 report

that they used contraception the first time they had sex compared to 80% in 2003. These very positive findings provide an explanation for the year-on-year reductions in teenage births in Ireland and the large reductions in the number of teenagers travelling to the UK for abortion. When teenagers are having sex, they are more likely to use contraception, primarily condoms, and this implies increased levels of planning and forethought prior to sexual intercourse.

While the majority of females are waiting a little longer before having first sex, among those who have had sex the data also shows that there is a larger proportion of young women who experienced sex for the first time before the legal age of consent in the 2010 survey. Findings also demonstrate that clear risk factors remain for not using contraception at first sex, such as economic hardship and educational disadvantage. Risk factors related to non-use of contraception at first sex for the younger age groups were: being male, having a pre-leaving certificate education only, being in lower social classes, and having sex before the age of 16.

Recommendations:

1. Sexual health education and promotion programmes should maintain a focus on empowering young people to take responsibility for their sexual behaviours and ensure relevant, evidence-informed initiatives such as www.b4udecide.ie are rolled out in school, home and community settings.
2. To address the increasing proportion of girls who are sexually active before 17 years, efforts should focus on early intervention, targeting girls in their early teenager years (12-15 years) with messages that promote healthy, responsible decision-making and the importance of self esteem, such as the 'b4udecide.ie' campaign messages. It will also be important to continue to focus on promoting contraceptive use among young people and ensure the proportion of young women and men using contraception at first sex continues to increase.
3. It will be very important that policy relevant to these findings developed by the Department of Children and Youth Affairs and the Department of Health strives to balance child protection concerns with the sexual health needs of sexually active young people to promote engagement with a range of sexual health service providers and health and education specialists.
4. Those at highest risk of not using any contraception at first sex (economically disadvantaged young men at risk of early school-leaving) should have priority access to supports and programmes that can encourage condom use. Initiatives to improve access to a range of health professionals and availability of free condoms in services need to be considered as part of policy developments in the area of sexual health.
5. In addition, young people might benefit from campaigns targeting them through youth venues and programmes, sports organisations, extra curricular educational venues and social welfare sources, with specific sexual health promotion strategies for the 'always use condoms' message.

13.2 Use of contraception

Chapter four focuses on contraceptive use and presents some findings suggesting new trends in usage in different age groups. For younger adults the findings are positive. Use of contraception in the last year among people who are sexually active, not actively trying to conceive and at risk of pregnancy, is higher in the younger age groups compared to older adults (1.5% of 18-25 year olds did not use contraception in the last year compared to 4.7% of 26-35 year olds and 11.2% in the oldest age group).The study also found that the proportion of young people who consistently used contraception every time they had sex had increased slightly between 2003 and 2010.

The single biggest reason for not using contraception was that people did not appear to be prepared – they simply took a chance if they had no contraception at the time they had sex; this has not changed over the seven-year period. The data suggests, however, that the proportion of people attributing their non-use of contraception to alcohol and drugs has decreased over the seven-year period.

There has been a significant increase in use of medium- and long-term contraceptive methods over the seven-year time period, particularly among 18-24 year olds. Use of medium-term methods (e.g. contraceptive ring, patch, or injection) increased (from 4.3% in ICCP 2003 to 12.0% in ICCP 2010). The use of long-acting reversible contraceptives (LARCs), such as the coil, IUD, or Mirena, increased in the overall population, from 5.7% in ICCP 2003 to 10.9% in ICCP 2010 - this change was mainly in the 26-45 age range. These contraceptives do not protect against sexually transmitted infections. However, the study found an overall increase in condom use from 57% in ICCP 2003 to 61% in ICCP 2010.

For older age groups there has been a slight decline in the proportion using contraception consistently, particularly for adults aged between 36 and 45 years. This may be explained by high levels of ambivalence to an unplanned pregnancy among older adults in comparison to their younger counterparts. One in seven adults aged 26-35 years and one in five adults aged 36-45 years who did not consistently use contraception every time they had sex reported that they 'did not care if pregnancy happened'.

Recommendations:

1. Significant work has been undertaken to promote condom and contraceptive use and to establish protective behavioural norms regarding consistent and correct contraceptive use in key at-risk groups. This work needs to continue.
2. The reported reduction in the role of alcohol or drugs in unprotected sex, particularly among the young, is very positive. We still see, however, that a quarter of 18–25 year olds give alcohol and drugs as reasons for non-use of contraception. Educational initiatives, programmes and campaigns aimed at raising awareness of sexual risk where alcohol and/or drugs have been consumed must be continued.

3. The evidence of ambivalence regarding pregnancy, together with complacency regarding consistent use of contraception and unintended pregnancy among 'older' (>25 years) adults is noteworthy. Additional qualitative research may be necessary to understand the reasons for this before solutions can be proposed.
4. While the increasing use of LARCS, particularly among younger people, is to be welcomed, LARCs do not provide protection from STIs. Health and education professionals must consider the best approaches to ensure this message reaches LARCs users.

13.3 Accessing contraceptive services

Chapter five highlights issues surrounding access to contraception. It could be argued that of all the interventions that might apply in relation to facilitating appropriate contraceptive use, removing barriers to access is the most fundamental as well as the most impactful. While the vast majority of sexually active adults living in Ireland have accessed contraceptive supplies (90%), more women and men reported some level of difficulty accessing these supplies in 2010 (15% of women; 9% of men) compared to 2003 (4% of women and 6% of men). The key challenges for these women and men who report some level of difficulty included issues to do with availability of a local service, embarrassment and ability to afford the service.

It is important to understand the degree to which cost of contraception is a barrier to its use, whether this is in terms of visiting a GP or specialist provider, or acquiring prescribed hormonal treatments or condoms. The study finds that of those who had used condoms in the last year (n=1393), 5.2% of men and 4.8% of women indicated that the cost of condoms had prevented them from using this method of contraception when they had sex in the last year. This issue was particularly pertinent for young men (10%) and women (7%) aged 18-25 years. One in eight women aged 18-25 (13%) reported that the cost of the contraceptive pill, patch or ring had prevented them from obtaining their contraceptive product.

In relation to healthcare provider, nearly half of women (47%) reported that they would prefer to get their contraceptive supplies from a pharmacy, followed closely by a GP (37%); men were more likely to choose a pharmacy (64%) or commercial outlets such as a petrol station or supermarket (17%).

Recommendations:

1. Easier and equitable access to contraceptive services is required, particularly for young people. Service planning developments from a provision and quality perspective need to be considered as part of policy development in the area of sexual health.
2. Further improvements are required in the training of health professionals and service providers in primary and other care settings to ensure patient or client sensitivities regarding accessing contraception are addressed.

3. Being able to afford contraception is a necessary pre-condition for its use, and those for whom cost is a barrier to using contraception are in urgent and particular need of supports in this area. There is a need to examine existing models of service provision that provide free, or greatly subsidised, contraceptive services and supplies for those in difficult economic circumstances.
4. Strategies that facilitate choice in accessing contraception should be implemented. The role of community pharmacists in the provision of sexual health advice and services needs to be further developed.

13.4 Pregnancy experiences

Chapter six outlines the lifetime pregnancy experiences of adults living in Ireland and how they fit with changes in the demographic landscape over the last seven years. Of all pregnancies reported in ICCP-2010, 74% ended in live birth, 18% in miscarriage, 4% in abortion, 1% in stillbirth or adoption, and 3% of pregnancies were on-going. More women reported experiencing miscarriage in 2010, compared with the 2003 survey.

68 women in ICCP-2010 had experienced an abortion in their lifetime; similar to 2003, the majority had experienced one abortion only (84.4%), with 13.5% reporting two abortions. Just one woman reported more than two abortions.

When considering the finding that lifetime occurrence of miscarriages and abortions among adults living in Ireland is higher now than in 2003, it is important to bear in mind that there have been vast changes in demographic patterns since 2003. We know that of the women who lived in the Republic of Ireland at the time they were seeking an abortion outside the State, the vast majority travelled to the UK to have this procedure. We also know that some non-Irish national women now living in Ireland may have availed of legal abortion in their country of origin prior to coming to Ireland. This may, in part, explain the increased proportion of women reporting the experience of abortion in 2010. By international standards the rate of abortion in Ireland (for women travelling abroad for the procedure) is very low, but remains of concern for the women who choose this option.

Recommendations:

1. Crisis pregnancy supports and post-abortion medical and counselling supports must be promoted in such a way that women from a variety of cultural and ethnic backgrounds are aware of and feel they can safely avail of services if required.
2. More research is needed into the challenges surrounding miscarriage and its management for the relatively large proportion of women who experience this event.

13.5 Crisis pregnancy

Chapter seven looks at the key issue of crisis pregnancy. In the 2010 study more women but fewer men reported experiencing crisis pregnancies in their lifetime than in ICCP 2003. Just over one in three pregnancies (35%) experienced by women surveyed in 2010 can be defined as a crisis pregnancy - a small increase from 28% in 2003. Interestingly, for men the proportion experiencing a crisis pregnancy remained relatively stable at around 22%. The increasing trend for women is concerning, and the data from this report provides some insights into this increase. Whilst the two main reasons for a crisis pregnancy in 2010 were the same as in 2003 (pregnancy not planned and being too young), financial reasons were more commonly reported in 2010 compared to 2003. Given the high unemployment rate and economic instability within the country at this later time, this finding is not entirely surprising. Increases in crisis pregnancy experience can be attributed to:

- Financial concerns: In this survey and in a large-scale survey of recent mothers published by the CPP in 2010, the proportion of women reporting that the pregnancy was a crisis for financial reasons had increased dramatically. This can be attributed to the current economic crisis.

- Age and cultural preferences for delayed childbearing: Women report they were too young to be pregnant in their mid-twenties. The average age of first-time mothers continues to increase as cultural and societal norms favour childbearing at later years. The average age of marriage has also increased.

What is surprising is that a considerable and increasing proportion of both men and women who experienced a crisis pregnancy and who did not use contraception and were at risk of unintended pregnancy did not actually think they were at risk of becoming pregnant on that occasion. This is an important finding to address.

The study's findings highlighting the negative emotional impact that crisis pregnancy can have on an individual's mental health are of particular concern. Almost one-quarter of the 107 women who reported low mood during the time of the crisis pregnancy had thoughts of self-harming or 'ending it all'. Also concerning is the fact that higher proportions of women (than in 2003) did not disclose to friends that they had had an abortion. It is interesting, that despite this there was no significant difference in the proportion of women who felt they needed on-going support after having an abortion compared with those who gave birth. The study also shows that while knowledge of crisis pregnancy counselling services is high, the proportion of people availing of these services is low. Many issues arise from consideration of these findings. It is important to consider what this data suggests regarding the support needs and the role of support services for women, their partners and families when experiencing crisis pregnancy. Clearly, more women are in need of services than the number actually availing of them.

Recommendations:

1. Crisis pregnancy prevention efforts, particularly focused on the at-risk 18 – 25 age group, need to continue and need to bear in mind the impact of the recession. Crisis pregnancy prevention efforts should also continue to focus on the need for younger sexually active adults to be more prepared for sexual encounters (if their choice is to have sex) and to ensure condoms can be accessed when needed.
2. Crisis pregnancy supports also need to focus on the 18-25 year old age-range. More women report a need for counselling services than actually avail of the services. It is critical that women and their partners are fully aware of the range and benefits of free services available to assist and support them at this time.
3. Further thinking is required on how best to heighten risk-awareness before and after unsafe sex and how to increase proactive, risk-reduction practices, such as accessing a sexual health service provider for emergency contraception or STI check-up.
4. Promotion of crisis pregnancy counselling and related supports will remain a priority. Given that a greater proportion of women would be less sure of the decision they would make if a crisis pregnancy happened to them, there needs to be further promotion of the availability of high-quality, non-directive, non-judgemental crisis pregnancy counselling services.
5. Focused consideration should be given to the needs of women in situations of acute distress while experiencing a crisis pregnancy. The acute levels of psychological distress reported by a minority of women experiencing crisis pregnancy is concerning. Ongoing efforts to address quality improvements in service delivery and standardise referral practices across services are important in this regard.

13.6 Sex education

Chapter eight highlights findings on people's experience of relationships and sex education and the impact of this experience. We find a number of positive trends in this chapter. We see that the proportion of young people reporting that they received sex education has increased. More important, the findings show that the proportion receiving sex education and stating that they considered this to be useful or very useful in preparing them for their adult lives has also increased. Younger respondents were more likely than all other age ranges to state they received sex education on each of a list of specific topics, from sex and sexual intercourse to STIs, homosexuality and relationships and emotions. Findings show that receipt of sex education is associated with a greater likelihood of young people using contraception at first sex. Findings also show, however, that the proportion of parents of 12-to-18 year olds stating that they had talked to their children about relationships and sexuality had decreased since 2003. Specifically, the results suggest that fewer parents are talking to their children about issues such as safer sex, homosexuality, sexual feelings and emotions in ICCP 2010 than they were in ICCP-2003.

Recommendations:

1. A 'life-cycle' perspective to sexual health should underpin policy in this area, as several findings demonstrate clear links and relationships between early life experiences and subsequent adverse outcomes later in life.
2. It is welcome news that not only are more young people now receiving sex education in schools than previously, but that greater numbers are describing the education received as being helpful to them, especially since the evidence shows that this is a protective factor in the use of contraception at a later time. It is therefore strongly recommended that:
    - The partnership between the Department of Education and Skills and the Crisis Pregnancy Programme, formalised in a Memorandum of Understanding, continues to systematically focus on addressing the factors contributing to poorer levels of RSE implementation and increase the impact of levers designed to improve implementation levels.
    - Strategies are even more progressively adopted to ensure that all young people receive timely, comprehensive sex education. This is a priority for all children and in all settings (school, community, home) but should focus particularly on at-risk groups including boys, all-boys schools, girls and boys from lower socio-economic backgrounds, and children at risk of leaving school early.
    - Students who are at risk of leaving school early are identified with a view to ensuring they receive comprehensive school-based Relationships and Sexuality Education (RSE) as part of the social, personal and health education (SPHE) programme in the post-primary period, before their fifteenth birthday. In addition, it is essential that SPHE/RSE is a priority feature of Youthreach and other community-based educational programmes.
3. Combined home and school sex education is associated with the best results, as evidenced in the report. It is therefore recommended that programmes that promote parental awareness, willingness and capacity to engage in this regard be strengthened and more widely implemented.
4. Stakeholders in the area of education and health play an important role in pressing for an agenda that supports comprehensive SPHE/RSE implementation of at school, supported by active relationship and sexual health communication in the home and community settings.

13.7 Knowledge, attitudes and STI testing

Chapter nine demonstrates that in some areas knowledge of and attitudes to contraceptive use, fertility and STIs have changed over the past seven years; yet in other related areas little has changed. Fewer people, for instance, have concerns regarding the adverse side-effects of contraceptive pill use; however, similar proportions of adults in 2003 and 2010 associate a woman carrying condoms with being 'easy' in relation to sex.

This highlights, perhaps, that it is easier to address knowledge deficits than to bring about attitudinal change.

More people are accessing the emergency contraceptive pill (ECP) when they need it.

The majority of adults now have accurate information on key issues regarding HIV transmission. It is important to remember that questions relating to HIV/STIs were asked of all adults responding to the survey, including those who had had same-sex experiences only. It is noteworthy that the proportions of men and women reporting having tested for HIV is high, at 36% overall. In terms of experience of testing for other STIs, the age group more likely to report testing experience was adults aged 26 to 35 years. 24% of men and 38% of women aged 26 to 35 years stated that they had had an STI test. Almost one in five (18%) of men in the youngest age range (18 to 25 years) and 30% of women in the younger age range reported having had an STI test. This is important data. The findings suggest higher testing rates than might have been assumed previously, particularly among women, which, in part, may explain increased diagnoses across a range of STIs over the last number of years.

Recommendations:

1. Continued support is required for a national, integrated, theory-driven, sexual health campaign that addresses a range of attitudinal, behavioural and socio-cultural factors related to adverse sexual health outcomes.
2. The increased use of the ECP, particularly among younger females, is welcome news. With the ECP now available over the counter at pharmacies, it will be important to monitor trends in ECP use and improve knowledge around its availability, efficacy and use.
3. Ongoing research is needed to identify any trend that may emerge where ECP might be used a substitute for routine contraceptive methods
4. The majority of adults living in Ireland have not had an STI or HIV test. The findings on inconsistent contraceptive use strongly suggest there is a significant unmet need for STI and HIV testing. Sexual health policies in Ireland need to address these issues.
5. Data on HIV and STI testing demonstrates consistently that women are more likely to have availed of an STI test than men, across all age groups. Drivers and barriers need to be better understood at a population level, including the relative impacts of testing regimens, such as the voluntary ante-natal testing service.
6. The relatively high level of reported testing for HIV and STIs is noteworthy, particularly given that we do not have an integrated national screening/testing or treatment programme; further research is needed into the patterns of testing, country of testing, types of tests and the degree to which this complements biological surveillance data. We need to ensure that all sub-groups, particularly those most at-risk, can avail of services equally.

7. Service delivery mechanisms need to be reviewed to ensure that sexual health services are more joined up and that reproductive, family planning and STI services are integrated and designed to meet the needs of patients holistically. This would enable more opportunistic screening and more comprehensive delivery of a suite of services, thereby reducing a range of risks.

13.8 Abortion attitudes

Chapter ten deals with attitudes toward abortion. In some regards attitudes appear very stable, with the same minority (approximately 9% over both surveys) believing that abortion is not permissible under any circumstances. A smaller proportion of adults in 2010, however, believe that abortion is permissible in all circumstances – this proportion has decreased from a borderline majority (51%) view in 2003 to 45% in 2010. That reduction over time is complemented by an increase in those who believe that abortion is permissible under certain circumstances - 44% in ICCP 2010 compared with 39% in ICCP 2003. Findings in relation to the use of abortifacients are new in the 2010 survey and are important to track, so we can address risks and respond to public health concerns by the provision of comprehensive information and supports to the public.

Recommendations:

1. Monitoring of public attitudes in relation to abortion is important. Literature on the topic demonstrates that culture and societal attitudes toward abortion impact on abortion experience, supports required at the time of the decision and ongoing psychological supports.
2. Continued monitoring of issues surrounding abortifacients should be undertaken. The implications of any future findings, particularly in relation to information needs and medical supports required by women considering abortion, need to be considered as part of any policy developments in the area.

13.9 Non-Irish national communities: The views of Nigerian and Polish women

Chapter eleven focuses on the experiences of women from two of the 'new communities' now resident in Ireland. The sampling process means that the findings cannot make a claim to being representative of such women but they nonetheless provide useful novel information of relevance to service provision and policy formation in this area. The findings reveal many similarities between this (supplementary) sample and the main sample of women participants in the study. Similar proportions had experienced sex and pregnancy; similar proportions had used condoms and the contraceptive pill, though comparisons are further limited by the way in which questions were asked in the main (national) sample compared to the supplementary sample. There were differences in reported experiences of crisis pregnancy and responses to it, but similar reasons for viewing a pregnancy as a crisis. The recommendations focus on further research, but the similarities evidenced in the findings mean that many recommendations from other

chapters in this study will also apply for women from Nigeria and Poland now living in Ireland.

Recommendations:

1. Monitoring and evaluating service access and use for non-Irish national women is required in order to ensure the needs of women and men from countries other than Ireland are understood and met.
2. Further research is required among a wider sample of non-Irish national women in order to identify areas of particular vulnerability that may exist among a very diverse and vulnerable population. The Crisis Pregnancy Programme is completing a qualitative study designed to address these issues and a more robust series of recommendations are required.
3. The range of sexual health issues impacting on the lives of non-Irish national women and men needs to be considered.

Technical notes

Chapter 2

There were slight differences between ICCP-2003 and ICCP-2010 in terms of how important information relating to social class was obtained. In ICCP-2003, respondents were asked about their current or most recent occupation, and that of their partner/ spouse. In ICCP-2010, respondents were asked about their employment status, and that of the person who is responsible for paying the household rent and bills (i.e., the head of the household). If the person or the head of the household was not currently working, they were not asked about their previous employment status. The high unemployment levels in Ireland in 2010 may have contributed to the high proportion of people classified into social class 7.

Chapter 6

In ICCP-2010, all respondents who had previously had heterosexual sex, excluding those who were infertile or had fertility problems (n=2,777), were asked if they had ever had sex that had resulted in a pregnancy. In ICCP-2003, the questionnaire was slightly different in that all respondents who had previously had heterosexual sex, regardless of whether they were infertile or had fertility problems (n=3,083), were asked if they had ever had sex that had resulted in a pregnancy. For the purposes of comparison, those respondents in 2003 who had reported fertility problems (n=42) were excluded from this analysis, resulting in a sample of 3,041. Information relating to all pregnancies experienced, including miscarriages and abortions, was collected.

Chapter 7

General experiences of crisis pregnancy:

A history of crisis pregnancy experiences and outcomes was recorded for all respondents who reported that they had experienced a crisis pregnancy. In total, 451 respondents experienced a crisis pregnancy in line with the definition read out by the interviewers. Following additional questioning, 60 respondents had experienced a crisis pregnancy because it resulted in a miscarriage or stillbirth. These respondents were excluded from any additional analysis in this report. This resulted in a sub-sample of 391 respondents. In ICCP-2003, 373 respondents experienced 474 crisis pregnancies (excluding those pregnancies that were a crisis because the pregnancy ended in a miscarriage or stillbirth).

Detailed experiences of crisis pregnancy (the additional 'crisis pregnancy' questionnaire):

In ICCP-2010, all respondents who experienced a crisis pregnancy (except those due to a miscarriage or stillbirth) (n=355) were asked to complete an additional questionnaire (specific male and female versions) about their experiences of their only or most recent crisis pregnancy, or their second most recent crisis pregnancy if their most recent

crisis pregnancy was before a miscarriage or stillbirth occurred. Respondents were asked to complete this section regardless of where they were living at the time of the crisis pregnancy. Overall, 347 respondents answered the additional crisis pregnancy questionnaire (105 men and 242 women).

In ICCP-2003, 373 respondents reported experiencing a crisis pregnancy. In contrast to ICCP-2010, any respondent who was living in another country at the time of the crisis pregnancy was not invited to complete the additional male or female crisis pregnancy questionnaire. This resulted in 335 respondents completing the additional crisis pregnancy questionnaire. To enhance comparability with the ICCP-2010 study, respondents in the ICCP-2003 study who experienced a crisis pregnancy before a miscarriage or stillbirth occurred were excluded from the analysis in this section (although these respondents were asked to complete the additional crisis pregnancy questionnaire in 2003). This reduced the sample to 299 respondents.

Appendix 1: Protocol for addressing respondent distress

Rape or non-consensual sex

Due to the nature of this survey, the RCSI, the CPP, and Amárach Research have tried to pre-empt where in the survey respondents might report potentially sensitive or distressing responses, in particular whether they have been raped or had non-consensual sex. In the CATI system, there are several points during the interview where the interviewer will be able to press a '**RAPE/NON-CONSENSUAL SEX**' button. On pressing this button, the interviewer will see the following text on the computer screen:
"I'm sorry to hear that. It sounds like you are (or have been) in a difficult situation. Can I offer you the freephone number of the Rape Crisis Centre (Freephone – 1800 778888) if you want to talk about this?"

Whether or not the respondent accepts the rape crisis centre details, the interviewer should say:
"The remaining sections in the survey relate to sexual experiences and attitudes towards crisis pregnancy. Are you happy to continue with the interview?"

Following a disclosure of rape or non-consensual sex, there are 3 possible routes the rest of the interview can take:

- The respondent continues the rest of the survey, with the preface that they can skip any questions that they do not wish to answer.
- The respondent does not wish to complete the rest of the survey, but is happy to answer questions in the demographic section.
- The respondent does not wish to answer any additional questions and the interviewer should skip to the EXIT for the study.

Suicidal thoughts or behaviour during a crisis pregnancy

In the crisis pregnancy section of the questionnaire, respondents who report feeling downhearted and blue or so down in the dumps that nothing could cheer you up, 'a good bit of the time', 'most of the time', or 'all of the time' during the crisis pregnancy are asked the following question:
"During this time, did you ever have thoughts of harming yourself or of ending it all (committing suicide)?"

If respondent reports experiencing this behaviour at all (i.e., a little of the time – all of the time), the interviewer will be prompted on the CATI system to say:
"I'm sorry to hear that. It sounds like you are (or have been) in a difficult situation. Can I offer you the CALLSAVE number of the Samaritans (1850 609090) if you want to talk about this?"

The interviewer should then ask the respondent whether they would be happy to continue with the interview. If the respondent is happy to continue with the interview, and does not appear to be distressed, the interviewer will be prompted to ask the following questions:

- What did you ever do about that, if anything? (Open-ended answer)
- Did you ever seek help or advice? If so, what? (Open-ended answer)
- And how do you feel now? (Open-ended answer)

If the respondent does not wish to answer these questions, the interviewer should SKIP the questions on the computer until the next appropriate question or go to the demographic section (question J11 – And finally a few questions about you and your household . . .)

What to do if the respondent becomes distressed

Every effort will be made to reduce the stress this study may cause participants. In the event of a participant becoming distressed at any point during the interview, the interviewer should be empathetic and use the following phrases. The 'right' words are not important. The interviewer should let the respondent talk and be willing to listen to whatever they have to say. Some phrases that can be used if the respondent is upset or in distress:

- I understand this must be difficult
- I know this is upsetting for you
- It's OK for you to be upset
- Are you OK?
- The information you have told me is very valuable/important

It is important for the interviewer to determine whether the respondent is happy to continue with the interview. To do this, the respondent should briefly outline the content of the remaining sections of the survey. The following phrases should also be used:

- Are you happy to continue with the interview?
- Are you comfortable to move on?
- Do you need to take a break?
- Take your time
- We'll go at your pace

If the respondent is happy to continue with the rest of the interview, the interviewer should remind them that they can skip any questions that they do not wish to answer.

If the respondent wants to stop the interview due to distress of any nature, or the interviewer feels that the interview should be stopped for any reason, the following prompts should be used to try and deal with the situation. The interviewer should let

the respondent talk, and be willing to listen to whatever they have to say. The following phrases can be used if the respondent is in distress:

- I understand this must be difficult for you
- I know this is upsetting for you
- It's OK for you to be upset
- Are you OK?
- The information you have told me is very valuable/important

Do not question the respondent's psychological defences

People who have been through a tough experience often cope with it by minimising its importance, by saying, for example, "it was not that bad". It is important that the interviewer does not question the respondent's reasoning or explanation for a specific situation, action, or event.

Be empathic

The interviewer should let the respondent know that they realise that what the respondent has divulged is very difficult to talk about. The interviewer should ask the respondent 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, for example a counsellor or their GP, before? If not, would they be willing to do so? Do they have someone in mind?

The interviewer should tell the respondent that they can give them some information about organisations that may be willing to help them. The interviewer should be prepared to take some time to pass this information on to the respondent. If possible, the interviewer should ask the respondent to write the numbers down because sometimes people don't think they need it, but later wish they had the information. If someone clearly does not want help, the interviewer must be careful not to seem to force them to seek help.

The following information can be given to respondents:

- Positive Options (Free-text 'LIST' to 50444): Will provide access to telephone numbers for a large number of crisis pregnancy agencies located throughout the country. If necessary, the interviewer can give specific details on these organisations (outlined later in this training manual).
- Respondents can also contact the RCSI freephone number (1800 940026) if additional information is required – contact Dr Orla McBride or Dr Karen Morgan.
- The Crisis Pregnancy Programme (01-8146292): Will give them information on and the direct telephone numbers of all other agencies who provide services for people who have experienced or are experiencing a crisis pregnancy.

Referrals

If a situation arises where the respondent is very distressed and does not seem to be interested in seeking help for himself/herself, and the interviewer is concerned for their welfare, she may ask the respondent whether they would like to be called the following day for a check-up on how they are feeling. If the respondent says yes, the interviewer should tell the respondent that a member of the research team at RCSI will be in contact with them as soon as possible. The interviewer should record their name and number on the call information sheet. In this circumstance, the interviewer must notify the supervisor on duty at Amárach Research immediately. The supervisor will notify the CATI director and she will contact the ICCP-2010 research co-ordinator at the RCSI. All referrals will be dealt with on a case-by-case basis in consultation with Prof. Hannah McGee, principal investigator for the ICCP-2010.

This procedure is in line with the Market Research Society's Code of Conduct (Rule A10) and all interviewers have been trained using this code of conduct. It can be viewed on their website: www.mrs.org.uk/code.

Appendix 2: Weighting parameters used in adjusting the 2010 data and the sources of the population totals

Table A2.1 Weighting parameters used in adjusting the ICCP-2010 data and the sources of the population totals

Control	Source	Note
Gender by five-year age group	CSO Population Estimated by Age Group, April 2010	The population estimates by age group use five-year age categories. Numbers aged 18 to 19 and aged 45 calculated by interpolation.
Gender by marital status (married by 3 age bands; single by 3 age bands; divorced/ separated; widowed)	Special analysis of CSO QNHS Q4 2009 microdata	Numbers aged 18 to 19 and aged 45 calculated by interpolation. Totals adjusted to match population estimates as of April 2010.
Gender by principal economic status	Special analysis of CSO QNHS Q4 2009 microdata	Numbers aged 18 to 19 and aged 45 calculated by interpolation. Totals adjusted to match population estimates as of April 2010.
Gender by education (primary or less; lower second level; upper second level; further/ higher education)	Special analysis of CSO QNHS Q4 2009 microdata	Numbers aged 18 to 19 and aged 45 calculated by interpolation. Totals adjusted to match population estimates as of April 2010.
Gender by region (Dublin; Border, Midlands and West; rest of country)	CSO Population Estimated by Region, April 2010	Numbers aged 18 to 19 and aged 45 calculated by interpolation.
Number of adults aged 18 to 45 in the household	Special analysis of CSO QNHS Q4 2009 microdata	Numbers aged 18 to 19 and aged 45 calculated by interpolation. Totals adjusted to match population estimates as of April 2010.
Nationality (Irish, UK, other EU15, accession states, elsewhere)	Special analysis of CSO QNHS Q4 2009 microdata	Numbers aged 18 to 19 and aged 45 calculated by interpolation. Totals adjusted to match population estimates as of April 2010.
Family type (a couple with no children; a couple with children; lone parent; or other)	Special analysis of CSO QNHS Q4 2009 microdata	Numbers aged 18 to 19 and aged 45 calculated by interpolation. Totals adjusted to match population estimates as of April 2010.
Telephone in household (landline only; mobile only; both)	Comreg 2009	Totals adjusted to match population estimates as of April 2010.

Appendix 3: Characteristics of the ICCP-2010 sample compared with characteristics of the population

Table A3.1 indicates the representativeness of the ICCP-2010 data by comparing the distribution of cases across a number of different characteristics of the general population (information from the 2006 Census and Quarter 4 of the 2009 QNHS). Two important differences exist between the categories used in the QNHS and the Census for age and marital status, and those used in ICCP-2010:

- Age is categorised in the Census and QNHS in the following age categories: 18–24, 25–34 and 35–45 years. To facilitate comparison with ICCP-2003, the following age categories are used in ICCP-2010: 18–25, 26–35 and 36–45 years. The general population estimates in Table A3.1 for age refer to the Census/QNHS categories.
- In relation to marital status, general population estimates are available for the following categories: single, married, and previously married. For the purposes of comparison with ICCP-2003, the following marital status categories are used in ICCP-2010: single, married/cohabiting, and previously married. The general population estimates in Table A3.1 for marital status refer to the Census/QNHS categories. The high response rate and effective re-weighting mean that the results are very representative of the general population of 18 to 45 year olds living in Ireland.

Table A3.1 Representativeness of ICCP-2010, compared with the general population, by gender

Demographic characteristics	Men				Women			
	Un-weighted sample	Un-weighted sample	Weighted sample	General population (CSO Q4 QNHS 2009)	Un-weighted sample	Un-weighted sample	Weighted sample	General population (CSO Q4 QNHS 2009)
	n	%			n	%		
All	1,440	48	50	50	1,562	52	50	51
Age†								
18–25 years	340	24	24	20	377	24	24	22
26–35 years	577	40	41	41	652	42	42	41
36–45 years	523	36	35	39	533	34	34	37
Marital status††								
Single	598	42	46	57	569	37	41	51
Married/cohabiting	799	55	52	41	916	59	55	45
Separated/divorced/widowed	41	3	2	2	75	4	4	4
Highest education								
Pre-Leaving Certificate	222	15	20	20	136	8.7	14.5	14
Leaving Certificate	370	26	31	32	361	23.1	29.9	30
Post-Leaving Certificate	848	59	49	48	1,065	68.2	55.6	56

† Estimates for the general population presented in this table are available from the CSO in the following age categories only: 18–24, 25–34 and 35–45 years.
†† Marital status data is missing for four cases (N=2,998). Estimates for the general population presented in this table are available from the CSO in the following categories only: single/cohabiting, married, and previously married.

Appendix 4: Demographic characteristics of the ICCP-2003 sample

Table A4.1 Demographic characteristics of ICCP-2003 sample, by gender

Demographic characteristics	Men			Women		
	Un-weighted sample	Weighted sample	General population†	Un-weighted sample	Weighted sample	General population†
	n	%		n	%	
All	1,356	50	50	1,961	50	50
Age						
18–25 years	386	31	31	469	30	30
26–35 years	449	35	36	683	37	37
36–45 years	521	34	33	809	33	33
Marital status						
Single	620	52	52	654	45	45
Married/cohabiting	709	46	45	1,227	50	50
Separated/divorced/ widowed	27	2	3	80	5	5
Highest education						
Pre-Leaving Certificate	280	27	28	330	22	22
Leaving Certificate	428	34	32	598	34	32
Post-Leaving Certificate	648	39	40	1,033	44	46
Region						
Dublin	342	31	31	489	32	32
Border, Midlands and Western	272	24	25	537	24	24
Rest of country	742	45	44	935	44	44

Note: † Estimates from 2002 Census.

Appendix 5: Demographic characteristics of the ICCP-2010 sample

Table A5.1 Demographic characteristics of the ICCP-2010 sample, by telephone type

Demographic characteristics	Landline (n=1,418)		Mobile (n=1,584)	
	Un-weighted sample	Weighted overall sample	Un-weighted sample	Weighted overall sample
	n	%	n	%
Sex				
Men	520	13	920	37
Women	898	24	664	26
Age				
18–25 years	338	9	379	15
26–35 years	508	12	721	30
36–45 years	572	16	484	18
Marital status†				
Single/cohabiting	648	17	910	38
Married	714	19	610	23
Separated/divorced/ widowed	56	1	60	2
Highest education				
Pre-Leaving Certificate	150	6	208	11
Leaving Certificate	366	13	365	18
Post-Leaving Certificate	902	19	1,011	33
Region				
Dublin	413	10	531	20
Rest of Leinster	414	12	404	16
Munster	317	8	440	18
Connacht/Ulster	274	8	209	8
Country of birth				
Republic of Ireland	1,131	29	1,310	49
Northern Ireland	31	1	13	<1
Britain	105	2	83	3
Rest of EU	56	3	77	6
Africa	38	1	38	2
Asia	22	<1	34	2
USA/Canada/Australia/ New Zealand	21	<1	14	1
Elsewhere	14	<1	15	1

† Marital status data is missing for four cases (N=1,580).

Table A5.2 Demographic characteristics of ICCP-2010 sample, by social class

Demographic characteristics	Social class (n and weighted % of sample)						
	1 (n=432) 11.8%	2 (n=814) 24.1%	3 (n=679) 23.1%	4 (n=327) 11.7%	5 (n=230) 9.5%	6 (n=39) 1.4%	7 (n=481) 18.3%
Sex							
Men	53	44	46	56	49	49	55
Women	47	56	54	44	51	51	45
Age group							
18–25 years	16	22	25	23	20	29	33
26–35 years	46	42	43	39	44	51	36
36–45 years	38	36	33	38	34	20	31
Marital status							
Single	34	41	42	33	40	54	62
Married/cohabiting	65	57	56	65	54	41	33
Separated/divorced/ widowed	1	2	3	2	6	5	5
Highest education							
Pre-Leaving Certificate	3	10	15	28	19	34	30
Leaving Certificate	17	23	36	37	37	29	34
Post-Leaving Certificate	80	67	49	35	44	37	36
Region							
Dublin	35	29	34	18	24	40	28
Border, Midlands and Western	20	26	22	34	34	30	24
Rest of country	45	45	44	48	42	30	48

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ISBN: 978-1-905199-32-7