

Is Alcohol a Factor in Unsafe Sex Among Women Seeking Emergency Contraception? A Two-part Study

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Executive Summary

This study has as its research focus the relationship between unsafe sex and alcohol consumption. Alcohol has been recognised as a contributing factor in unsafe sexual practices. Although research has been undertaken in Ireland on this link, it is far from unequivocal as to either the degree to which or even how the two are related. The same is also discernible across the international literature.

This study arose as a part of a Crisis Pregnancy Agency consultation process in which the Dublin Well Women Centre expressed an interest in exploring the patterns of alcohol use among a sample of women requesting emergency contraception (EC) at their clinics. Similar to research around alcohol and unsafe sex, the reasons and circumstances causing women to seek EC have not been thoroughly researched in the literature.

This study was designed firstly to explore the extent to which a sample of women requesting EC (EC group) in a family planning clinic drank alcohol during the period in which unsafe sex took place and secondly, to assess whether contraception was used on the occasion of unsafe sex. A sample of women attending the clinic for reasons other than seeking EC (OC group) was also included in the study. This enabled a comparison across the two groups of patterns of alcohol consumption over time.

The primary aims of this study were:

- To assess whether contraception was used on the occasion of unsafe sex
- To explore the extent to which a sample of women requesting EC drank alcohol during the period in which unsafe sex took place.

The study utilised a mixed methods approach to data collection: questionnaires and interviews. 238 women who attended a clinic for emergency contraception and 222 women who attended the clinic for reasons other than emergency contraception completed a questionnaire. This represented response rates of 96% and 95% respectively. A sub-sample of eight women volunteered to be interviewed.

Findings: Questionnaire data

Sample characteristics:

The findings demonstrate that the sample characteristics for EC and OC groups match each other quite closely in terms of age and educational attainment. Characteristics were also similar in terms of employment and relationship status, although the OC group tended to include a greater proportion of married women and women in full-time employment. Over 80% of women in the EC group were in a relationship of some kind. 46% were in a relationship for a year or more.

Alcohol use:

The data strongly suggests that there is very little difference in the patterns of reported alcohol use by both the ECC and OC group – across three different measures used to quantify alcohol use. There is a tendency for the majority of respondents in both groups to report that on average they drank '1-2 times a week', and a just under a quarter of respondents in both groups reported that they drank '3-4 times a week'. Just over half of participants in both groups reported getting drunk 'sometimes'. Approximately 30% in both groups reported 'rarely' getting drunk.

Use of contraception:

Among the EC group, 46% of respondents sought EC within 24 hours of having sex, 49% waited between 24 and 72 hours, and 6% sought it after 73 hours. 64% (148) of the EC clients reported that they had used some form of contraception prior to making an appointment at the clinic. EC was therefore not seen as the primary means of contraception for the majority of participants. 75% of EC participants had used EC previously.

Alcohol and requests for EC:

The data indicates that with regard to alcohol consumption prior to seeking EC, 58% of the respondents reported that they had been drinking when sex took place. It is important to note that 42% of respondents reported that they did not drink any alcohol on the occasion they had sex. Therefore, alcohol cannot be seen to be singularly attributable to women's need for EC.

Alcohol and use of contraception:

Of those who drank alcohol, a greater proportion (58.4%) claimed to have used contraception than those who used no protection. A higher proportion (72%) of those who did not drink alcohol claimed to have used contraception. This data suggests that in general, for women seeking EC, a greater proportion of women used contraception whether they were under the influence of alcohol or not. There is a trend, however, showing that a higher use of contraception is more likely when a woman has not consumed alcohol. A further study with a larger sample size would have to be conducted to explore this link in greater detail.

Most women in this study used contraception, irrespective of whether they had drunk alcohol or not. For a small number of women (n = 21) who reported being very or extremely drunk on the occasion when sex took place, most did not use contraception. While a larger study is required to test the significance of this finding, it would suggest that being very drunk affects use of contraception among EC clients in this setting.

Findings: Interview data

Within the group of eight interview participants there is a perception that alcohol can lead to sexual risk-taking behaviour and that this behaviour is embedded in the fabric of social life in Ireland. Risk-taking behaviour is perceived to be more associated with young people in their early twenties and most participants in this sample feel they have, in many ways, 'grown out' of this behaviour. Where alcohol is not an issue, the nature of the relationship between the man and woman is perceived to play an important role in sexual risk taking. There is a perception that couples take increasing risks as the relationship progresses.

The findings also suggest that different approaches to sexual health education and sexual health promotion may be required depending on the age of the women and the relationship she is in. More research is required to investigate these issues further, as the findings do suggest that risk behaviour is dependent on age and relationship status.

The final section of this report makes recommendations with respect to further understanding the alcohol-unsafe sex link; improving approaches to consultation with

women requesting EC; improving knowledge about the correct use of EC and pregnancy prevention and suggestions for further research.

Limitations of the study

Whilst the findings of this report provide some interesting indications of how alcohol is related to contraceptive use and women's requests for emergency contraception, it is important to recognise that these findings are specific to one women's health clinic in one city-centre location. Moreover the sample sizes were relatively small, especially in the qualitative component of the study. The data is not generalisable to women from non-urban locations or, indeed, to women who seek EC from GPs or other sources. Further research is required to examine the link between alcohol, sex and contraception in different contexts and among different populations of women.

1.0 Introduction

Summary

This study has as its research focus the relationship between unsafe sex and alcohol consumption. Alcohol has been recognised as a contributing factor in unsafe sexual practices. Although research has been undertaken in Ireland on this link, it is far from unequivocal as to either the degree to which or even how the two are related. The same is also discernible across the international literature.

This study arose as a part of a Crisis Pregnancy Agency consultation process in which the Dublin Well Women Centre expressed an interest in exploring the patterns of alcohol use among a sample of women requesting emergency contraception (EC) at their clinics. Similar to research around alcohol and unsafe sex, the reasons and circumstances causing women to seek EC have not been thoroughly researched in the literature.

This study was designed firstly to explore the extent to which a sample of women requesting EC drank alcohol during the period in which unsafe sex took place and secondly, to assess whether contraception was used on the occasion of unsafe sex.

1.1 Unsafe sex: influencing factors

A range of factors is related to unsafe sex and its consequences such as unintended pregnancy and sexually transmitted infections (STIs). These factors have been categorised at a number of levels (O’Keeffe 2003). These include the individual level (e.g. age, knowledge, attitudes, self-esteem), the situational level (e.g. contraceptive failure, alcohol use) relationship level (e.g. long-term, casual) and contextual levels (e.g. normative influences, service availability etc.). It is clear from research findings that these levels are not mutually exclusive and that they relate to each other and affect each other in different ways depending on the situation.

1.2 Alcohol, sex and contraception

Alcohol is one factor identified in the literature as playing an important role in determining a) whether sex takes place and b) whether contraception is used and used effectively. While research findings indicate that alcohol is a factor that contributes to unsafe sexual behaviours, the relationship between alcohol and sexual risk-taking is not a clear one.

The interim report from the Irish Government’s Strategic Task Force on Alcohol (2002) states that there is a continuum of alcohol related harm which can affect everyone across the community. These problems range from a once-off problem (fall, accident, fight, unprotected sex) to a recurring problem (poor work performance, financial hardship, relationship difficulties), chronic illness (cancer, liver damage) and to a sustained dependence (alcoholic disorder).

While there is national Irish data monitoring drinking patterns over time (e.g. The European School Survey Project on Alcohol and Other Drugs; SLÁN Survey; Health Behaviour of School Aged Children), until recently there has been a dearth of nationally representative data in the Irish context examining the link between alcohol and sexual risk-taking. Two national surveys have been recently published which attempt to quantify the extent to which alcohol plays a role in sexual risk-taking.

A nationally representative telephone survey of 3,317 adults was commissioned by the Crisis Pregnancy Agency in 2003. The Irish Contraception and Crisis Pregnancy Survey (Rundle, Leigh, McGee & Layte 2004) examined interviewees' explanations for non-use of contraception during the last year by those who did not want to become pregnant. The two main explanations given were that sex was not planned/they were not prepared (48%) and/or they were drinking alcohol or taking drugs (21%). These reasons were significantly more likely to be reported by younger age cohorts. In addition, interviewees were asked if alcohol ever contributed to them having sex. Over half of men (58%) and 38% of women agreed that drinking alcohol had contributed to them having sex. Furthermore, almost half of men (45%) and a quarter (26%) of women agreed that drinking alcohol had contributed to them having sex without using contraception. Correlates of agreement were male gender, lower educational level, lower social class and currently being in a casual relationship or not in a relationship.

The Department of Health and Children recently published findings from a postal survey of full-time undergraduate students across 21 third-level colleges conducted in 2001/2002 (Department of Health 2005). The questionnaire was completed by 3,259 students and examined aspects of sexual behaviour. The survey found a number of reasons students gave for not always using condoms. The six most common reasons reported were: 'don't plan', single partner, loss of sensation, impaired judgement due to alcohol, preference for other methods and loss of spontaneity. Availability and cost were also issues for some.

There have been a few other regional studies that have examined the relationship between alcohol and sex. A survey of 2,754 Galway pupils aged between fifteen and eighteen years found that out of 578 (21%) of pupils who reported having sexual intercourse, a sub-group of 32% responded that alcohol was a contributory factor in their sexual debut. Among a sample of 494 participants aged 15-25 in Cork and Kerry, Dunne (1997) found that 61% of male participants and 54% of female participants believed that alcohol contributes to sexual activity. A Northern Irish survey of 1,031 young people found that of those 537 individuals who reported having had sexual intercourse, 104 stated that the main reason for first sexual intercourse was being drunk (Schubotz, Simpson and Rolston 2003). A total of 149 respondents stated that being drunk was a factor but not the main reason. It was reported that 43% of young men and 34% of young women said they were drunk the first time they had sex. Interestingly, the younger rather than the older respondents were more likely to be under the influence of alcohol and drugs when they first had sex (35% of fourteen to sixteen year olds vs. 27% of 21-25 year olds).

An Irish study entitled 'Teenage Tolerance', commissioned by Women's Aid, found that 19% of a sample of 302 young people between the ages of fourteen and nineteen admitted having sex when drunk or under the influence of drugs. Focus group findings from this research suggested that being drunk was both 'an excuse to have sex and to eschew the responsibility for oneself and others' (Women's Aid 2001: 19).

This research suggests that for some young people drinking alcohol is a factor related to having sex and having sex for the first time. Survey data of the adult population further indicates that, especially for men, alcohol has contributed to people having sex and having sex without using contraception.

International research has made more robust attempts to deconstruct the relationship between alcohol consumption, unsafe sex and contraceptive use – although the findings are not always consistent. Bagnall, Plant and Warwick (1990) and Robertson and Plant (1988) found that drinking alcohol was associated with a failure to use a condom. Leigh (1990) found that the link between alcohol and unprotected sex was not so obvious. A number of American surveys have examined the links between alcohol, sex and condom use among adolescents. Strunin and Hingson (1992) conducted a telephone survey among sixteen to nineteen year olds in Massachusetts. They found that 66% of respondents had had sexual intercourse and 64% had had sex after drinking alcohol and 49% were more likely to have sex if they and their partner had been drinking. A minority of adolescents (17%) were less likely to use a condom after drinking. These authors conclude that adolescents are more at risk of STIs and pregnancy after drinking/drug use.

In one of the few studies exploring the alcohol-sex relationship in a sample of older adults, Graves (1995) found that having multiple sexual partners was more likely amongst those who consumed five or more drinks per sitting and that they were also less likely to use a condom. This work was conducted among a sample of 30 year olds. The authors concluded that alcohol is one factor that plays a role in the risk-taking behaviour. These findings concur with findings from Duncan, Strycker and Duncan (1999), who found that alcohol use, cigarette smoking, cannabis smoking and risky sexual behaviour were all interrelated among a sample of 644 fourteen- to nineteen-year-old American adolescents. These findings have been replicated elsewhere (see Castilla, Barrio, Belza and de la Fuente 1999). In an experimental study, Fromme, D'Amico and Katz (1999) conducted two studies to examine whether alcohol consumption resulted in differences in assessment of potential consequences relating from unsafe sex. The authors found that intoxicated respondents reported lower perceptions of risk than those in the water-drinking and placebo groups and that these respondents also reported fewer negative consequences. A study among 14-35 year olds in Liverpool found that condom use was least likely to occur among those who were solely consuming alcohol (rather than solely consuming drugs or consuming drugs and alcohol) (Henderson 2001). This suggests that the links between risk and drug taking are not similar for all types of drugs. What is clear from this data is that the relationship between alcohol consumption and unsafe sex is not a direct one. Other factors such as age, consumption of other drugs or sexual partnerships can affect the relationship. When an association does occur it tends to strongly suggest that for some individuals alcohol consumption means that they will be less likely to use contraception when having sex.

Findings from a recent consultation exercise conducted by the Crisis Pregnancy Agency (CPA) to inform its Strategy to Address Crisis Pregnancy in Ireland, found that most professionals working in the field of sexual health and education perceive alcohol to be directly associated with sex and crisis pregnancy. In particular, parents, educators and service providers working with young people and women in the context of reproductive health and crisis pregnancy reiterated the perception that excessive alcohol consumption leads to a higher propensity for women and men to engage in sex, and especially sex without contraception. Professionals use anecdotal evidence to support these claims. For example, feedback from practitioners working in sexual health clinics

suggested that alcohol consumption was playing a part in increased demand for emergency contraception (EC) in their clinics.

This research arose directly from the Crisis Pregnancy Agency's consultation process. Dublin Well Woman Centre proposed a study seeking to examine the patterns of alcohol use among a sample of women requesting EC at their clinics. The following sections address methodological considerations, research questions and some of the literature dealing with what factors motivate women to seek EC, and barriers to its use.

1.3 Researching the alcohol / unsafe sex relationship

It is clear that the methods used to examine the relationship between alcohol and unsafe sex or high-risk behaviours tend to be survey-based (relying on retrospective accounts) and tend to be oriented toward teenage samples. Irish research, until recently, tended to be based on data using adolescent samples. It is difficult to identify and secure access to a sample of women who have experience of unsafe sex, so the links to alcohol can be explored. Moreover, research does not tend to examine the amount of alcohol consumed, rather whether it was consumed or not. This may be part of the reason as to why findings in the area can seem contradictory. Furthermore, research that is conducted with women who have experienced unplanned or crisis pregnancy does not typically examine alcohol as a contributory factor.

It can be concluded that the relationship between alcohol, sex and contraception remains a complex one, and one which requires research specifically designed to explore these links and understand how they operate in different populations. Part of the solution to this problem lies in identifying a suitable and accessible sample where the links can be appropriately explored.

The next section will briefly describe research findings in the field of emergency contraception in order to identify any issues that needed to be considered in the design and interpretation of this study. Following this summary the research questions will be outlined.

1.4 Emergency contraception

In general terms, research on EC tends to focus on three main areas:

- its effectiveness and potential to reduce crisis pregnancy
- patterns of usage and knowledge
- barriers to its use and motivating factors.

Medical doctors prescribing EC to Irish teenagers have examined why teenagers need EC and their normal contraceptive practices. For example, Jones (2003) reviewed 200 teenage requests for EC in a Dublin sexual health clinic. Jones found that 48.5% of the sample reported condom failure, while 48% used no contraception. 75% of the sample reported that condoms were their usual contraceptive method. Approximately 65% of the sample had never used EC before, 24% had used it once and 9%, twice before.

The ICCP survey of 3,317 adults (Rundle et al. 2004) found that knowledge of the existence of the emergency contraceptive pill (ECP) was high (96%) among men and women. However, specific knowledge relating to correct usage was lacking. (Only 38% identified the correct time-period for use; 44% underestimated the time limit.). Of those

who had heard of the ECP, 29% of women had used it previously and 24% of men reported that a partner had used it. 31% of those who had heard of the ECP thought it would be difficult to obtain. They suggested the main barriers to accessing the ECP were locality/accessibility (66%) and attitudes of professionals (29%).

Various studies and discussion documents have supported the case for and quantified the potential of increasing the use of EC as a means of reducing unwanted and teenage pregnancies (see Free, Lee and Ogden 2002, Morris and Young 2000). Key to increasing the use of EC is ensuring that a) women are aware when they are at risk of having an unwanted pregnancy and b) women know about EC, how it works, when it is taken and, most importantly, how to access it confidentially, freely and easily.

International research in general demonstrates varying levels of knowledge about EC among women of different ages and in different countries. Goodger (1996) compared knowledge levels of 177 women seeking an abortion and 939 members of the public in the UK. The author reported that similar numbers of women of the same age in both surveys had heard of EC; a larger proportion of women seeking abortion knew the correct timing associated with the procedure (see also Burton, Savage and Reader 1990).

Several barriers to using EC have been outlined in the literature (see Free et al. 2002). These include:

- limited knowledge of EC
- concerns about side effects
- attitudes of GPs and pharmacists
- moral or religious reasons
- low sense of vulnerability to pregnancy
- EC negatively evaluated due to its link with 'undesirable behaviour'
- high level of concerns about what others would think
- service barriers, e.g. access, cost, confidentiality.

A number of factors that motivate women to use EC have also been outlined. These include:

- a high level of perceived vulnerability to pregnancy
- a strong motivation to avoid pregnancy, linked with a perception that risk of pregnancy is high.

The need for services to be accessible, confidential, targeted and available is also important.

1.5 Research aims

It is interesting to note that the reasons and circumstances causing women to seek EC have not been thoroughly researched in the literature. The role of alcohol as a possible contributory factor to unsafe sex (and therefore requests for EC) has not been examined. In light of research findings and anecdotal evidence, this research aims to directly address the link between alcohol, unsafe sex and requests for EC. More specifically this research has the following aims:

1. To explore the extent to which a sample of women requesting EC drank alcohol during the period in which unsafe sex took place. By including a OC comparative

group it is also possible to examine the degree to which drinking patterns for EC users are in any way different to those of other clients presenting at the clinic. It will also be possible to examine whether partners drank alcohol on this occasion.

2. To assess whether contraception was used on the occasion of unsafe sex; to explore previous patterns of contraceptive use; to examine whether variables such as relationship status, age or previous contraception history affect the relationship between alcohol consumption, contraceptive use and unsafe sex.

Secondary aims of the research were as follows:

3. To explore EC and fertility knowledge levels among a representative sample of women attending a Well Woman clinic, particularly with respect to knowledge of EC and other identified 'myths'.
4. Assess self-reported experiences of sex education sources with a view to identifying useful gatekeepers, who may be able to disseminate positive sexual health information.

2.0 The methodology of the study

Summary

The primary aims of this study are:

- To assess whether contraception was used on the occasion of unsafe sex
- To explore the extent to which a sample of women requesting EC drank alcohol during the period in which unsafe sex took place.

The study utilised a mixed methods approach to data collection: questionnaires and interviews. The data was collected over a nine-week period in Spring 2003 in a clinical setting.

The subsequent analysis was based on two main samples: 238 women who attended the clinic for emergency contraception and 222 women who attended the clinic for reasons other than emergency contraception. This represented response rates of 96% and 95% respectively.

A sub-sample of eight women volunteered to be interviewed.

2.1 Introduction

The methodology used for the study was a mixture of quantitative and qualitative approaches. The quantitative work consisted of two questionnaires, which were administered over a nine-week period from the middle of April until the end of May 2003. The qualitative work took the form of semi-structured interviews with clients from the clinic who volunteered to discuss their experiences of alcohol use and contraception in more detail.

In more general terms, the questionnaires and the interviews were designed to explore the links between sexual risk taking and alcohol use. In order to pre-empt problems such as self-reporting bias or inferences being made beyond those legitimately contained in the dataset, core questions were embedded within the participants' wider contextual environment. As set out in the introduction, the relationship between sexual behaviour, alcohol use and the perception of risk is not straightforward, but interwoven within and around a number of other factors. Furthermore, no matter how well designed, planned and undertaken any research is, it can only offer a partial window onto the issues and questions it sets out to explore. The current study is no exception to this general methodological rule.

2.2 Quantitative component – The questionnaires

The first questionnaire was designed to be used exclusively with those clients who visited the clinic for consultations relating to emergency contraception. The second questionnaire was designed to be used with those clients who attended the clinic for non-emergency contraception related reasons. After initial piloting, both sets of questionnaires underwent a number of revisions before being administered. Final versions of both questionnaires can be found in Appendix 1. The next two sections briefly outline the construction of the questionnaires.

Questionnaire 1: Emergency contraception clients (ECC)

The first questionnaire was designed to explore the relationship between alcohol use and contraception. It was exclusively administered to those women who had visited the

Well Woman clinic for a consultation relating to EC. As such, the content focused firstly on the women's self-reported use of alcohol in general and, more specifically, their use of alcohol at the time of the sexual encounter that triggered their visit to the clinic. The second focal point was the women's use and knowledge of different forms of contraception. In addition, questions were asked to help contextualise the clients in relation to their age, level of education and where they lived. Given the nature of the issues to be explored by the questionnaires, much effort was directed at how best to handle and present a series of questions that would be both sensitive and succinct. It was important that the questionnaire was not perceived to be either onerous or overly intrusive by the participants. It was also important that clients should know that participation in the study was completely voluntary and their treatment in no way depended on their completing the questionnaire. Time constraints were also a consideration in a clinic setting. The running of the clinic and its appointment system had to be factored into the length of the questionnaire to ensure that respondents would have time to complete it. Therefore, it was considered a priority that the final questionnaire should be as brief as possible, but able to encompass all the areas needed to make any analysis and subsequent inferences meaningful. The high response rate and the lack of any comments regarding either the content or length of the questionnaire could be taken as a proxy indicator of its effectiveness¹. It is important to note that the questionnaire was not administered to women who could not speak English or where the clinic staff had difficulty communicating with or understanding the client.

There are a number of limitations which are worth foregrounding. Constructing questions around self-reported alcohol use has been identified as problematic. Such questions rely on an individual's degree of honesty and their ability to reflect on their drinking behaviour in a meaningful way. Moreover, what constitutes drunkenness for any individual is subjective, and there are degrees of difference between individuals. Self-reported use of alcohol is also problematic in that there is no verification of what is being reported.

There was much debate around whether or not to allow people to describe their drinking in the form of standardised units. This method has a veneer of 'objectivity', yet it is still plagued by the same problems as asking more 'subjective' questions. Also, using standardised units shifted the emphasis away from perceived risk (one of the research questions), to one of trying to measure in a pseudo-scientific but very imprecise way how much people thought they drank (in alcohol units). In order to ensure the trustworthiness of the data, measures were taken in the design and pilot stages to create the best environment and data collection tool so as to successfully resolve the research questions.

Questionnaire II: Other clients (OC)

The second questionnaire was designed to work as a 'check' as to how typical or atypical the EC clients were (with respect to alcohol consumption), in comparison with other clients of the clinic. In terms of content, the second questionnaire contained the same questions as the ECC questionnaire, minus those that related to contraceptive use.

Our rationale for using two questionnaires with these two groups stemmed from a concern around the issue of whether or not the patterns of alcohol consumption by the

¹ Only in one questionnaire did a respondent indicate their dissatisfaction with the survey.

ECC group matched those of women more generally. Although there was no a priori reason to assume that they would not, we also had no good reason to assume that they would. As no comparable data was pre-existing, we took the step of designing the second questionnaire, which would give us an insight into the extent to which the ECC group matched the clinic's other clients along certain variables such as age, employment status and alcohol consumption.

2.3 Sampling frames and sample sizes

The sampling frame for this study consisted of all women requesting EC at one city-centre Well Woman clinic. It was presumed that this sampling frame would be comprised of women who have had or who considered themselves to have had unsafe sex and who also felt they were at risk of an unintended pregnancy. The study was, therefore, designed to examine the nature of the relationship between alcohol and unsafe sex among a sample of women requesting EC.

In order to make meaningful statistical comparisons within and between the two groups we opted for sample sizes of approximately 200 respondents for each group (ECC and OC). These sample sizes were chosen to ensure that the samples were representative of the clinic's clients in general and also to support the analysis. It is important to note that small sample sizes and any subsequent analysis undertaken by constructing sub-groups (based on, for example, age or occupation) have the effect of reducing confidence in the results. Therefore, the larger the sample the more room for manoeuvre in relation to undertaking any fine-grained analysis.

From our analysis of attendance data we calculated that to attain a cohort size of 200, we needed to administer the questionnaire over a minimum six-week period. This was subsequently adjusted to nine weeks during the fieldwork, as numbers of EC clients did not match up to our predicted volume. The non-emergency contraception clients (OC), who proportionally make up the majority of the clinic's client group, were systematically sampled over the six-week period using the day of the week as the inclusion criteria (week 1 = Monday, week 2 = Tuesday, and so on). This strategy was adopted to ensure that the number of questionnaires completed would, given some random fluctuations, reflect previous daily and weekly patterns of appointments. This approach appears to have been successful, as the number of questionnaires completed was roughly in line with past patterns of clinic usage and patterns of the nine-week study period. In total, 222 clients completed the OC questionnaire and 238 completed the ECC questionnaire. In terms of the accuracy of this strategy, the results from both questionnaires indicate that those women who attended the clinic for EC over the duration of the study were similar – relative to various key characteristics – to other women who used the clinic. The results are discussed in detail in Section 3.

2.4 Administration of the questionnaires

The administration of the ECC questionnaire was conducted over a nine-week period and the OC questionnaire over a six-week period. This was done in an attempt to ensure that the numbers of women in the ECC group and OC group did not deviate wildly from the volume and frequency of typical clinic usage. Women were approached in the waiting area of the clinic and asked if they would like to complete the questionnaire, after the aims of the study had been explained to them. Women were reassured that they were

under no obligation to participate or to answer any questions they did not want to. From an analysis of the daily and weekly patterns of visits over a three-month period from January to March 2003 it was decided that in order to represent the 'peaks', 'troughs' and 'flats' in visits to the clinic six weeks would be a sufficient time period. The number of weeks was adjusted during the fieldwork to nine weeks of data collection for EC clients, as the number of EC clients during the first six weeks was lower than expected. For the ECC group, therefore, the questionnaire was administered by the clinic's staff to all clients attending the clinic over nine weeks to allow for a desired sample size of approximately 200. In contrast, the OC questionnaire was administered on different days of the week throughout the first six weeks of data collection. This, as we expected, would both generate a sample size of approximately 200 and be representative of the 'ebb' and 'flow' of the clinic's client group.

2.5 Analysis of the questionnaires

Analysis of the questionnaires was undertaken using SPSS computer software, a package that is commonly used in academic, governmental and non-governmental organisations and commercial environments for working with complex numerical data sets. The data is first screened for any errors, which are usually a consequence of data-inputting mistakes, and then explored (primarily with descriptive statistics) with a view to seeing what patterns emerging from the data need more detailed investigation. This was carried out jointly between Trinity College and the CPA to ensure that the data and any emerging questions were explored from different perspectives.

2.6 Qualitative component – The interviews

The inclusion of semi-structured interviews in the study was done on the basis that it would be advantageous to explore contextual factors (outlined below) in more detail when examining the links between risk-taking and alcohol. The exploration of contextual factors would allow the information gathered from the questionnaire data to be expanded upon. The interviews were designed to look at participants' attitudes towards and experiences of four areas:

- sex education
- 'normal' behaviour with regards to sex
- emergency contraception
- alcohol use.

In the first section participants were asked about how they acquired information on sex and contraception and how adequate they rated it. The participants were asked to speculate about how they thought men learned about sex and contraception and what the best methods of teaching sex education would be. Secondly, the participants were asked questions about their own use of contraception, sexual risk-taking, barriers to using contraception, and reasons why someone might take risks. Alcohol could spontaneously emerge as an issue during this and other sections. In the third section, participants were asked questions concerning the extent of their knowledge of EC and the factors affecting their decision to use it. In the final section of the interviews, alcohol was explicitly discussed in relation to its role in people's lives and any possible effects, both positive and negative, in people's behaviour and decision making. A copy of the discussion guide for the interviews is attached in Appendix 2.

2.7 Interview procedure and recruitment

In order to recruit interview participants, time was spent in the waiting area of the clinic. Women were approached after they had completed the ECC questionnaire. The purpose of the study was explained and prospective participants were asked if they would like to speak in greater detail on some of the themes in the questionnaire. Only those women seeking EC were initially asked to participate. Four women were recruited in this way. Most women were very reluctant to volunteer for the interview, the main reason being that they had work and/or family commitments and did not have the time. To boost the sample size, women who attended the Well Woman Centre for other services were asked to participate. A further four women were recruited in this way. As with the primary group, most women who were asked to participate declined due to time constraints. In order to increase the sample size, nurses and doctors working in two other Well Woman clinics were briefed about the study and were asked to help recruit clients for interview. This approach did not yield any further participants. Consideration was given to recruiting participants from other settings, such as a student population. It was decided to avoid this sampling route to allow for comparability between the qualitative data and quantitative data. Consideration was also given to offering a financial incentive to encourage women to participate. This was also avoided as it was felt that, due to the sensitive nature of the subject matter, it was important that women freely consented on the basis of full information about the aims and objectives of this research. These issues must be addressed if further research is to be conducted among Well Woman Centre clients.

Ethical considerations

To ensure consistency across encounters and adherence to good ethical practice, an interview protocol was drawn up. In short, prior to the beginning of each interview it was explained to each participant that the interview would be taped, everything they said would be confidential and no identifying information would be released in subsequent reports. Participants were also reassured that they could terminate the interview at any time and for any reason, and they were free to skip any questions that they did not wish to answer. At the end of each interview participants were asked if there was anything else they wished to add or ask. All participants reported that they enjoyed the interview experience, and all the questions asked by the interviewer were answered.

Analysis of the data

The interview data were analysed using a thematic open-coding approach. After interviews were transcribed the interviews were read a number of times each to familiarise the analyst with material. For analytical purposes the interview was divided into four sections. After this, themes or topics emerging from responses were coded in the text, and similar themes were categorised together. Furthermore, the frequency of how many individuals mentioned a particular theme was recorded. These themes were either participant-defined themes, whereby the title of the theme or code is what the participant actually said; e.g. 'alcohol plays a big part in risk taking'. Other codes were researcher based, where the analyst gives the title of the code herself; e.g. 'alcohol perceived as a problem specific to "other" younger people'. Themes being generated were compared both within and across transcripts to help the analyst gain an understanding of the relationships in the themes emerging from the data set. Finally,

related themes were grouped together into sets, which facilitated a more coherent understanding of the meanings participants ascribed to various issues.

While recruiting participants for this study was problematic, and compounded by the setting of the research, the depth and richness of the data gathered provided many insights.

3.0 Findings: The questionnaires

Summary

Sample characteristics

The findings demonstrate that the sample characteristics for ECC and OC groups match each other quite closely in terms of age and educational attainment. Characteristics were also similar in terms of employment and relationship status, although the OC group tended to include a greater proportion of married women and women in full-time employment. Over 80% of women in the ECC group were in a relationship of some kind. 46% were in a relationship for a year or more.

Alcohol use

The data strongly suggest that there is very little difference in the patterns of reported alcohol use by both the ECC and OC group – across three different measures used to quantify alcohol use. There was a tendency for the majority of respondents in both groups to report that on average they drank '1-2 times a week', and a just under a quarter of respondents in both groups reported that they drank '3-4 times a week'. Just over half of participants in both groups reported getting drunk 'sometimes'. Approximately 30% in both groups reported 'rarely' getting drunk.

Use of contraception

Among the ECC group, 46% of respondents sought EC within 24 hours of having sex, 49% waited between 24 and 72 hours, and 6% sought it after 73 hours. 64% (148) of the ECC clients reported that they had used some form of contraception prior to making an appointment at the clinic. EC was therefore not seen as the primary means of contraception for the majority of participants. 75% of ECC participants had used EC previously.

Alcohol and requests for EC

The data indicates that with regard to alcohol consumption prior to seeking EC, 58% of the respondents reported that they had been drinking when sex took place. It is important to note that 42% of respondents reported that they did not drink any alcohol on the occasion they had sex. Therefore, alcohol cannot be seen to be singularly attributable to women's need for EC.

Alcohol and use of contraception

Of those who drank alcohol, a greater proportion (58.4%) claimed to have used contraception than those who used no protection. A higher proportion (72%) of those who did not drink alcohol claimed to have used contraception. This data suggests that in general, for women seeking EC, a greater proportion of women used contraception whether they were under the influence of alcohol or not. There is a trend, however, showing that a higher use of contraception is more likely when a woman has not consumed alcohol. A further study with a larger sample size would have to be conducted to explore this link in greater detail.

The findings suggest that whether women drink alcohol or not, a majority of women will use contraception. For a small number of women (n = 21) who reported being very or extremely drunk, most did not use contraception. While a larger study is required to test the significance of this finding, it would suggest that being very drunk affects use of contraception among this group of EC clients.

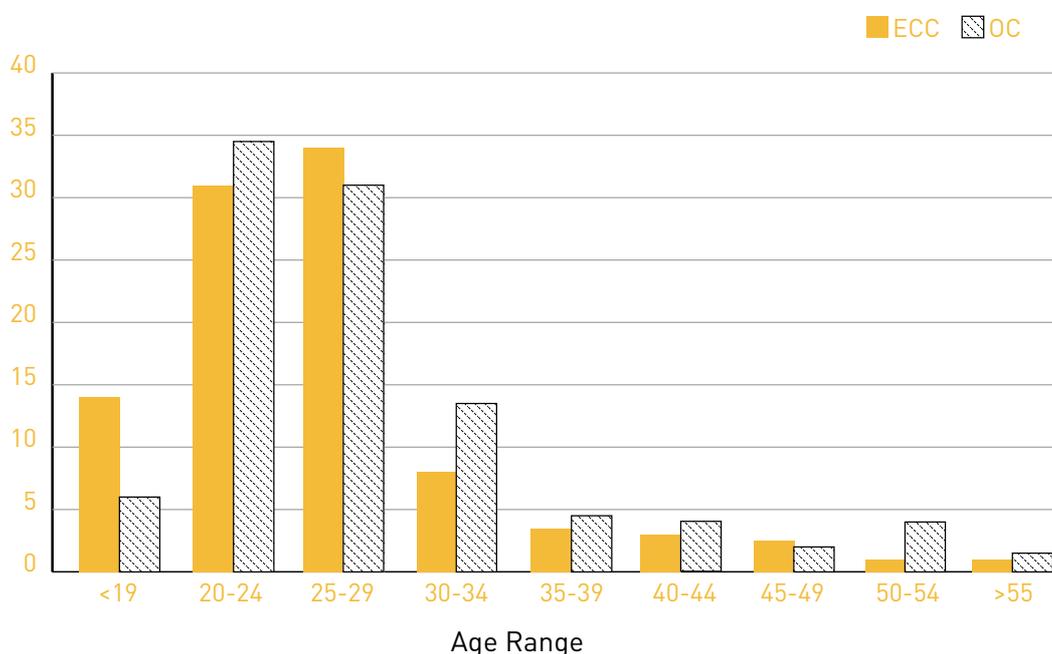
3.1 Introduction

This chapter will present the findings of the two questionnaires that were administered at the Dublin Well Woman Clinic. The first part of this chapter will offer a descriptive overview of the data and the second part, a more detailed analysis, which will explore some of the interconnections within the data. Although we will focus primarily on the questionnaire that was issued to those clients who attended the clinic for emergency contraception, we will draw on some of the findings from the OC questionnaire, completed by those clients who attended the clinic for other reasons. This second questionnaire has allowed us to determine the extent to which the emergency contraception client group (ECC group) matched the profile of the more general client group of the clinic (OC group).

3.2 Contextual information

The ECC questionnaire was completed by a total of 238 participants over a period of nine weeks. The number of clients who attended the clinic for emergency contraception over this period for the days the questionnaire was administered was 249, which gives a response rate of 96%. 222 OC clients completed the second questionnaire, which represented 95% of the those who attended the clinic on the days data was gathered. As described in Section 2, the study methodology sought to ensure that the volume of responses was roughly representative of the flow of clients in the Well Woman centre over this time frame. The following tables show the age profiles, geographical location and nationalities of the respondents. Please note that due to some respondents not completing some questions, the totals on the tables do not always add up to 238 for the ECC group and 222 for the OC group.

Chart 3.1 Age profile of the ECC and OC respondents (%)



As can be seen above, the majority of the ECC respondents (63%) fall into the 20-24 and 25-29 age groups. Respondents' ages ranged from fourteen years of age (n=1) to 55 (n=1), with the average age being 25. This is comparable to the OC group, where 60% of respondents fell into the 20-24 and 25-29 age ranges. The average age (28) is slightly older for this group and the age range is from seventeen to 60 years old.

To help gain an understanding of where the ECC and OC respondents lived, we asked them to indicate their postcode if they lived in Dublin and their county if they did not. 81% (192) of the ECC respondents said that they resided in Dublin city, with the remaining clients coming from surrounding counties, apart from two people from Galway and one from Cork. A similar pattern was noted with the OC group, though proportionately fewer women (72%) said they resided in the Dublin area (n= 160). The women came from a larger number of counties. This can be seen in Table 3.1 below.

Table 3.1 Current residence of ECC respondents

County	Number of ECC Respondents	Number of OC Respondents
Not stated	14	24
Co.Cavan	1	1
Co.Cork	1	-
Co.Dublin	17	13
Co.Kildare	2	6
Co.Louth	1	-
Co.Laois	-	1
Co.Meath	1	8
Co.Westmeath	-	1
Co.Wicklow	-	4
Cork	1	-
Dublin	192	160
Galway	2	-
Kildare	2	1
Louth	1	-
Meath	2	1
Wicklow	-	1
Total	237	221

In relation to the nationality of the ECC and OC groups, the majority of respondents in both instances classified themselves as 'Irish': 84% for the ECC group and 80% for the OC respondents. In both groups there were a range of other nationalities, but these tended to appear as single individuals rather than small clusters. It should be recognised, however, that the questionnaire was not administered to clients where the language barrier prevented them filling in a questionnaire. Clinic staff identified these individuals when they arrived at the clinic.

Two further contextual questions were asked of both the ECC and OC respondents. These concerned their level of education and employment status. The responses for both groups can be seen in Table 3.2 below.

Table 3.2 Final educational level for ECC and OC respondents

Educational Level	ECC Group		OC Group	
	Number of Respondents	% of Respondents	Number of Respondents	% of Respondents
No formal education	2	1	2	1
Primary education	2	1	1	1
Junior or intermediate certificate	16	7	10	5
Leaving certificate	59	25	51	23
Non-degree	68	29	56	26
Primary degree	41	17	59	27
Postgraduate diploma	17	7	16	7
Postgraduate degree	32	14	23	11
Total	237	100.0	218	100.0

A sizeable minority of the both the ECC group and OC group reported having a non-degree or degree-level qualification and a smaller proportion held some sort of postgraduate qualification. The OC group had a higher proportion of respondents who reported having a 'primary degree' than the ECC group. There were very few participants who reported having a level of formal education up to junior or intermediate certificate level. However, it is important to bear in mind that the ECC sample did have more adolescents than the OC sample. As can be seen in Table 3.3, the majority of the ECC respondents reported being in 'full-time employment' (61%) with the next largest group being that of 'students' (21%). For the OC group, there is a higher proportion of those in 'full-time employment' (79%), fewer students (11%) and fewer women stating they work part-time (7%). Job titles were quite varied for both groups.

Table 3.3 Occupational status of ECC and OC groups

Educational Level	ECC Group		OC Group	
	Number of Respondents	% of Respondents	Number of Respondents	% of Respondents
Full-time	143	61	173	79
Part-time	32	14	16	7
Unemployed	7	3	4	2
Student	49	21	23	11
Homemaker	4	2	2	1
Retired	0	0	1	1
Total	235	100.0	219	100

The last set of contextual questions asked the respondents about their personal relationship status at the time of their visit to the clinic. Chart 3.2, and Tables 3.4 and 3.5 show the responses for the ECC and OC groups.

Chart 3.2 ECC and OC respondents' reported relationship status (%)

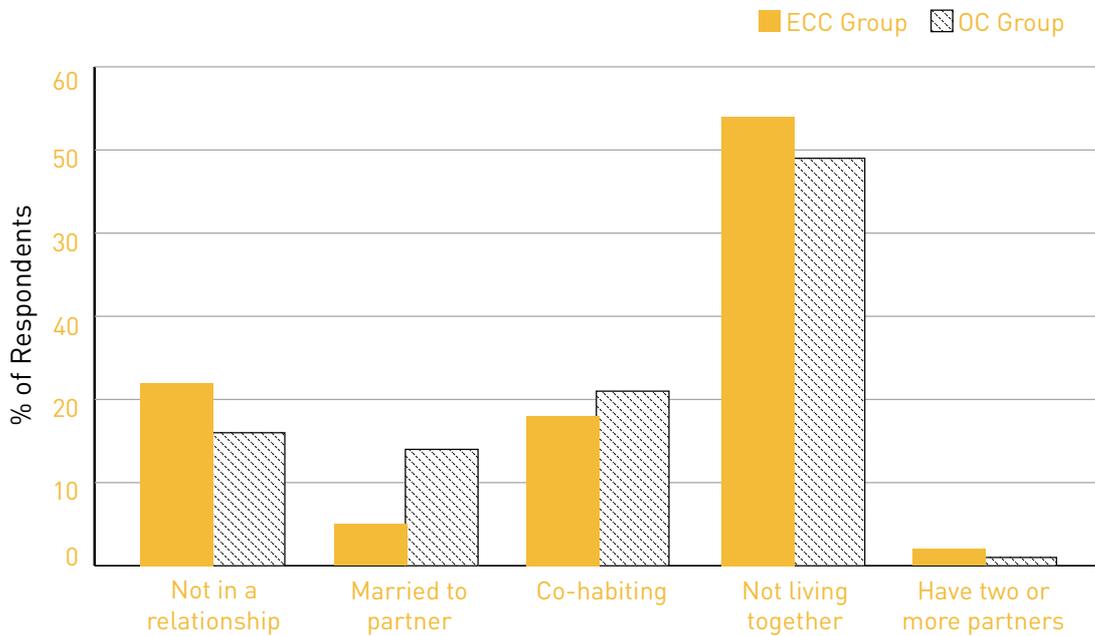


Table 3.4 ECC and OC respondents' reported duration of relationship

Duration	ECC Group		OC Group	
	Number of Respondents	% of Respondents	Number of Respondents	% of Respondents
No regular partner	30	14	21	10
Less than 3 months	33	16	16	8
4-6 months	34	16	21	10
7-12 months	19	9	18	9
1 year or more	97	46	129	63
Total	213	100.0	205	100.0

It is important to note that there are a few differences between the ECC and OC groups in terms of their relationship status. Firstly, from Chart 3.2 it can be seen that there are more women who describe themselves as 'married' (14%) in the OC group than the ECC group (6% married). There is a slightly higher proportion of ECC respondents who describe themselves as 'not in a relationship' (22%) or 'not living together' (53%) in comparison to the OC respondents (16% and 49% respectively). Table 3.4 shows the reported duration of relationships of the ECC and OC groups. It can be seen that 63% of the OC group reported to be in a relationship of '1 year or more' as compared to 46% of the ECC group. Table 3.5 below unpacks this in slightly more detail by crosstabulating 'time in relationship' by 'relationship status'.

Table 3.5 Crosstabulation of time in relationship by relationship status by number of ECC respondents

Time in Relationship	Relationship Status					Totals
	Not in a relationship	Married to partner	Co-habiting	Not living together	Two or more	
< 3 months	2 (6%)	-	-	31 (85%)	-	33
4-6 months	-	1 (3%)	3 (9%)	29 (85%)	1	34
7-12 months	1 (5%)	-	3 (16%)	15 (79%)	-	19
1 year or more	1 (1%)	13 (13%)	36 (37%)	46 (47%)	1 (1%)	97
Totals	4	14	42	121	2	183

The above table is useful in exploring the connections between duration and status of relationship. The data suggests that the majority of the ECC sample are in some type of relationship. For example, 97 respondents reported being in a relationship for longer than 12 months. What this suggests, particularly when looked at in relation to Section 5 below, is that with this sample casual unprotected sex is a less significant factor in seeking emergency contraception. However, it cannot automatically be assumed that these relationships are stable or that the respondents' decision to seek EC is due to

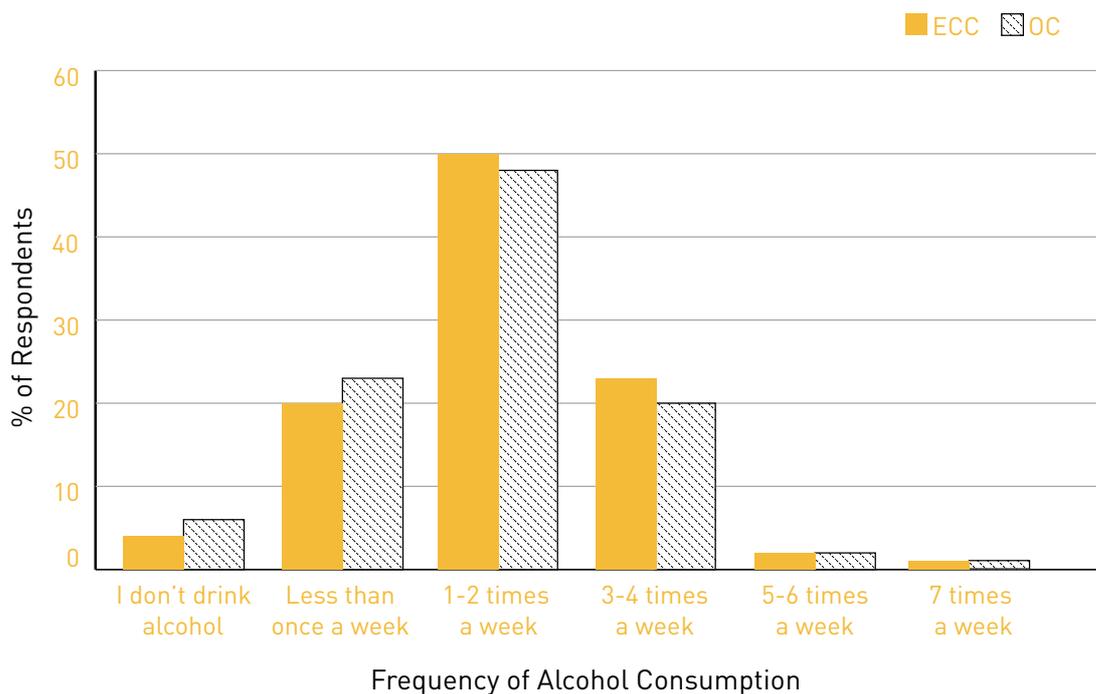
intercourse with their regular partner.

In summary, based on the contextual data reported on above, both the ECC and OC groups match each other quite closely. There are, of course, some variations but these would be expected with any random sampling process. Looking at the characteristics of the ECC group gives the impression that they are mainly young women, relatively well educated, in some form of employment and in a relationship of some description. The OC group is similar in many respects but has a slightly older profile and has a greater proportion of married participants in full-time employment.

3.3 The respondents and alcohol use

This next section will describe the findings from the set of questions that we used to explore both the ECC and the OC groups' self-reported use of alcohol. Chart 3.3 and Table 3.6 show the findings for both the ECC group and the OC group. The questions about alcohol use, and the comparisons drawn between the two groups, provide interesting data, which challenge assumptions surrounding the relationship between alcohol use and emergency contraception.

Chart 3.3 ECC group and OC group response to the question: Please can you tell us on average how often you drink alcohol? (%)



As can be seen in Chart 3.3, the proportion of responses to the question concerning how much the ECC and OC groups drink mirror each other quite closely. There is a tendency for the majority of respondents in both groups to report that on average they drank '1-2 times a week' (ECC = 118 and OC = 104), and a just under a quarter of respondents in both groups reported that they drank '3-4 times a week'. Not dissimilar numbers of respondents (ECC = 48 and OC = 50) reported drinking alcohol 'less than once a week'. What this suggests is that, at the descriptive and inferential level, the ECC group does not deviate much from the more general client base of the clinic in relation to alcohol usage². This is also reflected in the pattern of responses – which can be seen below in Tables 3.6 and 3.7 – to the follow-up questions we asked concerning how clients described their drinking. The purpose of these questions was to ascertain, in a fairly general manner, how people perceived their drinking and to partially allow us to deal with the ambiguities that stemmed from the previous question. The frequency with which someone drinks can not automatically be linked to the volume of alcohol that is consumed. Merely because someone might report that they drink regularly, for example 5-6 times a week, does not necessarily mean that they consume large amounts of alcohol.

Table 3.6 ECC group and OC group response to the question: If you drink alcohol please can you tick the statement which most closely describes your drinking?

Statement	ECC Group		OC Group	
	Number of Respondents	% of Respondents	Number of Respondents	% of Respondents
I do not get drunk	16	7	15	7
I get drunk rarely	62	27	61	30
I get drunk sometimes	128	57	109	53
I get drunk often	20	9	21	10
Total	226	100.0	206	100.0

In looking at the results from Table 3.6, there is a good parity of responses between the two groups in terms of how they describe their drinking within the parameters of the question. When explored in relation to age there is also little difference in the proportion of responses. This suggests that the two groups are more alike than different in their self-reported drinking patterns. Table 3.7 below shows the results from the follow-up question, which asked the respondents to report on whether or not their drinking leads to a lack of recall as to how much they have drunk. As can be seen, the responses between the two groups are quite similar.

² A Mann-Whitney U test of difference, which is suitable for rank-ordered data, generated a statistically non-significant result ($p = 0.246$ at the $\alpha < 0.05$).

Table 3.7 ECC group and OC group response to the statement about levels of intoxication

Statement	ECC Group		OC Group	
	Number of Respondents	% of Respondents	Number of Respondents	% of Respondents
I don't drink	10	4	16	7
Sometimes I can't remember how much I've drunk	72	31	65	30
I regularly can't remember how much I've drunk	11	5	5	2
None of the above	137	60	133	61
Total	230	100.0	219	100.0

In summary, we can be reasonably confident in stating that there is very little difference in the patterns of reported alcohol use by both the ECC and OC groups, as explored by these questions. This is important, as it suggests that the ECC group, at least in terms of this variable, matches the OC group. As such, drinking patterns of women who attended the clinic for EC are not, in any sense, aberrant; rather, they mirror the drinking patterns of all women who attended the clinic over the same period. This observation is also supported by the use of a simple chi-square test on the data in Table 3.7, which produces a non-significant result ($\chi^2 = 0.474$; $p = .925$). In short, this result implies that a respondent's reported drinking pattern is not contingent upon 'membership' of a given category i.e. ECC or OC. A non-statistically significant result ($\chi^2 = 2.186$; $p = .535$) was also obtained by using the data from Chart 3.3 on the respondents' reported 'average' times they drank alcohol during the week. When the questions 'I get drunk often' and 'I regularly can't remember how much I've drunk', are examined, it can be seen that the kind of drinking activities reported would indicate that both groups do not engage in excessive forms of drinking. When crosstabulated against age, similar patterns also emerge between the two groups.

3.4 Contraception and alcohol and the ECC group

In this section we will discuss the findings in relation to a set of questions that were only asked of the ECC group. The content of these questions explored: 1) their last sexual encounter, 2) whether contraception was used and 3) if it was, what prompted them to seek EC. We will also explore the respondents' reported use (and non-use) of alcohol during this encounter. The first three questions, which are set out in tabular form below, were concerned with when the respondent had sexual intercourse, whether or not they were using any form of contraception and, if so, what method was used. The second set of questions asked the respondent if they had been drinking alcohol on this occasion. Given that one of the key questions of the research was to explore the relationship between the use of EC and the use of alcohol, it seems appropriate to include these items in this section.

Table 3.8 ECC group response to the question: How many hours ago did you have sexual intercourse?

Hours after Sex	Number of Respondents	% of Respondents
Less than 12 hours	46	20
Between 13-24 hours	61	26
Between 25-48 hours	79	34
Between 49-72 hours	34	15
Over 73 hours	13	6
Total	233	100.0

As can be seen in Table 3.8, 46% of the respondents sought EC within 24 hours of having sex, 49% waited between 24 and 72 hours, and 6% sought it after 73 hours.

Chart 3.4 ECC group response to the question: Did you or your partner decide to use any form of contraception? (n=232)

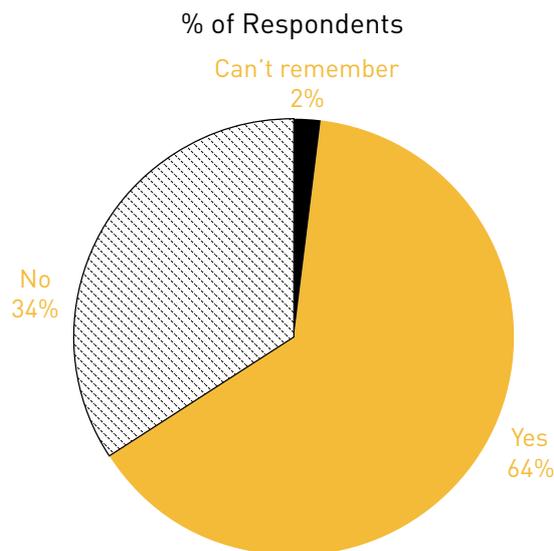


Chart 3.4 is revealing in that 64% (148) of the respondents reported having used some form of contraception when sex occurred prior to making an appointment at the clinic. From this it is possible to infer, for the majority of this group at least, EC was not viewed as the primary means of contraception. In addition to asking whether or not they used any form of contraception we also asked what type was used. As can be seen in Table 3.9 below, out of 156 women who answered this question 76% said they used a condom. By far the most common explanation given as to why they sought EC was problems with the condom, such as it 'slipping off' or 'bursting'. Although some of the responses are vague, it is nonetheless possible to discern that some of the group see emergency contraception as a way of being 'doubly sure'. 20% of the group reported that they had used the pill, which raises interesting questions as to why they sought emergency contraception. From the written responses of seventeen women there were a variety of

explanations, but the most common were variants on 'I forgot to take the pill'.

Table 3.9 ECC group response to the question: What form of contraception were you using?

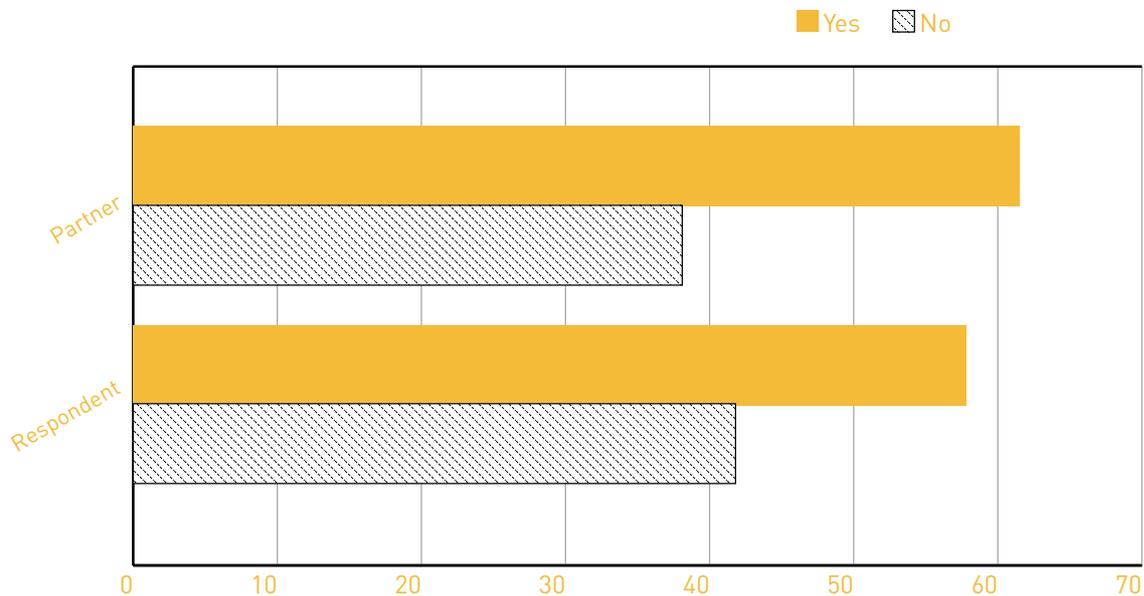
Method	Number of Respondents	% of Respondents
Withdrawal	6	4
Pill	30	19
Injection	2	1
Condom	118	76
Total	156	100.0

In addition to asking the ECC group about their use of contraception, we asked a number of questions that were directly related to their own and their partner's use of alcohol prior to this sexual encounter. As can be seen in Table 3.10 and Chart 3.5, 58% of the respondents reported that they had been drinking and 62% reported that their partner had been drinking. Table 3.10 illustrates that 42% of respondents reported that they did not drink any alcohol on the occasion they had sex. Therefore, in terms of the link between alcohol use and EC, it is clear that not all women seeking EC will have been drinking when sex occurred. Therefore alcohol cannot be singularly attributed to affecting the need for EC.

Table 3.10 ECC group response to the question: On this occasion had you or your partner been drinking alcohol?

	Respondent		Partner	
	number	%	number	%
Yes	130	58	134	62
No	94	42	83	38
Don't Remember	1	1	1	1
Totals	225	100.0	218	100

Chart 3.5 ECC group response to the question: On this occasion had you or your partner been drinking alcohol? (Percentages)



In exploring this slightly further, Table 3.11 below shows a crosstabulation between the reported use of alcohol by the respondent and their use of contraception. It is interesting to note that of those who reported drinking alcohol, a greater number claimed to have used contraception (n=73) than those who used no protection (n= 52). Therefore, 58.4% used contraception while under the influence of alcohol. Meanwhile, of those who did not drink alcohol a greater proportion claimed to have used protection (72%; n=67) than those who said they did not (28%; n=26). This data suggests that in general, for this group of respondents, whether drinking alcohol or not, a greater proportion of women will use contraception; therefore, alcohol does not appear to be directly associated with less contraceptive use. However, there is a pattern suggesting that a greater proportion will use contraception if not under the influence of alcohol³. The data for the use or non-use of alcohol is similar for both the respondent and their partner.

Table 3.11 Crosstabulation of 'used contraception' by 'used alcohol'.

Used contraception	Used alcohol on this occasion		Total
	Yes	No	
Yes	73 (58%)	67 (72%)	140 (64%)
No	52 (42%)	26 (28%)	78 (36%)
Total	125	93	218

The next table, Table 3.12, explores in more detail those participants who had reported drinking alcohol and how much they and their partner had consumed. As can be seen, there is very little difference in the reported state of intoxication of the respondent and

³ This pattern is small and therefore any conclusions drawn will be tentative. A further study with a larger sample size would have to be conducted to explore this link in greater detail.

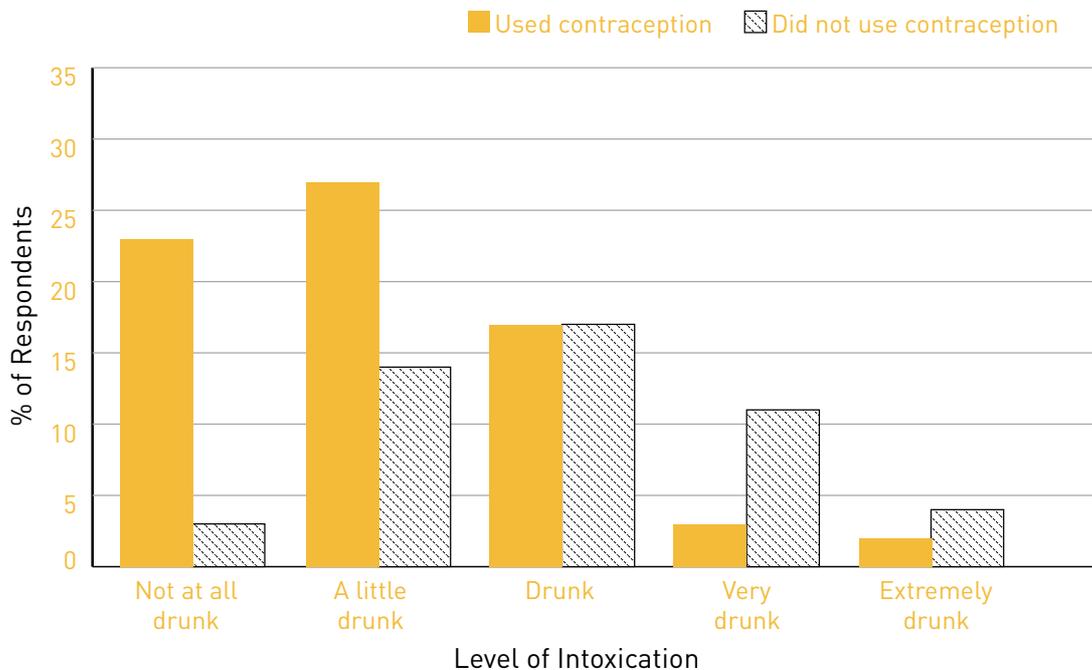
their partner. In both instances the majority of responses fall into the 'not at all drunk', 'little drunk' and 'drunk' categories, with only small proportions reporting that they and their partner were 'very drunk' or 'extremely drunk'.

Table 3.12 ECC group response to the question: How drunk were you and your partner on this occasion?

Statement	Respondent		Partner	
	number	%	number	%
Not at all	36	26	26	29
Little drunk	43	32	26	29
Drunk	36	26	25	28
Very drunk	15	11	10	11
Extremely drunk	6	4	3	3
Totals	136	100	90	100

In looking at this in more detail, the following chart provides a crosstabulation using the data on levels of intoxication with the responses to the question on whether or not they used contraception.

Chart 3.6 Crosstabulation of 'used contraceptives' by 'level of intoxication'. (Percentages)



The above chart suggests that all women who consumed alcohol (those who did and who did not use contraception), tended to fall into the following categories: 'a little drunk' and 'drunk'. The majority of women who were 'a little drunk' used contraception; women who were 'drunk' were as likely to have used contraception as not to have used contraception. There is descriptively a pattern showing that those few respondents who categorised themselves as 'very drunk' or 'extremely drunk' also reported not using contraception in higher proportions than those who did; however, these numbers are very small (n=16, or 12%) in relation to the rest of the sample who responded to both these questions (n=135), so care needs to be exercised in drawing any conclusions. Also, when placed in the context of the whole ECC sample, the size of this sub-sample falls to eight percent.

3.5 Use of contraception in general by the ECC group

As well as exploring what kind of contraception, if any, the ECC group were using immediately prior to their visit to the clinic, we asked a series of questions concerning their general use of contraceptive methods. Table 3.13 shows the ECC group response to the question about their past use of contraception. When reading this table it is important to note that there was not an equal number of responses to each item. Although we included a 'never use' response category to help us gauge across the group what methods were not applied, only some of the respondents made use of this option. Therefore, when interpreting the response to each method it is important to take note of the total number of respondents replying; this is given in the far right-hand column.

Table 3.13 ECC group's reported past use of contraceptive methods

Method	% Never	% Rarely	% Sometimes	% Often	% Always	Total number of responses
Pill or mini-pill	19	12	23	20	26	172
Condom	5	5	14	38	37	187
Withdrawal	48	24	16	7	5	96
Diaphragm	97	2	-	-	1	96
Rhythm	87	1	7	4	-	95
Emergency contraception	36	44	17	2	1	94

'-' indicates no response.

From the data in the table it is noticeable that the 'condom' is by far the most widely used method of contraception, followed by the 'pill or mini-pill'. The 'diaphragm' and 'rhythm' are methods that do not seem to be particularly favoured, followed by 'withdrawal'. In addition to the above question we also asked the respondents if they had used emergency contraception on previous occasions and, if so, where they acquired it. Table 3.14 sets out their responses. It is interesting to note that while only 94 respondents in Table 3.13 reported on their use of EC, when asked directly the majority

of respondents (n= 164 or 69%) reported that they had used it in the past, which has implications for clinical practice, as discussed in Section 5.

Table 3.14 Reported sources of emergency contraception

Source	No of respondents	% of respondents
Well Woman	87	53
GP/Family Doctor	44	27
Other reproductive health clinic	27	16
Campus medical centre	9	5
Total	164	100

164 or 69% of the ECC group reported that they had used EC previously, which suggests that 31% were first-time 'users'. Table 3.14 shows that for women who had used EC in the past the Well Woman Clinic was the most popular source, followed by GP/family doctor, then 'other reproductive health clinic'.

In summary, it would appear that past use of contraception by the ECC group is marked by a high tendency towards the condom as their primary method, as indicated by the proportions falling into the 'often' and 'always' response categories. Furthermore, most of those sampled had used EC in the past.

3.6 ECC and OC groups' experience of sex education and knowledge

As discussed in the introduction to this report, it was considered that the study would make a good context in which to explore the clinic's client group's experience of and attitude towards their own sex education. This section reports the findings from two questions. The first question presented respondents with a list of six short statements related to contraception; respondents were asked to state which of them were true or false. Table 3.15 below shows the results for the ECC and OC groups

Table 3.15 ECC group and OC group beliefs about contraception and sexual health

Statement	ECC Group		OC Group	
	% True	% False	% True	% False
I am most likely to become pregnant if I have unprotected sex in mid-cycle	84	17	81	19
I am safe from getting a sexually transmitted infection because I am on the pill	1	99	1	99
I cannot get pregnant if I have sex during my period	17	83	14	87
For emergency contraception to work, I can take it up to 72 hours after having sex	96	4	77	23
Taking a contraceptive pill for more than 2 years causes fertility problems	18	82	9	91
You can have a sexually transmitted infection and not even be aware of it	96	4	95	5

The second question we asked of both groups was about their experience of sex education. We wanted to know what sources of information they had been exposed to and how they rated the quality of the information they received. Chart 3.7 shows the responses for the ECC group and Chart 3.8, for the OC group.

Chart 3.7 Experience of sex education: ECC group

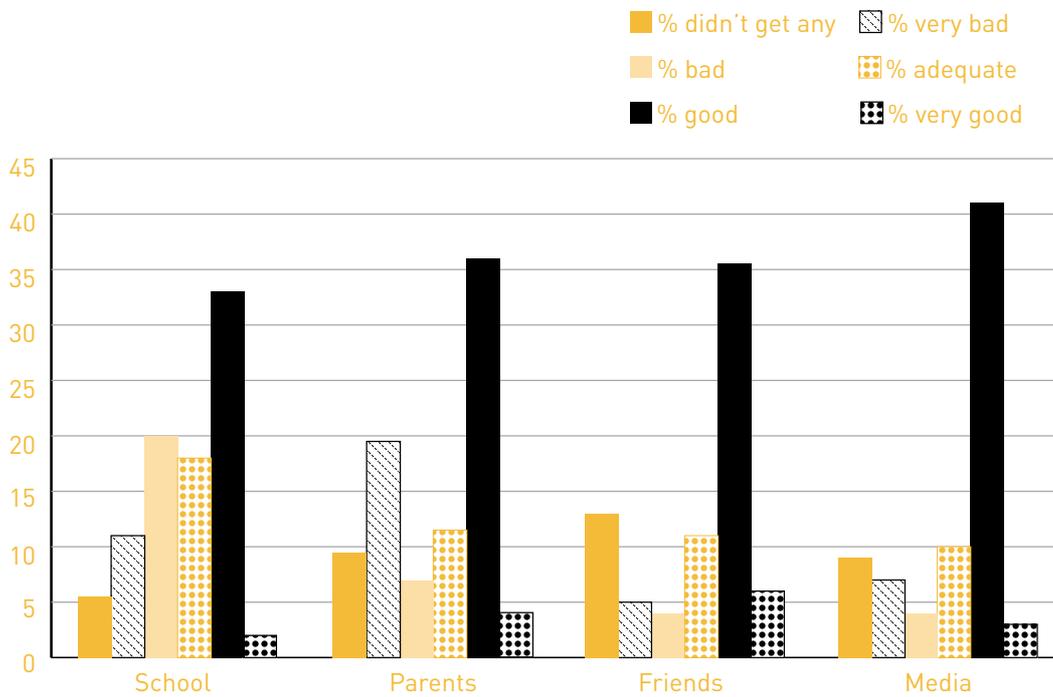
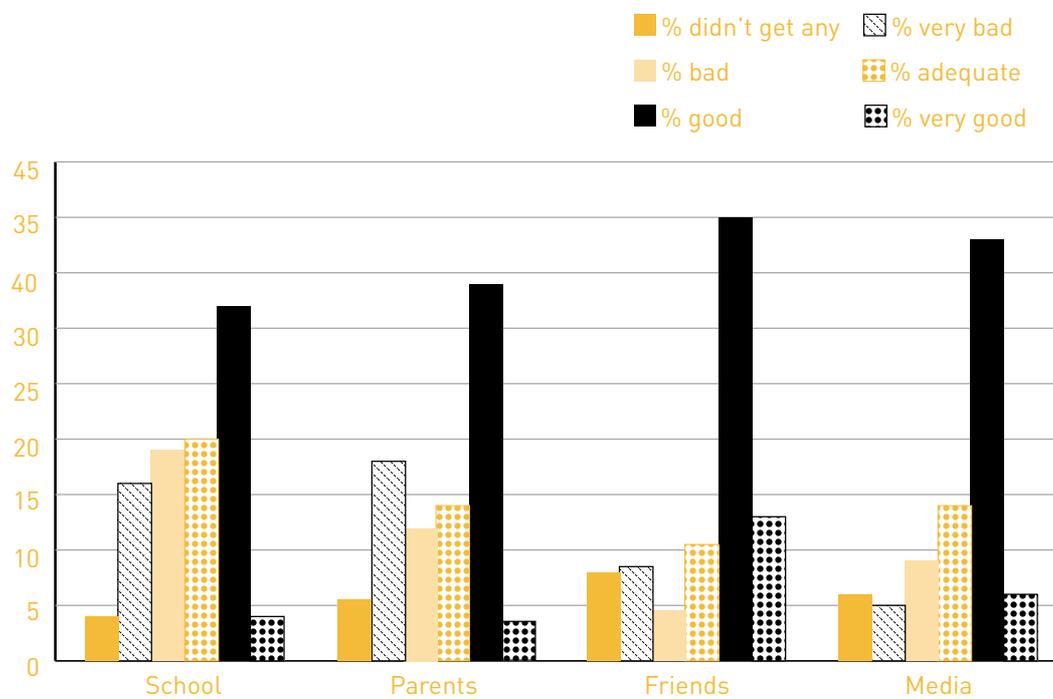


Chart 3.8 Experience of sex education: OC group



The above two charts illustrate how these two groups experienced and rated the quality of their sex education. To begin with, both groups rated the quality (if measured by the 'good' and 'very good' response categories) of their experience of sex education via their

friends and the media over and above school and parents. However, it is important to note that a sizable minority in both groups opted for the 'adequate' response category. The 'school' for both groups (36% ECC and 40% OC) drew a sizable proportion of responses from the three negative categories. There was also a similar pattern of response to 'parents': 38% ECC and 36% OC. Conversely, 51% and 40% of the OC group and 45% and 51% of the ECC group described their sex education via their parents and school respectively, as being 'good' or 'very good'. However, if this data is crosstabulated against age, there is a tendency for the younger ECC group members i.e. under nineteen and between 20 and 24, to rate their schools and parents in the 'good' or 'very good' categories. For the OC group the patterns are much more diffuse.

We can tentatively conclude that both groups, as measured by the questions in Table 3.15, have a good knowledge of sex related issues, but this knowledge is derived from a range of sources, rather than a single, authoritative institution or group.

3.7 Summary of findings

Findings demonstrate that the sample characteristics for ECC and OC groups match each other quite closely. The ECC group is made up of mainly young women, relatively well educated, in some form of employment and in a relationship of some description. Despite the slightly older married profile of the OC group there is a similar pattern with respect to demographic characteristics. The data demonstrate that there is very little difference in the patterns of reported alcohol use by both the ECC and OC group, as explored by a series of questions. As such, the drinking patterns of women who attended the clinic for EC are not, in any sense, aberrant, but mirror the drinking patterns of all women who attended the clinic over the same period. The findings also demonstrate that 64% (148) of the ECC clients reported that they had used some form of contraception prior to making an appointment at the clinic. From this it is possible to infer that, for this group at least, EC was not viewed as the primary means of contraception. This is despite the fact that most women (69%) had used EC in the past.

With respect to alcohol consumption prior to seeking EC, 58% of the respondents reported that they had been drinking when sex took place. It is important to note that 42% of respondents reported that they did not drink any alcohol on the occasion they had sex. Findings suggest that whether women drink alcohol or not, a majority of women will use contraception. This study used three different measures of alcohol consumption to help tease out underlying issues. What is clear from analyses using these measures is that the relationship is not straightforward among this sample. Findings that can be drawn include:

- a) Not all women requesting EC will have consumed alcohol at the time they had unsafe sex;
- b) Of those who consumed alcohol, a greater proportion used contraception;
- c) Of those who reported being 'not at all drunk', or 'a little drunk' the majority did use contraception. Of those who reported being 'drunk', they were equally as likely to have used contraception or not. Of the small number who reported being 'very/extremely' drunk, they were more likely to have used NO contraception;

- d) While a larger study (comprising larger cell sizes) is required to test these relationships it would appear that drinking alcohol may lead to a lower proportion of women using contraception in the first instance and if 'very drunk' then it is more likely that contraception will not be used.

4.0 Findings: The Interviews

Summary

Within this group of eight participants there is a perception that alcohol can lead to sexual risk-taking behaviour and that this behaviour is embedded in the fabric of social life in Ireland.

This risk-taking behaviour appears to be more associated with young people in their early twenties and most participants in this sample feel they have, in many ways, 'grown out' of this behaviour.

Where alcohol is not an issue, the nature of the relationship between the man and woman is perceived to play an important role in sexual risk-taking. There is a perception that couples take increasing risks as the relationship progresses.

The findings also suggest that different approaches to sexual health education and sexual health promotion may be required depending on the age of the women and the relationship she is in.

More research is required to investigate these issues further, as the findings do suggest that risk behaviour is dependent on age and relationship status.

4.1 Introduction

The second part of the research involved a qualitative, interview-based study with Well Woman Centre clients to examine how they understood and defined the relationship, if any, between sex and alcohol. This section will describe the analytic method and discuss the qualitative findings. As outlined in Section 2 on methodology, the purpose of the interviews was to explore in much more detail the themes and issues covered in the questionnaire. The section begins with a description of the clients' sexual education; this will partially, though not entirely, help to contextualise their responses. Next we will discuss their experiences and attitudes towards contraception, including EC. Finally, we will explore the participants' attitudes towards and use of alcohol.

In total, eight Well Woman clients agreed to participate in the interview study. These participants ranged in age from 20 to 38 years. In terms of their relationship status, two were single, five were in a relationship and one was married. Their level of education ranged from leaving certificate to degree level. Seven were employed, of whom one was on maternity leave, and one was unemployed. Five of the participants described themselves as Irish, one was Danish, one Spanish, and one Canadian. The women not born in Ireland were all judged by the interviewer to be fluent speakers of English. Four of the participants had used EC at some stage and were not in the clinic for EC on this occasion, whilst the remaining four were in the clinic for that purpose when asked to volunteer for the interview.

4.2 Experience of sex education

Of the eight interviewees, three stated that their sex education came mostly from their parents, with comments ranging from it being 'very open' to 'reasonable'. It was observed from the responses that those nominating parents as their teachers rated them as a much better source of information than any of the other methods. Not

unsurprisingly, given the responses to the questionnaire, seven out of the eight women described the sex education they received from school as 'inadequate', apart from one interviewee who received an hour a week for a year. Similar to the findings from the questionnaire data, most of the women remarked that talking with friends, television, books and magazines contributed to their knowledge. The following short quotes illustrate the range of experiences:

When I was younger, my parents gave me reasonable sex education but when you are a teenager, I don't think it matters anyway. What they were saying wasn't relevant to what...your parents aren't to be listened to anyway. When we had sex education in school, I was already pregnant. (Interviewee 1, aged 38)

I was never actually sat down and gone, 'this is the story'. It was always pretty much open in our house and then we got a small bit from school. (Interviewee 2, aged 22)

I learned from my mother when I was about in second class ... there was nothing in national school. In the secondary school ... I don't think there was anything apart from Home Economics. (Interviewee 5, aged 30)

Sex education, I probably got most of it from Cosmo, I'd say, magazine. The first time I asked ... my mum to explain to me about sex, she told me it was the difference between a man and a woman. (Interviewee 8, aged 27)

The majority of participants expressed the view that schools should provide better sex education, with many suggesting a set course run by somebody from outside the teaching staff at an early age. Other research suggests that in the UK pupils want sex education from teachers they trust and who they perceive as not being embarrassed (Allen 1987). Most of the eight interviewees believed that parents would be less inclined to talk to boys about sex education and that males may be more inclined to use their friends as a source of knowledge. In general, the eight interviewees held the view that girls receive better sex education than boys.

4.3 Sexual behaviour and contraceptive use

Of the eight participants, six stated that they would not, at present, have unprotected sex and the remaining two conceded that, in general, sex is protected but risks occur. It is useful to note that for the participants alcohol emerged spontaneously during the interviews as a factor associated with sexual risk-taking. In order to develop an understanding of normative behaviour, questions were asked about participants' perceptions of the behaviour of their peers and friends. When participants discussed the behaviour of their friends, it was generally observed that they perceived the behaviour of others more negatively than their own. In general, friends and acquaintances were seen to have more unprotected sex, be less sensible and drink more than the participant. The following quotes illustrate some of these findings:

All of us have had moments, it certainly wouldn't be something that we would do ... intentionally. See, I think alcohol and drugs have a big part. (Interviewee 3, aged 30).

I will never have unprotected sex and none of my friends will have. (Interviewee 7, aged 20)

However, when speaking of people known to her, Interviewee 6 (aged 35) reported:

I manage a team of eight girls and two boys and they are all in their twenties ... and the amount of time that they would come into me on a Monday morning, they've been out at the weekend and they don't know whether they did or they don't know whether they used a condom and I've actually sent them to get the morning-after pill. (Interviewee 6, aged 35)

With respect to awareness of pregnancy and/or STIs, four participants stated that they would worry more about sexually transmitted infections, two more about pregnancy and the remaining two were worried about both. Seven of the eight participants described that they would never judge whether or not a partner has a sexually transmitted infection, while one participant stated that she would, despite knowing that a healthy appearance does not make a person any less likely to be infected. However, no participant would ask a partner to get tested for a sexually transmitted disease and would trust that they had no infections.

In terms of contraceptive use, five participants agreed that they would use condoms and the oral contraceptive pill over other forms of contraception, while another two reported using condoms alone. The contraceptive pill tended to be associated with being in a relationship or for medical purposes. Three women mentioned either trying or looking into using Depo-Provera, but all three agreed that this was not a preferred method of contraception. This finding is very much consistent with the literature, which reports that the most frequently used method of contraception is the pill, followed by condoms for those in a relationship.

All participants had experience of unprotected sex or unsafe sex. The women interviewed tended to associate these experiences with risks taken due to alcohol when they were younger, or problems with the contraceptive method e.g. condoms bursting. The following quotes illustrate these findings:

Alcohol-related...alcohol and youth. You do dumb stuff when you're young. (Interviewee 1, aged 38)

Well the first one was the condom actually slipped and came completely off and the second one, the second one, it didn't even split but in the back of my mind, it was...there was a worry. (Interviewee 2, aged 22)

I'd just like to say that it happened with people I've had long-term relationships with ... because you're under the influence of alcohol, you might ... you go, "Ah, I'll just get the morning-after pill." (Interviewee 3, aged 30)

Because I was in a bad way myself. I was ... I was going through a bad way myself...family problems...I started taking drugs and I was completely ... so that was it, in that time then. (Interviewee 8, aged 27)

Most participants did not feel any pressure from external sources to use or not to use contraception. One participant stated that she felt some social pressure, another felt that there was huge pressure from family, friends and herself not to become pregnant, and a third commented that there is a lot of pressure from men not to use contraception.

I think there are social pressures...I think it's more left up to the female because men can just run away whereas women are stuck with a baby. (Interviewee 1, aged 38)

Well I think everyone, both male and female, it's an equal responsibility and I don't think pressure has got a lot to do with it. (Interviewee 2, aged 22)

From men pretty much...I mean I wouldn't trust a man...and I know none of my friends would either...yeah I think men would...I know my friends, and talking to them, they would definitely say if she didn't say to put on a condom, they wouldn't bother. (Interviewee 8, aged 27)

The eight interviewees were asked what factors might affect their decision to use contraception and a combination of different factors emerged. These factors, along with the number of how many women stated them, are illustrated in Table 4.1 below.

Table 4.1 Factors affecting use of contraception

Factors	Number of interviewees
Alcohol	8
Relationship	7
Drugs	3
Personal situation	3
Wanting a baby	3
Availability of contraception	2
Pressure from men	3
Self-confidence	1
Religion	1
Finance	1

As suggested by some of the previous quotes, all participants mentioned the role alcohol plays in making this decision, and, interestingly, seven stated that being in a relationship affects contraceptive use – with couples taking more risks over time. It was generally observed that when one is in a relationship, contraception use becomes relaxed in terms of pregnancy and more risks are taken with regards to sexually transmitted diseases. Three participants suggested drug-taking affects contraceptive use, followed by one's personal situation, wanting a baby, availability of contraception at the time, pressure from men not to use contraception, self-confidence, religion, and finance. The following quotes illustrate these factors:

I think alcohol is one [factor] and I think...and again pressure from men would be another if you're not all that sure of yourself...I also believe that self-confidence and religion would have a good part to play...religion would have a good part to play in terms of whether you would actually engage in sex or not anyway. (Interviewee 1, aged 38)

I'm not sure, again there's as a contraceptive and then there's as a sexually transmitted disease protector, if you know what I mean. I think, if you are in a relationship, some people let down...as regards the protection from sexually transmitted diseases, the guard drops when you are in a relationship. The fact is, if you are going out on the town, pretty much the main one is alcohol. (Interviewee 2, aged 22)

See I think alcohol and drugs have a big part...I think maybe people are in a situation...if they were with someone that they really, really liked and this person that they liked didn't want to use anything...if you are in a long-term relationship, you kind of let...I'm sure you can let it slip. (Interviewee 3, aged 30)

I think that's [alcohol] the biggest one for my friends, it's like because you're...you don't think. (Interviewee 4, aged 26)

Alcohol, finance, availability...yes, the whole thing about being clucky. I know some girls who just want to have children. And that can affect decisions. (Interviewee 5, aged 30)

Alcohol, drugs, personal problems...I suppose when you are with somebody a long time, you do tend not to use condoms and stuff...definitely if you are in a long-term relationship, it would change it, yeah. (Interviewee 8, aged 27)

4.4 Emergency contraception

Knowledge of emergency contraception

All eight participants had taken EC, and they stated that they were glad that it was available and thought it was a good idea. However, three thought it should be used only in emergency situations, one thought only as a back-up and one answered that you should not take it too often. Another stated that she had used EC as a form of contraception previously when she was not on the oral contraceptive pill and had no condoms at the time. Most women sourced their knowledge about EC from friends, magazines and other women who have taken it.

In terms of their knowledge of EC, five participants stated that they understood how it worked, while the remaining three either stated that their knowledge was not good or they had forgotten what they were told. All eight had a good knowledge of where to avail of emergency contraception, knew that it does not prevent sexually transmitted diseases, and that it does not prevent pregnancy on all occasions. Half of the participants knew that the emergency contraception was effective up to 72 hours, and three suggested that the time limit was 48 hours, whilst one participant thought that a woman would only have 24 hours to avail of it. Most respondents expressed a belief that emergency contraception could cause nausea and some suggested that other side effects included hormone disruption, moodiness, and headaches⁴. All participants stated that men's knowledge of emergency contraception is poor unless they are informed by a

⁴ It is interesting to note that Levonelle, which has been a licensed emergency contraceptive in Ireland since June 2003, has fewer side effects (such as nausea) than Ovran.

girlfriend. It is interesting to note that participants used the label 'morning-after pill' when talking about emergency contraception. This has implications for how emergency contraception is promoted and how misconceptions with respect to the correct time limit for its use are challenged.

Yes I have taken it and I think it's a good idea to have it there. I don't know much about it at all...twenty-four hours I thought...at the latest forty-eight hours. I expect it probably would [prevent pregnancy] but I don't know that anything's 100%. The pill has been around a lot longer than that morning-after thing and I don't think that sticking something that strong in your body quite often is a very sensible move; it's going to stuff up your hormone levels, anyway. (Interviewee 1, aged 38)

My attitude towards the morning-after pill is that it's not...that it's not advisable to take it too often and not to use it as a contraception. I learned from a magazine or from friends. I just know that it prevents you getting pregnant...up to 48 hours...GPs and the clinics. (Interviewee 3, aged 30)

I am pleased it's available...the only person who told me – she was a couple of years older than me and she brought me to the Well Woman clinic the next morning. I think I would be looking for it in the first 15 hours, I don't know if it is 48 hours. The morning-after pill is a very high dosage and very strong so you wouldn't want to be taking it too often...vomiting is the big one – huge nausea. (Interviewee 5, aged 30)

It's alright, yeah, because if you have unprotected sex...if something goes wrong, you need something to.... One friend of mine told me, but years ago because she had to take it...up to 72 hours. Most of the time it does [prevent pregnancy] it depends on how long you...the more quick you take it, it's more effective. Maybe it is riskier to take the morning...next morning because it's like a bomb for your body. (Interviewee 7, aged 20)

Use of emergency contraception

Participants were asked about why some women chose to get emergency contraception while others did not. A variety of answers was given in response to this question; these are listed below:

- lack of knowledge
- self-judgement of likely pregnancy risk
- money
- embarrassment and likely practitioner response
- indifference towards pregnancy
- denial of fertility.

When speaking of the barriers to using EC, five participants attributed lack of knowledge as a barrier to use, i.e. not being aware of EC, where to get it, time limits etc.

Four participants suggested that women make a judgement as to the likelihood of pregnancy depending on where they are in their menstrual cycle. For instance, three of the women stated that they would not take EC if they were due their period or if their period had just finished, while the other interviewee stated she would 'chance it' only if she had just finished her period.

Because I actually think about how big the chance is that I would get pregnant – where I was in my period and stuff like that. (Interviewee 4, aged 26)

In some cases it might be that they've just literally finished their period....Availability, possibly, as I only knew where to go from one of my friends. (Interviewee 5, aged 30)

Five participants stated that they would be put off by previously having encountered a negative attitude from a nurse/doctor; these participants stated that they would not return to this nurse/doctor or clinic again. One participant stated that she always feels judged by nurses/doctors but that this would not affect her. Another stated that she did not think that a judgemental attitude from a practitioner would affect her if she experienced it. These feelings are reiterated in previous research; for example Barrett and Harper (2000) suggested that the attitudes of GPs and pharmacists might deter women from seeking EC.

The first doctor I saw...she was great...and then the second time...I just felt I was slightly being looked upon. I wouldn't be seeing him again. (Interviewee 2, aged 22).

Four of the participants named financial reasons as a potential barrier to getting EC, despite knowing that having a baby would work out to be far more expensive. Three participants believed that embarrassment or not being worried about an unplanned pregnancy/wanting a baby might prevent women from seeking EC. Others thought that denial of fertility and having already used emergency contraception that month were further reasons.

Money is another – it costs a lot to get it so people are not going to get it so you have more teenage pregnancies. . .Financial reasons really would have been the main thing and I know that's stupid because if you had a baby it would be ten times worse...absolutely no other reason why I wouldn't go. (Interviewee 3, aged 30)

I know what would put the girls off going every time it happened is they're embarrassed about going to the doctor. (Interviewee 6, aged 35)

4.5 Attitudes towards alcohol

Drinking patterns were discussed with all participants from the time they began drinking up to the present time. It was noted that the interviewees related the times when they were drinking more to occasions when sexual risks and unsafe sex occurred, especially when participants were in their early twenties. All the participants stated that they used to drink more in the past and had since become more sensible in terms of alcohol and sexual behaviour. Furthermore, as mentioned previously, interviewees were inclined to say that their friends drank more than they did and were more inclined to have unprotected sex.

There has been a change. I know as you get older, over the past twenty years, you just become more sensible. It would not be an issue for me to get shit-faced at one stage and not really care about what was going on and I think, in my twenties, I had the odd blackout, that's when I stopped drinking like that. Part of it's age, part of it's sensibility, part of it's the fact that it takes such a long time to get over a hangover when you are older. (Interviewee 1, aged 38)

Years ago it was just a social thing and I just...it is out of control but it was a social thing and everybody did it so it was just the norm. Yeah, I mean I've certainly cut down and I'd even go out a bit later, wouldn't drink maybe as much in regards to really trying to slow down drinking. (Interviewee 3, aged 30)

When you're younger, I think it plays a big role...like, but as soon as you hit twenty-two, twenty-three it doesn't play that big a role. I think a lot of people, I think they actually drink a lot. They have to go out Friday and Saturday but we don't do that as much in Denmark and we don't get that drunk like they do over here...they don't drink as much in Denmark as they do over here. (Interviewee 4, 26)

Well I drink once or twice a week. But I'd say, normal for me could be anything from four drinks to eight drinks or ten drinks. I didn't drink at all [as a teenager]. I didn't drink a lot until I was about twenty-two and I did that just for a couple of years...drink and drugs. (Interviewee 8, aged 27)

With respect to recognising the risk of unprotected sex before it occurs, seven of the eight participants stated that they would never worry before going out that they might get drunk and have unprotected sex and that such a worry would only become an issue afterwards. The remaining participant stated that she would worry and, consequently, would drink very little, but her friends would not worry. Four stated that they doubted men would worry at all, one stated that men only worry about getting caught, and three stated that they think men might worry but not as much as women.

Like I don't know about before but afterwards you'd get a phone call – there's somebody on the other end on the line panicking [men]. Maybe not so the next day because if it is somebody that they kind of don't know or whatever and might not see him again whereas if a girl's pregnant as a result of that, a girl has that worry. (Interviewee 2, aged 22)

Oh, no, no, no! You wouldn't even think about that...you'd just worry about it the next morning. (Interviewee 3, aged 30)

Men would be more hoping than worrying. (Interviewee 6, aged 35)

It is interesting to note that even though this study comprises a small and diverse group of participants there is a clear perception that alcohol can lead to sexual risk-taking behaviour and that this behaviour is embedded in the fabric of social life in Ireland. It is also interesting that this behaviour appears to be more associated with young people in their early twenties and that most participants in this sample feel they have, in many ways, 'grown out' of this behaviour. Where alcohol is not an issue, the nature of the relationship between the man and woman is perceived to play an important role in sexual risk-taking. There is a perception that couples take increasing risks as the relationship progresses. This phenomenon has been identified in academic literature and is known as 'progressive remissness' (Hyde 1996). More research is required to investigate these issues further, as the findings do suggest that risk behaviour is dependent on age and relationship status. Furthermore, the findings suggest that different approaches to sexual health education and sexual health promotion may be required depending on the age of the women and the relationship she is in.

5.0 Discussion

From the analysis of this data, based on 238 women seeking emergency contraception in one Dublin city-centre Well Woman Centre, it would appear that in this particular sample of women, the link or relationship between drinking alcohol, use of contraception while having sex and the use of emergency contraception is not straightforward. 42% of participants in the ECC group did not consume alcohol at the time unsafe sex occurred; for those who did drink, the majority used contraception (58%).

While the findings from this study are not generalisable to other populations, it is interesting that - in this sample - EC users are not remarkably different from the general population of women receiving other sexual health services. They match each other in terms of age, educational levels, relationship status (to a large extent), and drinking patterns. This sample of EC users appears to be mainly young women, relatively well educated, in some form of employment and in a relationship of some description. The finding that three-quarters of women seeking EC categorise themselves as being in some sort of stable relationship directly challenges the myth that women who seek EC do so after casual sex and one-night stands.

These findings challenge the crude stereotype of EC users as being women who have had unprotected casual sex while drunk and who use EC as a primary method of contraception, rather than a secondary method. 58% of the ECC group reported that they had been drinking on the occasion when sex occurred. The majority of these women were either a little drunk or not at all drunk. Most women (those who drank and those who did not) did use some form of contraception while having sex. It is clear that the majority of EC users demonstrate responsible contraceptive practices both in terms of their initial efforts to use contraception and their secondary efforts to protect themselves from an unwanted pregnancy by seeking EC within a 72-hour time frame. Most women (34%) had appointments for EC within 25–48 hours of having sex, followed by 26% of women who got EC within 12-24 hours and 20% who had an appointment less than 12 hours after intercourse. It is clear that this sample of women appear to have a strong sense of vulnerability to pregnancy and take measures to act on this. The majority use contraception, and if this fails they ensure they protect themselves a second time by using EC. Research with other populations of women, such as women seeking EC from GPs or hospitals, is required to determine whether the relationship between alcohol consumption and EC use described in this study is typical.

It is also important to note that there was a small number of women who were very drunk and did not use contraception. Even though the sub-sample size is small most of them did NOT use contraception. Therefore it is important to not lose sight of the relationship between excessive alcohol consumption and unprotected sex. It is possible to argue that there is likely to be a group of people who are at risk of unplanned pregnancy and who do not use contraception or seek emergency contraception. This is an at-risk population that would not have surfaced in this sample; this group should be targeted in further studies.

In terms of general contraceptive use among women seeking EC, it is interesting to note that over 75% of the sample report using condoms always or often. This is followed by

the contraceptive pill (under 50%). Of particular note is that 28% of those who responded reported that they use 'withdrawal' as a contraceptive method either sometimes, often or always. It is important to acknowledge that for those who used contraception on the occasion when sex took place, the contraceptive method failed for a number of reasons, as outlined previously. What is also interesting is that it failed more so for women who were not drinking on the occasion when sex took place. In addition to this, for most respondents this was not their first time availing of EC. These findings have important implications for the function of EC consultations and the role of the GP/health practitioner. There is an opportunity in this setting for practitioners to address issues such as contraceptive history and experience of contraceptive failure. Practitioners are ideally placed to give recommendations or advice for long-term consistent contraceptive use that best suits the lifestyle of the client. In light of these findings the EC consultation is very important in terms of contraceptive counselling, and advice with respect to the broad range of contraceptive choices and prevention of unplanned pregnancies. These issues are outlined.

It is clear that the link between alcohol, sex and contraception is a decidedly complex one, and one that requires further research to examine it in different contexts and among different populations of women. It is important to recognise that these findings are specific to one women's health clinic in one city-centre location. The data is not generalisable to women from non-urban locations or, indeed, to women who seek EC from GPs. Further research is required to examine the extent to which this data is generalisable to other populations and locations.

It is possible to argue that there is a group of people who are at risk of unplanned pregnancy and who do not use contraception and who do not seek emergency contraception either. This is an at-risk population that would not have surfaced in this sample and who should be targeted in further studies. Just because the link between alcohol and unsafe sex is not a clear one among a sample of women requesting emergency contraception does not imply that the link is not clear among the general population, especially those who do not seek EC after unsafe sex.

There was a tentative pattern identified suggesting that the proportion of women seeking EC who also used contraception could be slightly higher among women who did not drink alcohol. This pattern would have to be tested among a larger sample of women to see if it is statistically significant.

Although great efforts were made to reduce the possibility of 'social desirability' affecting individuals' responses, it is impossible to eradicate this phenomenon. It is widely acknowledged that women may feel embarrassed to divulge that they had not used contraception to protect themselves when they had sex, especially to a doctor when requesting EC. The wording of questions in the questionnaire, guarantees of anonymity and procedures in the clinic to anonymise the survey process all contributed to reducing this possibility. Piloting procedures and feedback suggested that women would feel comfortable and reassured to answer these questions truthfully.

Key points of relevance for practice and policy

This work has a number of important implications both in terms of practice and research recommendations. This is the first piece of work that attempts to directly

address the link between alcohol use, unsafe sex and emergency contraception in an Irish context. The findings have important ramifications with respect to further understanding the complex links between alcohol and sex, training of family-planning practitioners/GPs, information needs for women and pregnancy prevention messages for women. These are listed below:

1. Understanding the alcohol-unsafe sex link

As described in the discussion section, the link between alcohol consumption and unsafe sex in a sample of women requesting EC is not a direct one. A significant proportion of women did not consume alcohol and among those who did, a majority reported to have used contraception. Only 21 out of 237 EC clients reported being very or extremely drunk when sex took place. What is clear is that in order to comprehensively address and understand the alcohol-unsafe sex relationship a broader sampling frame may be required. It is very likely that there is a group of people in the general population who consume alcohol, do not use contraception and do not seek emergency contraception either. Further research designed to specifically target this population, at risk of crisis pregnancy, is required. It is also important to acknowledge that while the link between alcohol and unsafe sex in this study is not a direct one, there was a trend for very drunk respondents to not use contraception and for alcohol to affect the proportion of women reporting to have used contraception. These trends, requiring a larger study to fully test the associations, do mean that even in women seeking EC, alcohol may still play a role in affecting use of contraception.

2. Approaches to consultation

There is a common misperception that EC is mainly used by women who have unprotected sex as a result of a drunken one-night stand. The findings from this study and previous research (Barrett and Harper 2000) suggest that some practitioners who prescribe EC share this view of EC users as irresponsible. Judgemental attitudes that affect the consultation process and women's experience of a consultation need to be challenged, not least to ensure women are not discouraged from requesting EC. Protocols for service providers that outline how best to approach an EC consultation need to be developed: how women should be addressed; how to proactively assess women's reproductive needs; how best to facilitate women's reproductive needs in an encouraging, non-judgemental way. Protocols need to encompass existing best-practice models, which seek to harness responsible behaviour and address the broader issues affecting women's reproductive health.

In terms of implications for consultation there are issues to be addressed with respect to contraceptive failure. The majority of those using contraception that did not work were using condoms that had either burst or slipped off during intercourse. Unfortunately, most sex education programmes do not include teaching on how to use condoms properly. Nearly 20% of women seeking EC (see Table 3.9) reported that they were using the oral contraceptive pill. Most women reported that they had missed a pill. The fact that they were aware that missing a pill had made them more vulnerable to pregnancy is a sign that they have a certain level of knowledge about correct pill use. However, this knowledge did not prevent 10% of the ECC group from missing a pill. Moreover, 70% of this group had used EC before. This is a clear indication that there is a need for general education around the use of the pill, and strategies should be devised to ensure it is taken consistently.

The majority of participants reported that they had used EC before. This has implications for the EC consultation, which provides an opportunity to discuss clients' problems with consistently using contraception. The EC consultation is also an ideal forum to discuss risk-taking and practical methods to avoid risk. Maximising the benefit women obtain from the EC consultation, which could increase the effectiveness of primary methods of contraception, is something that could be addressed in training for healthcare practitioners.

Many women are not aware of the wide range of alternatives to the oral contraceptive pill. Options that are less susceptible to human error include a hormone patch, an implant, an injection, a vaginal ring and intrauterine devices. The EC consultation provides an opportunity to discuss contraceptive choices and prevention strategies to ensure the woman is not putting herself at risk of an unplanned and unwanted pregnancy through contraceptive failure or misuse. Research suggests that the more contraceptive choices that are available to women the more they are likely to take up a method. Therefore it is important for practitioners to be aware of and offer and discuss a full range of contraceptive methods. The cost of alternative methods also needs to be addressed so as not to preclude women for whom money may be a barrier to making positive contraceptive choices. Communication strategies and contraceptive advice aimed at preventing unwanted pregnancies need to specifically address the fact that some women are still using withdrawal as a primary means of contraception. The contexts that give rise to this need to be addressed in terms of effectively targeting this group of women.

3. Information about the correct use of EC

The reduction in the possibility of conception after taking Levonelle is 95%, if the woman takes it within 24 hours of having sex. Over 50% of this sample presented for EC over this time limit. Over 20% of the sample had had intercourse more than 48 hours previously. If EC is taken 48 to 72 hours after intercourse its effectiveness is reduced to 58%. There is a clear need to promote the use of EC and to communicate the message that effectiveness is related to how quickly it is taken after having sex. It is noticeable that more women in the OC group did not know the correct time limit for taking EC. Women using family planning services are considered to be a more informed group. The fact that knowledge gaps exist even within this group suggests that there may be higher levels of ignorance in the general population. This makes the need for education about EC use all the more important.

4. Information about contraception and women's health

Over 16% of women seeking EC agreed with the statement 'I cannot get pregnant if I have sex during my period'. Furthermore, 18% of women seeking EC agreed with the statement 'Taking the contraceptive pill for two years causes fertility problems'. It is important that myths such as these, which directly lead to women leaving themselves vulnerable to unwanted pregnancy, are challenged and that information needs are addressed. Women in this study relied on formal and informal sources of sex education, and many rated the informal sources, such as friends and the media, more favourably than formal school sex education. These data suggest that strategies to improve the quantity and quality of information received by women will need to address the fact that women get their information from a variety of sources.

5. Research implications

Although this study begins to explore the relationship between unsafe sex and alcohol consumption in the Irish context, it is nonetheless a partial one. That is, it begins to inform us about the relationship in one client group in this one clinical setting. Given this, it is imperative that other settings (e.g. geographical and institutional) are explored as well. Most importantly the links between alcohol and unsafe sex need to be explored in different populations – not just women seeking emergency contraception. It may also be beneficial to consider the importance of research examining practitioner experiences of alcohol and sexual risk-taking among client groupings. Practitioners are a key group, essential to communicating the dangers of alcohol and its affects on contraceptive use and risk behaviours. They are also a key group to work with when developing health promotion messages and education campaigns.

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APPENDIX 1

ECC Questionnaire

Women's Health Survey 2003

In partnership with the Crisis Pregnancy Agency, Well Woman is conducting an independent research project, which looks at the links between alcohol and contraceptive usage.

To do this, we are looking for your help.

This short survey will take about 10 minutes of your time. It is completely anonymous, we do not need to know your name and all responses will be treated in absolute confidentiality.

This questionnaire asks some questions about your drinking patterns and your use of contraception. We realise that for some people, these are sensitive issues and we want to reassure you that they will be treated in confidence. When you have completed the questionnaire, you can put it in the envelope provided and drop it in the 'questionnaire box' located in the reception area.

By filling in this form, you are allowing us to gather important information that will:

- Improve the delivery of targeted contraceptive health services for women in Ireland
- Contribute to improving sex education and health promotion programmes for women
- Develop health promotion campaigns that reflect the reality of women's lives
- Influence the development of better social policy

If you have any questions about our survey, please speak to the Nurse or Doctor during your visit.

The results of this research will be available from our website and the Crisis Pregnancy Agency's website toward the end of the summer.

Thank you for your help and interest, and for taking the time to fill in our survey.

www.wellwomancentre.ie

www.crisispregnancy.ie.

Questions 1 – 7 relate to information such as your age and your relationship status. This information is important for us to know as it will help provide a detailed picture of women who use the services of this clinic.

1. Please can you tell us how old are you? _____ years
2. Please can you tell us where you currently live?
 Dublin postcode _____ (e.g. 6W, 17, 3)
 County (if applicable) _____ (e.g. Dublin, Meath)
3. What is your nationality? (e.g. Irish, French, Indian).

4. Please can you indicate which of the following categories apply to you? Tick (✓) one only.

Not in a relationship

Married to partner

Co-habiting/living with partner

In a relationship, but not living together

I have two or more partners now

5. Please tell us for how long have you been with your current partner? Tick (✓) one only.

No regular partner

Less than 3 months

4 – 6 months

7 – 12 months

1 year or more

6. Please can you indicate what is the highest level of education you have attained? Please place a tick (✓) in the relevant box.

No formal education	<input type="radio"/>	Non-degree (e.g. National Certificate, Diploma)	<input type="radio"/>
Primary education	<input type="radio"/>	Primary Degree (e.g. Bachelors)	<input type="radio"/>
Junior/Intermediate Certificate	<input type="radio"/>	Postgraduate Diploma	<input type="radio"/>
Leaving Certificate	<input type="radio"/>	Postgraduate Degree (e.g. Masters, Doctorate)	<input type="radio"/>

7. Are you working? Please place a tick (✓) in the relevant box.

Full time	<input type="radio"/>	Student	<input type="radio"/>
Part time	<input type="radio"/>	Homemaker	<input type="radio"/>
Unemployed	<input type="radio"/>		

If you are working either full-time or part-time, could you please state your job title e.g. primary teacher, sales assistant, car mechanic.

8. Is your visit today for the morning after pill?

Yes No

9. Please can you tell us on AVERAGE how often you drink alcohol? Please tick (✓) one.

I don't drink alcohol

3-4 times a week

- less than once a week
- 5-6 times a week
- 1-2 times a week
- 7 times a week

10. If you drink alcohol, please tick (✓) the statement that most closely describes your drinking?

- I do not get drunk
- I rarely get drunk
- I get drunk sometimes
- I get drunk often

11. Do any of the following statements apply to you? Please tick the one that best applies.

- I don't drink
- Sometimes I can't remember how much I've drunk
- I regularly can't remember how much I've drunk
- None of the above

12. How many hours ago did you have sexual intercourse?

- Less than 12 hours
- Between 13 and 24 hours
- Between 25 and 48 hours
- Between 49 and 72 hours
- Over 73 hours

13. Did you or your partner decide to use any form of contraception?

- Yes
- No
- I can't remember

14. Can you please explain your answer? For example, why you decided to use contraception or not.

15. If you answered 'Yes', what form of contraception were you using? Please tick (✓) the relevant answer (s).

- | | |
|----------------------------------------------|------------------------------------------------|
| Diaphragm <input type="radio"/> | Coil (IUD, Mirena) <input type="radio"/> |
| Implant (Implanon) <input type="radio"/> | The pill or mini-pill <input type="radio"/> |
| Withdrawal <input type="radio"/> | Injection (Depo Provera) <input type="radio"/> |
| Rhythm <input type="radio"/> | Condom <input type="radio"/> |
| Other (please specify) <input type="radio"/> | |

16. If you used contraception can you please tell us why you want the morning after pill?

17. On this occasion, had you or your partner been drinking alcohol? Please tick one box for you and one for your partner.

A		B	
ME		PARTNER	
Yes	<input type="radio"/>	Yes	<input type="radio"/>
No	<input type="radio"/>	No	<input type="radio"/>
I can't remember	<input type="radio"/>	I can't remember	<input type="radio"/>

If you have answered no to both section A and B above, then please jump to question 21 on page 7.

18. If yes, could you please rate how drunk you and your partner were on this occasion? Please tick (✓) the box that best applies to you and your partner

	Not at all drunk	A little drunk	drunk	Very drunk drunk	Extremely drunk
ME	<input type="radio"/>				
YOUR PARTNER	<input type="radio"/>				

19. Could you please indicate how many drinks YOU had? Please write the number (e.g. 3) of drinks you had in the boxes under the following headings.

Wine	Beer/Lager	Spirits	Alcopops
Glasses <input type="radio"/>	Pints <input type="radio"/>	Bottles <input type="radio"/>	Shots <input type="radio"/>
	Bottles <input type="radio"/>		
Don't remember <input type="radio"/>			
Don't know <input type="radio"/>			

20. If your partner drank alcohol, could you please indicate how much you think HE had to drink?

Wine	Beer/Lager	Spirits	Alcopops
Glasses <input type="radio"/>	Pints <input type="radio"/>	Bottles <input type="radio"/>	Shots <input type="radio"/>
	Bottles <input type="radio"/>		
Don't remember <input type="radio"/>			
Don't know <input type="radio"/>			

21. Have you ever used the following contraception in the past?

	Method	Never used	Have used
Coil (IUD, Mirena)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implant (Implanon)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injection (Depo Provera)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. Could you please indicate what forms of the following contraception you have used in the past? Please tick one box for each type of contraception.

Method	Never	Rarely	Sometimes	Often	Always
The pill or mini-pill	<input type="radio"/>				
Condom	<input type="radio"/>				
Diaphragm	<input type="radio"/>				
Withdrawal	<input type="radio"/>				
Rhythm	<input type="radio"/>				
Morning After Pill	<input type="radio"/>				
Other (please specify) _____					

23. If you have used the Morning After Pill on previous occasions, where did you get it?

- Well Woman centre
- GP / family doctor
- Other family planning clinic
- Student's union / campus
- medical centre
- Other (please specify)

24. Could you please indicate whether you believe the following statements to be true or false?

Statement	True	False
I am most likely to become pregnant if I have unprotected sex in mid-cycle	<input type="radio"/>	<input type="radio"/>
I am safe from getting a sexually-transmitted infection because I am on the pill	<input type="radio"/>	<input type="radio"/>
I cannot get pregnant if I have sex during my period	<input type="radio"/>	<input type="radio"/>
For the Morning-After Pill to work, I can take it up to 72 hours after having sex	<input type="radio"/>	<input type="radio"/>
Taking a contraceptive pill for more than 2 years causes fertility problems.	<input type="radio"/>	<input type="radio"/>
You can have a sexually transmitted infection and not even be aware of it	<input type="radio"/>	<input type="radio"/>

25. Can you please rate how good or bad the sex education was that you received (e.g. how the menstrual cycle works, contraception, safe sex)?

Method	Didn't get any	Very bad	Bad	Adequate	Good	Very good
Sex education in school	<input type="radio"/>					
Sex education from parents	<input type="radio"/>					
Sex education from friends	<input type="radio"/>					
Sex education in the media	<input type="radio"/>					
Other (Please Specify) _____						

As part of this project, we are also interested in listening to and understanding our clients' opinions of contraception and preventing unplanned pregnancy. We are looking for clients that are interested in participating in a small number of interviews with Karen, our independent researcher from Trinity College.

All interviews will last about one hour and will be STRICTLY CONFIDENTIAL AND ANONYMOUS. If you are interested in participating in this research please notify the Nurse or Doctor during your visit or you can call KAREN on [number given]

Please tear this LAST page from the questionnaire and take it away with you if you want to arrange an appointment to meet Karen.

The collection box is located at the end of the reception area.

Thank you for taking the time to fill in this survey.

OC Questionnaire

Women's Health Survey 2003

In partnership with the Crisis Pregnancy Agency, Well Woman is conducting an independent research project, which looks at the links between alcohol and contraceptive usage.

To conduct this research, we are looking for your help.

This short survey will take about 2 minutes of your time. It is completely anonymous, we do not need to know your name and all responses will be treated in absolute confidentiality.

This questionnaire asks some questions about your drinking patterns and opinions of sex education only. We realise that for some people, these are sensitive questions and we want to reassure you that they will be treated in confidence. When you have completed the questionnaire, you can put it in the envelope provided and drop it in the 'questionnaire box' located in the reception area.

By filling in this form, you are allowing us to gather important information that will:

- Improve the delivery of targeted contraceptive health services for women in Ireland
- Contribute to improving sex education and health promotion programmes for women
- Develop health promotion campaigns that reflect the reality of women's lives
- Influence the development of better social policy

If you have any questions about our survey, please speak to the Nurse or Doctor during your visit.

The results of this research will be available from our website and the Crisis Pregnancy Agency's website toward the end of the summer.

Thank you for your help and interest, and for taking the time to fill in our survey.

www.wellwomancentre.ie

www.crisispregnancy.ie.

Questions 1 – 7 ask for details, such as your age and your relationship status. This information is important for us to know as it will help provide a detailed picture of women who use the services of this clinic.

1. Please can you tell us how old are you? _____ years
2. Please can you tell us where you currently live?
 - Dublin postcode _____ (e.g. 6W, 17, 3)
 - County (if applicable) _____ (e.g. Dublin, Meath)
3. What is your nationality? (e.g. Irish, French, Indian).

4. Please can you indicate which of the following categories applies to you? Tick (✓) one only.

Not in a relationship

Married to partner

Co-habiting/living with partner

In a relationship, but not living together

I have two or more partners now

5. Please tell us for how long have you been with your current partner? Tick (✓) one only.

No regular partner

Less than 3 months

4 – 6 months

7 – 12 months

1 year or more

6. Please can you indicate what is the highest level of education you have attained? Please place a tick (✓) in the relevant box.

No formal education	<input type="radio"/>	Non-degree (e.g. National Certificate, Diploma)	<input type="radio"/>
Primary education	<input type="radio"/>	Primary Degree (e.g. Bachelors)	<input type="radio"/>
Junior/Intermediate Certificate	<input type="radio"/>	Postgraduate Diploma	<input type="radio"/>
Leaving Certificate	<input type="radio"/>	Postgraduate Degree (e.g. Masters, Doctorate)	<input type="radio"/>

7. Are you working? Please place a tick (✓) in the relevant box.

Full time	<input type="radio"/>	Student	<input type="radio"/>
Part time	<input type="radio"/>	Homemaker	<input type="radio"/>
Unemployed	<input type="radio"/>		

If you are working either full-time or part-time, could you please state your job title e.g. primary teacher, sales assistant, car mechanic.

8. Please can you tell us on AVERAGE how often you drink alcohol? Please tick (✓) one.

I don't drink alcohol

3-4 times a week

less than once a week

5-6 times a week

1-2 times a week

7 times a week

9. If you drink alcohol, please tick (✓) the statement that most closely describes your drinking?
- I do not get drunk
 - I rarely get drunk
 - I get drunk sometimes
 - I get drunk often
10. Do any of the following statements apply to you? Please tick the one that best applies.
- I don't drink
 - Sometimes I can't remember how much I've drunk
 - I regularly can't remember how much I've drunk
 - None of the above
11. Could you please indicate whether you believe the following statements to be true or false?
- | Statement | True | False |
|-----------------------------------------------------------------------------------|-----------------------|-----------------------|
| I am most likely to become pregnant if I have unprotected sex in mid-cycle | <input type="radio"/> | <input type="radio"/> |
| I am safe from getting a sexually-transmitted infection because I am on the pill | <input type="radio"/> | <input type="radio"/> |
| I cannot get pregnant if I have sex during my period | <input type="radio"/> | <input type="radio"/> |
| For the Morning-After Pill to work, I can take it up to 72 hours after having sex | <input type="radio"/> | <input type="radio"/> |
| Taking a contraceptive pill for more than 2 years causes fertility problems. | <input type="radio"/> | <input type="radio"/> |
| You can have a sexually transmitted infection and not even be aware of it | <input type="radio"/> | <input type="radio"/> |
12. Can you please rate how good or bad the sex education was that you received (e.g. how the menstrual cycle works, contraception, safe sex)?
- | Method | Didn't
get any | Very
bad | Bad | Adequate | Good | Very
good |
|------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Sex education in school | <input type="radio"/> |
| Sex education from parents | <input type="radio"/> |
| Sex education from friends | <input type="radio"/> |
| Sex education in the media | <input type="radio"/> |
| Other (Please Specify) _____ | | | | | | |

As part of this project, we are also interested in listening to and understanding our client's opinions of contraception and preventing unplanned pregnancy. We are looking for women that are interested in participating in a small number of interviews with Karen, our independent researcher from Trinity College.

All interviews will last about one hour and will be STRICTLY CONFIDENTIAL AND ANONYMOUS. If you are interested in participating in this research please notify the Nurse or Doctor during your visit or you can call KAREN on [number given]

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Thank you for taking the time to fill in this survey.

APPENDIX 2

Discussion guide for semi-structured interviews.

Aim: To elucidate the views and experiences of women in relation to: Sexual health and pregnancy prevention, with specific focus on the role of alcohol and use of the morning-after pill.

Interview topics will include the following:

Information and educational needs of women (and men)

- How women know and understand sexual health issues e.g. how to prevent unplanned pregnancy and sexually transmitted infections.
- How do women learn, where do they learn from (information/educational sources), do we need more education, does education need to be improved?
- What about men's knowledge?

Unplanned and unintended pregnancy – and contextual influences

- How does unplanned pregnancy happen, what causes it to happen, what are women's experiences of risk, why do women take risks? Are there pressures out there on women? If so, what are they, how do they feel?
- What are the 'usual' experiences of women you know, of your age? What is considered the norm?
- What role do men play in this picture? Whose responsibility is it for contraceptive use? Are there also pressures out there for men, if so what are they?
- When are you most likely to use contraception? When not? Does risk taking differ depending on the relationship – e.g. a casual fling versus when in a relationship?
- What can prevent it from happening, what needs to happen to reduce the number of women who experience crisis pregnancy?

The role of alcohol in contributing to risk taking in relationships (if not already addressed) AND the effect of the environment and settings on drinking behaviour

- What are women and men's attitudes toward alcohol, have these changed? What part/role does alcohol play in the lives of women and men nowadays?
- Is alcohol part of the lives of people around you, e.g. school, college, work, neighbours, community?
- Is alcohol an issue with respect to taking risks and not using contraception?
- What effect does it have on sexual behaviour – for women, for men?
- What are the consequences for women and men, following sex under the influence of alcohol? What are women thinking the following day? What are men thinking?
- What about drugs other than alcohol? Are there issues with respect to these and risk taking behaviour?

The morning-after pill

- Attitudes toward the use of the morning-after pill and knowledge of it, where to get it, when to use it etc.
- How do women learn about the morning-after pill – where do they access information like this?
- What role does the morning-after pill have in the lives of women today? When would it be used, what would make a woman consider using it, when is it most effective?
- Why do some women use it and others not, what prevents women from using it?

Background details

E.g. age of participant, if in a relationship, if working etc. Details will transpire during the course of the interview.

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