About the project

- Exploring trends in sexual activity, contraceptive use, and pregnancy experiences in Ireland: a secondary analysis of national survey data from the last decade

- One year Fellowship awarded by Irish Research Council (formerly the Irish Research Council for Humanities and Social Sciences (IRCHSS) and the Health Service Executive – Crisis Pregnancy Programme (HSE-CPP)
Project aims

- Investigate emerging trends related to crisis pregnancy, sexual activity and contraceptive use, reproductive decision making and health services research
- Identify knowledge gaps
- Provide a focus for future research
Structure of Project

1. Consequences of early onset of heterosexual intercourse
2. Experiences of crisis pregnancy
3. Experiences of sexually transmissible infections (STIs) and HIV
4. Experiences of sex education

Datasets used:
Researching sexual behaviour: 
Taking up the challenge

PROFESSOR KAYE WELLINGS
SEXUAL HEALTH SCREENING: EXPERIENCES OF STI AND HIV TESTING
Background

- Sexually transmitted infections, as well as HIV, are an important global health issue
- There has been a steady increase in STIs notified to the HPSC/NDSC in Ireland since 1989 e.g. rates in 2011 had increased by 12.2% compared with 2010

- Number of new HIV infections in Ireland has remained relatively constant over the last number of years (approx. 300 new cases p.a.)
- UK HIV levels are at an all time high and nearly half of all infections in 2011 were through heterosexual intercourse
• STI/HIV prevention and control serve as a cost-effective health intervention that can lessen the burden of disease, but it is not without its challenges

• Young adults decisions to seek STI screening are influenced by: Ref
  • health service characteristics
  • patient characteristics
  • personal acknowledgement of engaging in risky sexual behaviours
  • real or suspected symptoms
• Non-uptake of health screening has been found to be associated with lower SES groups, income and age (younger women in particular)

• Poor global STI surveillance and the lack of data on predictors of attendance for sexual health screening in Ireland means ascertaining the types of people and the reasons why they do or do not engage in this behaviour remains unknown
Study Aims

1. To generate a profile of the socio-demographic and background characteristics and sexual health history of adults living in Ireland who have tested for STI and/or HIV

2. To examine whether there are any significant differences in these socio-demographic/background/sexual health history variables between those that have tested for STI/HIV and those that have not
Study Design

• **Surveys:** ISSHR, and ICCP-2010

• **Respondents:** All adults aged 18-45 years
  – ISSHR, n = 5175 and ICCP-10, n = 3002
  – Total n = 8159
Analysis

- **Outcome variable:** A lifetime history of STI or HIV testing
  
  - *ICCP-2010* - Those that had a STI or HIV test as part of the antenatal screening programme
  
  - *ISSHR* – Those who reported STI screening at GP surgery and/or GUM clinic were only counted once
  
  - ONE ATTENDANCE COUNTED
  
  - Numbers for STI and HIV testing combined to create *Sexual Health Screening Behaviour* variable
Covariates

Demographic/Background
- Gender
- Education
- Marital status
- Household social class
- Locality
- Access to subsidised healthcare
- Survey year

Sexual health history
- Receipt of sex education (Yes/No)
- Sexuality
- Age at first sexual intercourse (17 years +/Under 17 years)
- Contraception use at first intercourse (Yes/No)
- Number of years sexually active
**Table 1:** Descriptive statistics of those who reported a history of sexual health screening for The Irish Study of Sexual Health and Relationships Survey (ISSHR-2006) and The Irish Contraception and Crisis Pregnancy Survey 2010 (ICCP-2010)

<table>
<thead>
<tr>
<th></th>
<th>ISSHR N = 5157</th>
<th>ICCP-10 N = 3002</th>
<th>Total N=8159</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>358 (41.4)</td>
<td>440 (41.9)</td>
<td>798 (10.1)</td>
</tr>
<tr>
<td>Women</td>
<td>507 (58.6)</td>
<td>609 (58.1)</td>
<td>1116 (14)</td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25 yrs</td>
<td>279 (32.3)</td>
<td>178 (17)</td>
<td>457 (5.7)</td>
</tr>
<tr>
<td>26-35 yrs</td>
<td>367 (42.4)</td>
<td>469 (47.3)</td>
<td>863 (10.9)</td>
</tr>
<tr>
<td>36-45 yrs</td>
<td>219 (25.3)</td>
<td>375 (35.7)</td>
<td>594 (7.5)</td>
</tr>
<tr>
<td><strong>Education:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Leav</td>
<td>110 (2.7)</td>
<td>103 (9.8)</td>
<td>213 (2.7)</td>
</tr>
<tr>
<td>Leav. cert +</td>
<td>755 (87.3)</td>
<td>946 (90.2)</td>
<td>1701 (21.4)</td>
</tr>
<tr>
<td><strong>Marital:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>542 (62.7)</td>
<td>541 (51.6)</td>
<td>1083 (13.6)</td>
</tr>
<tr>
<td>Married</td>
<td>294 (34)</td>
<td>451 (43)</td>
<td>745 (9.4)</td>
</tr>
<tr>
<td>Sep/Div/Wid</td>
<td>29 (3.4)</td>
<td>56 (5.3)</td>
<td>85 (1.1)</td>
</tr>
<tr>
<td><strong>Social Class:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>447 (51.7)</td>
<td>478 (45.6)</td>
<td>925 (11.7)</td>
</tr>
<tr>
<td>3-4</td>
<td>238 (27.5)</td>
<td>315 (30)</td>
<td>553 (7)</td>
</tr>
<tr>
<td>5-6</td>
<td>136 (15.7)</td>
<td>89 (8.5)</td>
<td>225 (2.9)</td>
</tr>
<tr>
<td>7</td>
<td>32 (3.7)</td>
<td>167 (15.9)</td>
<td>199 (2.5)</td>
</tr>
<tr>
<td><strong>Locality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>350 (40.5)</td>
<td>523 (49.9)</td>
<td>873 (11)</td>
</tr>
<tr>
<td>Rural</td>
<td>515 (59.5)</td>
<td>526 (50.1)</td>
<td>1041 (13.1)</td>
</tr>
<tr>
<td><strong>Access to Sub HC:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>139 (16.1)</td>
<td>285 (27.2)</td>
<td>424 (5.3)</td>
</tr>
<tr>
<td>No</td>
<td>726 (83.9)</td>
<td>764 (72.8)</td>
<td>1490 (18.8)</td>
</tr>
</tbody>
</table>
**Table 2:** Sexual health history profile of those who reported a history of sexual health screening for The Irish Study of Sexual Health and Relationships Survey (ISSHR-2006) and The Irish Contraception and Crisis Pregnancy Survey 2010 (ICCP-2010)

<table>
<thead>
<tr>
<th></th>
<th>ISSHR N = 5157</th>
<th>ICCP-10 N = 3002</th>
<th>Total N=8159</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex Education:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>652 (75.4)</td>
<td>784 (74.7)</td>
<td>1436 (18.1)</td>
</tr>
<tr>
<td>No</td>
<td>205 (23.7)</td>
<td>265 (25.3)</td>
<td>470 (5.9)</td>
</tr>
<tr>
<td><strong>Sexuality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>819 (94.7)</td>
<td>994 (94.8)</td>
<td>1813 (22.9)</td>
</tr>
<tr>
<td>Homosexual/Lesbian</td>
<td>31 (3.6)</td>
<td>21 (2)</td>
<td>52 (0.7)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>13 (1.5)</td>
<td>34 (3.2)</td>
<td>47 (0.6)</td>
</tr>
<tr>
<td><strong>Age 1st Hetero. Sex:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 17 yrs</td>
<td>240 (27.7)</td>
<td>257 (24.5)</td>
<td>497 (6.6)</td>
</tr>
<tr>
<td>17 yrs or older</td>
<td>606 (70.1)</td>
<td>765 (72.9)</td>
<td>1371 (18.13)</td>
</tr>
<tr>
<td><strong>Contra. Use 1st Sex:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>652 (75.4)</td>
<td>755 (72)</td>
<td>1407 (19)</td>
</tr>
<tr>
<td>No</td>
<td>160 (18.5)</td>
<td>267 (25.5)</td>
<td>427 (5.8)</td>
</tr>
</tbody>
</table>
Results: Regression

• Women (OR=1.42), homosexual (OR=3.60) and bisexual (OR=2.32) respondents, respondents aged between 26-35 years (OR=1.82), those from an urban location (OR=1.20), and those access to subsidised healthcare were more likely to report STI/HIV testing.

• Those less likely to report sexual health screening included those with pre-Leaving Cert. education (OR=0.66), lower social classes (OR = 0.69-0.70), married (OR=0.58) and separated/divorced/widowed respondents (OR=0.85).

• Respondents from ICCP-2010 were more likely to report STI testing than respondents from ISSHR (OR = 2.62).
Results: Regression

• Participants who reported early first sex (i.e. Before the age of 17 years) were more likely (OR=1.71) to have had a STI and/or HIV test in the past.

• Those who reported using contraception on this occasion (OR=0.76) were less likely than those who did not, to have engaged in sexual health screening.

• No differences were found between those who screened and those who did not in relation to the number of years sexually active.
Conclusions

• This a valuable snapshot of adults living in Ireland who have and have not engaged in sexual health screening in the past
  – information on when, where and why they engaged in this testing remains unknown.

• Differences found between demographic groups in could reflect more health conscious health seeking behaviour among certain groups, or increased risk behaviour

• Differences over time also need to be investigated further

• Early age at first sex was associated with the increased likelihood of sexual health screening and the use of contraception on this occasion with decreased likelihood of this behaviour
1. A greater understanding of the reasons why there are differences between demographic groups in STI screening is required. Further research is necessary into whether the demographic groups who were more likely to report sexual health screening engaged in more risky sexual behaviours, including their patterns of contraceptive use.

2. In line with the recommendation in ICCP-2010, sexual health policies need to address unmet needs, and barriers and drivers to testing, therefore further research is needed into whether there is an unmet need for sexual health screening, particularly among the groups who were less likely to have a history of sexual health screening.

3. Ensuring access to service provision also needs to be considered in relation to the broader access to health care. Access to subsidised healthcare was associated with a history of sexual health screening and whether there are financial barriers to testing or a lack of awareness of current services needs to be explored further, particularly in the current economic climate.
3. Attention needs to be paid to the context of first sex in both the policy and service delivery arenas as both the timing and contraceptive use at first sex was associated with the reporting of sexual health screening. This supports the recommendation in the ICCP-2010 for the design of integrated, holistic reproductive family planning and STI services.

4. Further longitudinal research is required to examine why individuals were more likely to report having engaged in sexual health screening in 2010 in comparison to 2004/2005 and whether this reflects a promising trend.
Discussion of key findings
PARENTAL INVOLVEMENT IN SEX EDUCATION
Background

• Due to the health risks associated with inconsistent safe sex practices, adolescent sexuality has transitioned from the domain of the private family sphere to a pressing public health issue

• Key aim of sexuality education is to provide young people with essential knowledge and skills that will enable them to make empowered and healthy decisions about their sexual health and relationships

• Parents have an intrinsic role in sexuality education
Background

• National studies assessing the receipt of sexuality education generally embed questions within a broader assessment of sexual health e.g. ISSHR, NATSAL

• Range of factors can influence the level of parental involvement in sexuality education: parents sexual health careers; family structure and profile; family ethos; and other sources of sexuality education

• While parents largely concur that they should play a fundamental role in this aspect of their child’s education these beliefs may not always translate into practice
Aims

1. To identify key parental characteristics that predict whether a parent reports providing sexuality education to their children

2. To contribute to the debate on how information relating to delivery of sex education by parents to their children can be best obtained and analysed in large national sexual health surveys
Method

• Data from ICCP-2010: N = 3002; 21-45 years
• All participants who were parents to a child/children aged 6 years and older were included (n = 966)
• Data was weighted
• Analysis: Propensity score analysis and logistic regression
Results: Demographics

• Parents who reported that they or their partner *had* (n=475) or *had not* (n=488) spoken to their child/children about sexual matters

• Groups were broadly similar in terms of education level, those currently married and living with a spouse, locality, household social class, and importance of religious beliefs

• 67.4% of those who provided sex education were women/mothers, and 79.8% were in 36-45 years age group
Results: Post-matching logistic regression model

• A test of the full model containing all predictor variables against constant-only model was statistically significant, $\chi^2 (15, 951) = 85.67, p < .001$

• Three independent variables made a unique statistically significant contribution to the model (in order of strength)
  1. Age (OR = 1.87, p<.001)
  2. Gender (OR = 1.18, p<.001)
  3. Number of children (OR = 1.15. p<.05)
Summary of key findings

• Parents who reported that they or their partner had spoken to their children about sexual matters were more likely to be female, aged between 36-45 years and have a larger number of children.

• Therefore, mothers, older parents, and those with increasing numbers of children, are more likely to have engaged in sexuality education with their children

• These findings support previous research which has highlighted the link between parental age, gender, and number of children with the increased likelihood of engaging in sexuality education with their children.
Conclusions

• This study makes a valuable contribution to our knowledge of factors that predict parental involvement in sexuality education in Ireland.

• The enduring and empirically supported importance of parents in influencing adolescent risk-taking behaviours (Resnick et al. 1997) provides a sound rationale for the present study and future national surveys, but perhaps in more innovative ways.

• Future cross-sectional national surveys need to be designed cognisant of the inherent health-related bias on which those surveys are often based, and wary of the assumptions we might make when we ask parents about their involvement in sexuality education.
1. Continued efforts to encourage parental involvement in sexuality education should target at-risk groups such as fathers, younger parents and those with smaller (and most likely younger in age) numbers of children. Best evidence would suggest that sexuality education should begin at an early age with age-appropriate and accurate information.

2. Given the key role of parents in sexuality education, there has been no national survey in Ireland, specifically designed to assess parental involvement in the sex education of their children, barriers and facilitators to that involvement, and the content and scope of information delivered.
3. The apparent decline in parents in Ireland speaking to their children about sex is also important to understand. Furthermore, a well-constructed survey of parents and their involvement in sexuality education successfully circumnavigates any sensitivity issues related to asking young people or adolescents about these topics, while simultaneously providing a deeper understanding of the integral role parents have in this learning.

4. Design of a survey such as this warrants an initial re-evaluation of what we already know about parents who do, and do not engage in sexuality education, with a view to identifying gaps in that understanding, and producing a reliable and representative evidence base that can inform primary prevention efforts, service planning and future policy development.
Discussion of key findings
1. **Tutorial Room (TR) 1 - Crisis pregnancy** - Maeve O’ Brien (HSE-CPP) & Dr. Ashling Bourke (Project Research Team)

2. **Tutorial Room (TR) 2 - Consequences of early intercourse** - Prof. Richard Layte (ESRI) & Gemma Smith (Project Research Team)

3. **Tutorial Room (TR) 3 - Sex education** - Frances Shearer (National Co-ordinator for SPHE) & Dr. Karen Morgan (Project PI)

4. **Tutorial Room (TR) 4 - Sexual health screening (STIs/HIV)** - Dr. Derval Igoe (HPSC) & Dr. Caroline Kelleher (Project Research Team)
FEEDBACK FROM WORKSHOPS
Sexual health and young people: research, rhetoric, and responsibility

PROFESSOR ROGER INGHAM