Scoping Study for National Survey of Sexual Attitudes and Behaviours

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Chapter One: Introduction

Although there were surveys of sexual behaviour before the 1980s such as the Kinsey Report of 1948 (and the subsequent Little Kinsey report in Britain by Mass-Observation in 1949), it was only in the late 1980s after the full implications of the AIDS epidemic had become clear that surveys of sexual knowledge, attitudes and behaviour (KAB) became more common (Stanley 1995). In trying to understand the spread of HIV and form some strategic response, it became obvious in most countries that more information was needed about the sexual practices of the population such as the prevalence of risky behaviours and number of sexual partners. As a result, the last two decades have seen over 40 national surveys of sexual behaviour carried in western countries, the largest of which is the National Survey of Sexual Attitudes and Lifestyles (NATSAL) survey in Britain. The NATSAL survey was first completed in 1990 (NATSAL1) and repeated a decade later in 2000 (NATSAL2). The information from national surveys has been invaluable both for increasing our understanding of patterns of sexual behaviour and helping policy makers design interventions in the area of sexual health. For example, in Britain, results from the two NATSAL surveys (Wellings et al 1994, Johnson et al 2001) explained why the incidence of STIs had been increasing in Britain in the previous decade by showing an increase in a wide range of behaviours associated with a heightened risk of HIV and STI transmission, including the numbers of partners, concurrent partnership, heterosexual anal sex and payment for sex. Moreover it also explained the higher rates of infection in those younger than age 25 as reported in national surveillance statistics by showing that rates of new partner acquisition among this age group and among those not cohabiting or married were higher.

Surveys such as the NATSAL have shown that if we understand patterns of sexual behaviour in a population we are in a better position to understand the spread of sexually transmitted diseases such as HIV, as well as understanding conception rates and other sexual health outcomes. This understanding provides the basis for more effective health and social policy.

To date no national survey of sexual knowledge, attitudes and behaviour (KAB) has been carried out in Ireland. In 2000 the report of the National AIDS Strategy Committee (AIDS Strategy 2000) recommended that a national KAB study be carried out in line with other European countries. A KAB study in Ireland offers the prospect of vastly increasing our understanding of the pattern of health behaviours in the area of sexuality and their relationship to both the attitudes/beliefs and socio-demographic characteristics of individuals. Such a survey will provide a benchmark for future work in the area of sexual health promotion in Ireland.

The chapters of the scoping study are structured as follows. In this first chapter we present the background to the scoping study, describe the policy context within which the study was commissioned and describe the approach taken when carrying out the scoping exercise. In the next chapter we examine the studies and data that are currently available on sexual knowledge, attitudes and behaviour in the Republic of Ireland, but also refer to several studies which have been carried out in Northern Ireland. In Chapter Three we review the literature which has emerged from other countries which have already carried out KAB surveys. This chapter concentrates on
the issues that have emerged as important in other countries and how these have been tackled within KAB surveys. In the fourth chapter we review the operational and methodological choices that would need to be made when establishing and operating an Irish KAB study. Throughout this chapter we draw lessons from surveys carried out in other countries. In the fifth Chapter we describe the results of the consultation process which included a survey of stakeholders and a consultation day. In the sixth and final chapter we draw on the deliberations and conclusions of all the previous chapters to develop the terms of reference for a National Irish survey of sexual attitudes and behaviours including the substantive issues that should be covered and the most effective and cost-efficient methodology.

1.1 Commissioning the Scoping Study

The lack of any detailed information on sexual knowledge and behaviour in Ireland has been a considerable obstacle to the development of sound national policy across a range of areas. In the area of HIV/AIDS this realization led to the National AIDS Strategy Committee recommending in 2000 (p41) that a national KAB study be undertaken in Ireland that would produce information of a kind similar to that collected now in a number of countries (National Aids Strategy Committee 2000).

In May 2002 the Education/Prevention Sub-Committee of the National AIDS Strategy Committee invited tenders for a scoping study for a national survey of sexual knowledge, attitudes and behaviour and assessed several tender applications. In September 2002, the Department of Health and Children commissioned a consortium from the Economic and Social Research Institute (ESRI), Royal College of Surgeons in Ireland (RCSI) and an independent research consultant to conduct a study to examine the practical and methodological issues involved in undertaking a new and separate national survey of sexual attitudes and behaviour. The research has one broad aim: to present a scoping study for a national survey of sexual knowledge, attitudes and behaviour. The study has four interlinked objectives outlined below.

- To review the issues which could feasibly be addressed in a national survey of sexual knowledge, attitudes, and behaviour in Ireland.
- To review the operational and methodological procedures and cost implications relevant to a survey in this area.
- To consult with relevant stakeholders.
- To recommend terms of reference for a national survey of sexual KAB

1.2 Study Approach

There were two principal components to the scoping study:

1. A review of previous major national surveys of sexual attitudes and behaviour, and a survey of the research literature examining the methodological options for the survey.

2. A consultation with potential users of the data to determine the types of information that would be required from such a survey.
1.2.1 Literature Review

The first objective of the study was to investigate any national surveys such as the 1994 ISSP survey and those surveys of sub-population groups which have already been carried out in Ireland and UK\(^1\). Surveys such as the recent Sexual Abuse and Violence in Ireland (SAVI) (McGee et al 2002), the Gay Health Network Survey of gay and bisexuals (Carroll et al 2002), and the FpaNI survey (Schubotz et al 2002) of sexual behaviour of 18 to 25 year olds are summarized in Chapter Two of this report. Studies are summarized in table format by research population, sampling procedures, data collection method, sample size and response rate.

The scoping study also sought to review national surveys of sexual behaviour and attitudes\(^5\) which have been carried out elsewhere in Europe, North America, Australia and New Zealand. Given the large number of studies which have been carried out on the subjects of sexual behaviour and health, it is not practical to list all surveys, thus in Chapter Three only national general population surveys of sexual knowledge, attitudes and behaviour outside Ireland and the UK are reported. Chapter Three presents a summary of the findings of this review listing surveys in terms of the features (e.g. age of population, language etc) of the survey, specific content (knowledge, attitudes, behaviours), and methodological/operational considerations. Consideration was given to lower and upper age ranges, and associated benefits and limitations. Where younger age groups have been included consent and ethical procedures are documented (where available).

1.2.2 Search Strategy

Reports of national surveys were identified through a number of methods. Searches of electronic databases such as Medline, AIDSLINE, Web of Science, Embase, PsycLIT, and Cinahl were carried out using the keywords: Sexual behaviour, Survey, Population Survey, KABP, KAB, National. Web searches were carried out using Google and Dogpile search engines.

Further information of surveys identified from the database searches were gathered from direct contact with the lead authors of the research through letter, email, and/or telephone contact. The team enquired about consultation procedures, ethical approval, use of incentives, and the validity and reliability of methods. Requests were made for details of pilot procedures and sample copies of questionnaires from each survey.

One of the team interviewed two key researchers from the British NATSAL2 survey (Kaye Wellings from the London School of Hygiene and Tropical Medicine in London, Sally McManus from the National Centre for Social Research in London). Researchers at the LaTrobe University in Australia, and the NORC Institute in the US were contacted through email.

1.2.3 Data Synthesis

\(^1\) The scope of this research does not permit a review of all surveys of sub-group populations.

\(^2\) National Surveys of the General Population rather than sub-groups such as gay men, drug users
A data extraction criteria proforma was developed to assist with the synthesis of the different surveys, and the characteristics of each of the surveys were summarized in table format.

1.2.4 Consultation

One of the most important aspects of the scoping study was the use of a consultation process which aimed to explore the information needs of potential users of the survey data and to examine how these might influence the design and content of the proposed survey. The consultation process began with the identification of those organisations that may have an interest in contributing to the development of a national KAB study, and also identified individual specialists, medical professionals and academics who might be able to contribute to the process.

An initial contact was made with those organisations and individuals in October 2002. This initial contact included a description of the scoping study and a questionnaire which sought information from contacts on their information needs from a future KAB study. In early November invitations to a consultation day to be held at the Royal College of Surgeons in Ireland, Dublin on December 5th were circulated followed in late November by the circulation of the initial scoping study document which was to be the focus for discussion at the consultation day.
Chapter Two: Findings from the Review of Irish Research

Little detailed insight is available on the sexual attitudes and lifestyles of the Irish population. That which is available relates almost exclusively to problems with sexual health or practices, e.g. sexually transmitted diseases and unwanted pregnancy.

Information on sexually transmitted disease including HIV/AIDS are routinely collected by the National Disease Surveillance Centre and recent statistics for the second quarter of 2001 show that 2440 cases of STIs were notified in Ireland, an increase of 14% over the same quarter in 1999. This increase continues a recent increasing trend in STI notifications that has seen the cumulative rate of STI infections per 100,000-population increase from 121 in 2000 to 133 in 2001. Chlamydia, NSU and genital warts are the two most common sexually transmitted infections with men reporting more STIs than women (53.2% compared to 46.7% in quarter 2 2001).

Recent figures indicate that approximately 2500 people in Ireland have been diagnosed with HIV or AIDS. The latest breakdown of HIV infection data from the HIV Surveillance system showed that by the end of December 2001, of the 299 reported cases for that year, 58% were among heterosexuals, 13% among intravenous drug users (IDUs), 24% among homosexual men, and the remainder made up from those with haemophilia or with mother-child transmission (Epi-Insight, 2002).

Teenage and unwanted pregnancies continue to be a cause for concern as 6673 women travelled (10% of all conceptions) to GB for terminations in 2001. Just over four thousand (n=4039) young women aged under 20 became pregnant in 2001, a quarter of which were terminated (n=944) (Crisis Pregnancy Agency, Personal Communication).

2.1 Researching Sexual Health in Ireland

Few studies have explored sexual behaviour among the general population in Ireland in depth, though a number of national studies have included questions with relevance to sexual behaviour and attitudes. For example, in 1994 the Irish component of the International Social Survey Project (ISSP) (www.issp.org) included questions on how often and with whom respondents had sex and number of questions on attitudes to various issues around sexuality. Similarly, the Sexual Abuse & Violence in Ireland (SAVI) research (McGee et al 2002), the all-Ireland survey of gay & bisexual men (Vital Statistics Ireland), the European Values study (Halman 2001) and the Irish Society for the Prevention of Cruelty to Children (ISPCC 1996) have all investigated aspects of sex and sexuality in the Irish population. Details of these studies are provided in Table 2. These surveys provide evidence of the feasibility of a national survey of sexual knowledge, attitudes and behaviour, and have clear lessons for future work in this area.
In addition to the national studies, a small number of small-scale studies provide a patchwork picture of sexual behaviour and lifestyles among young people in Ireland. Research with young people provides important information on young people’s knowledge, attitudes and behaviour, and has clear implications for national research with this age group. Table 1 provides a summary of studies by population group and approach. In the following sections we now go on to provide a brief overview of both the national and small-scale population studies.

2.2 National Surveys

Although there have not been any full surveys of sexual knowledge, attitudes and behaviour (KAB) in Ireland, there have been a number of more limited surveys that can offer facets of the Irish situation. Perhaps the most important of these in terms of giving general information about sexual practices was the Irish component of the ISSP survey carried out in 1994. Another important national survey, though on one specific aspect of sexual health is the national Survey of Sexual Abuse and Violence in Ireland (SAVI), published in 2002 (McGee et al 2002). Also published in 2002 was the national study of gay and bisexual men in Ireland (Carroll et al 2002). Whilst not having a primary focus on sexual behaviour, the European Values Survey (Halman 2001) included a number of questions on sexual beliefs and attitudes. We now discuss these and a number of other surveys individually in the sections below.

2.2.1 The International Social Survey Project (ISSP)

The ISSP is a truly international project that collects data on a large number of issues that are seen as important for social science on an annual basis. The ISSP organisation brings together pre-existing social science projects and coordinates research goals cross-nationally to produce comparative data. At the moment there are 38 member countries. In 1994, member countries, including Ireland added a module on sexual behaviour to their surveys in response to the spread of the AIDS virus. Although this module was not large, in the Irish context it collected important information on sexual practices that had not been collected for a national sample either before or since. The Irish data has been almost unused since its collection and there are no papers in the public domain which use it. The module included questions on number of sexual partners over different periods in the past (12 months, 5 years, life), the sex of these partners, partners outside marriage, how partners were met and how often sex took place. There was also a large number of socio-demographic questions in the main ISSP survey and information on attitudes to marriage, children, pre-marital sex, under age sex, sex outside marriage while married and homosexual sex.

Given that this information forms the baseline against which any future KAB data will be compared. We briefly outline some results from the data here. It is worth pointing out that this is the first time that results from this valuable survey have been published.

The ISSP survey interviewed 938 individuals randomly sampled from a national sampling frame. Those interviewed ranged in age from 18 to 99 years with a median
of 44 and 51.8% female. The questions on sexual practices were given to respondents as a self-completion survey and they were requested to send this back to the researchers in a prepaid envelope. Only 53% of these surveys were returned which is a rather high level of non-response. Nonetheless, the data are still valuable as the only national Irish source of information on sexual practices among a random survey of adults.

Among the sample, 74.2% had had sex in the previous five years (75.7% among women and 72.6% among men). 54.7% of men and 64.5% of women had had one partner in this period, with 12.3% of men and 7.3% of women having three or more partners over this period. Of those having sex over the last 12 months, among men, 2.9% had been solely homosexual over this period with none having sex with both men and women; among women 3.8% had been homosexual over this period with 0.5% having both male and female partners. The figures for homosexual experience in the last five years are higher for both men and women compared to the NATSAL 2000 survey in Great Britain (2.6% for both men and women).

The mean lifetime (since age 18) number of female partners reported by men is 3.9 and 1.8 among women with 2.9% of men and 3.2% of women reporting ever having had homosexual sex. The anomaly of the proportion reporting lifetime homosexual experiences being lower than the proportion reporting such experiences over the last five years is due the higher non-response on the life-time frequency question. The life-time proportions are lower than those reported by Johnson et al (2001) for the NATSAL 2000 survey, but extrapolating from experience in the last five years among the Irish sample it is likely that the proportion is actually higher.

2.2.2 The European Values Survey

The European Values Survey (Halman 2001) is a large-scale survey of ‘basic values’ and associated attitudes. The basic aim of the survey is to describe these values in a format that allows comparisons to be made between countries and over time. The first survey was conducted in 1981 at which point ten Western European countries took part. Researchers from other countries joined the project later such that comparable surveys were conducted in 26 countries in 1990 and 33 countries in 1999/2000, the most recent wave available for analysis at present. Irish data is available for all three waves of the European Values Survey, 1999/2000 being a sample of 1009 individuals, 49.2% of whom are male. The survey covers Irish people’s values and attitudes towards modern life. Included in this survey were questions on homosexuality, marital infidelity, divorce, casual sex, under age sex, prostitution and attitudes toward particular groups of people such as those with AIDS or homosexuals. This survey is limited to attitudes and does not include knowledge or behaviour questions. However, the design of the survey, whereby each country asks the same questions at the same time period provides important information for cross-European comparisons.

The latest survey produced some interesting findings with Ireland appearing to be more conservative on issues of sexuality than other Northern European countries. In terms of attitudes toward specific groups, 23% of the Irish sample stated that they would not like to have someone with AIDS living as a neighbour and 27% would not like to have a homosexual as a neighbour. These proportions are rather high in Northern European terms (almost three times the proportions found in France and the
Netherlands for having someone with AIDS as a neighbour) and are more akin to the proportions found in Portugal and Italy, but lower than in Eastern European countries. The 1999/2000 EVS also includes questions on how justifiable certain forms of behaviour are on a scale from one to ten (one=never justified). On this scale, just under 70% of the Irish sample rated homosexuality at 5 or less (on the less justified end of the scale), 88% rated having casual sex in this manner and 98% rated having sex under the legal age of consent in this way. To put this in international context, if we use the mean score of the Irish sample on these questions, the Irish score on homosexuality is the lowest in Western Europe except for Portugal and Northern Ireland, and on the issue of casual sex and sex under the age of consent, Ireland has the lowest score in Western Europe (i.e. these behaviours are seen as less justified).

### 2.2.3 Sexual Abuse & Violence in Ireland (SAVI)

Only one study has examined the lifetime experience of sexual abuse and violence in Ireland (McGee et al 2002). The Sexual Abuse and Violence in Ireland (SAVI) was a national study of 3,120 adults concerning the prevalence of various forms of sexual violence; patterns of disclosure of such abuse to others including professionals; levels of post-traumatic stress disorder in those experiencing abuse and attitudes of the public to 'rape myths' and to disclosure of abuse. Data were collected in 2001. Recommendations were made for future developments in public awareness, prevention, service delivery and policy development.

The prevalence of sexual violence was assessed by anonymous telephone interviews with randomly selected participants from the general population (N=3,120 completed interviews; 71% participation). More than four in ten women (42%) and over a quarter of men (28%) reported some form of sexual abuse in their lifetime. Attempted or actual penetrative sex was experienced by 7.6% of girls and 4.2% of boys. Equivalent figures in adulthood were 7.4% (women) and 1.5% (men). Hence, girls and women were more likely to be subjected to serious sexual crimes than boys and men. Levels of serious sexual crimes committed against women remained similar from childhood through adulthood. Risks for men were lower as children than they were for women and decreased three-fold from childhood to adult life. Almost half of SAVI-reported abuse (47%) had not been disclosed to another person before the survey. Older people and those abused in childhood were least likely to disclose. Main reasons cited for non-disclosure were shame and embarrassment. Disclosure to, and use of, professional services was strikingly low (7% to Gardaí, 5% to medical professionals and 12% to counsellors). In the event of being personally sexually assaulted, over a quarter (28%: 19% of women and 37% of men) said they would not know where to go for help if the situation arose. A quarter (25%) of women who had been abused and 16% of men had at some time since experienced symptoms of post-traumatic stress disorder as a consequence, with a further 17% of women and 10% of men currently experiencing symptoms.

Of relevance to public attitudes on sexual health more generally, SAVI documented public beliefs about and perceived prevalence of sexual violence. Estimates of prevalence of most types of sexual abuse indicated that about half were quite inaccurate - under-estimation was more common. However, estimates regarding prevalence of incest were substantially higher than actual rates reported. Participants significantly overestimated the percentage of cases reported to Gardaí (estimated 34%
by women and 16% men; actual 10% women and 6% men). Attitudes about common rape beliefs were assessed. Men were significantly more accepting of attitudes reflecting rationalisations or victim-blaming concerning sexual violence than women, particularly with regard to motivation for rape and sexual violence committed against men. Attitudes towards media coverage of sexual violence were predominantly positive. Findings from SAVI can be used to inform recommendations for targeted developments in public awareness, prevention and management of sexual violence.

2.2.4 Vital Statistics Ireland

The Gay Health Network (GHN) in collaboration with Sigma Research undertook a survey of gay and bisexual active men across the island of Ireland (including Northern Ireland) in 2000 (Carroll et al. 2002). The research builds on previous research carried out by the Gay Health Action (1989) and the Eastern Health Board/Gay Men's Health Project (1992). The aims of the research were to provide a snapshot of the sexual lifestyle of gay/bisexual men, and to identify the sexual health and HIV prevention needs of this group. 1500 short self-completion questionnaires were distributed across Ireland (similar questionnaires have been distributed in the UK). The questionnaire included questions on sexual partnerships, HIV testing, Hepatitis B vaccination, STI checkups, sexual practices, condom use, recreational drug use, current status beliefs and sexual assertiveness. Due to the nature of the research population, random sampling methods could not be employed and the representativeness of the research is unknown. The research does provide information on the sexual behaviour and lifestyle of homosexually active men living in Ireland, and will provide an important source of information from which data from homosexually active men within a general population can be compared.

2.3 Surveys of Young People in Ireland

Over the last decade a number of small-scale research projects have attempted to collect information on young people's sexual knowledge, attitudes and behaviour. A selection of these studies are summarised in the following sections. The methodological details are presented in Table 2.

2.3.1 Galway – Survey of Post Primary Schools 1997

MacHale & Newell (1997) reported on a survey of 2799 pupils aged 15-18 attending post primary schools in the Galway area. The questionnaire included questions on sources of information on sex, knowledge about condoms/contraceptives in preventing infections, sexual debut and sexual behaviour, condom use, alcohol and drug use. Prior permission was obtained from school principals, and a participation rate of 85% was achieved. This study indicated that 21% reported previous sexual behaviour (gender difference were evident 29% boys compared to 15% females). The mean age for sexual debut was 15.5 years. This survey provides evidence of the feasibility for a school based survey of sexual attitudes, knowledge and behaviour. The limitation of such of approach is that particular young people such as early school leavers, excludees or truants are less likely to be included.
2.3.2 Midlands Health Board Research

In 1996 the Midland Health Board undertook a survey of 12 post primary schools. A total of 1645 young people aged 16-18 completed the general lifestyle survey which included a module on sexual behaviour (Bonner 1996). The survey provided information on sexual behaviour together with data on drug and alcohol use.

‘Life as It Is’ was a qualitative study of values, attitudes and norms among youth living in the Midland area (Sheerin 1998). The research explored experiences of sex education (formal & via parents), age of first intercourse, levels of awareness of contraception, levels awareness and sources of information on sexually transmitted infections, awareness of and barriers to the use of sexual health services. The study does not provide information on sexual attitudes and behaviours that can be generalised but does expand on the quantitative survey completed by Bonner (1996), and provides some insights into the views and experiences of young people.

2.3.3 AIDS Alliance

In 1997 Cork AIDS Alliance, now Alliance Sexual Health Centre, expanded its remit from a focus purely on AIDS to a broader perspective on sexual health. This move developed from the work of the Alliance, which showed that there was a requirement for information on the needs of young people regarding AIDS, relationships and sexuality generally. As part of this wider remit, Alliance applied for funding both from the EU and the Southern Health Board for a research project into young people’s attitudes, practices and knowledge together with current AIDS and sex education practices (Dunne et al 1997). Funding for the project was given and between late 1995 and summer 1996 the Alliance distributed a self-completion questionnaire to around 800 young people aged between 15 and 24 in Cork city. At the same time four focus groups were set up, three among early school leavers and one of people from different social backgrounds aged 15 to 25. Overall, the project aimed to collect descriptive data on the knowledge, values and practices of young people in Cork City in the area of relationships, sexuality, AIDS, alcohol and drug use.

The self-completion questionnaires where distributed in a wide range of schools, colleges, youth groups and voluntary organisations. The questionnaires included questions on knowledge of and where respondents gained information on AIDS, where they would prefer to get such information, questions on current sexual practices and behaviour, first sexual intercourse, alcohol and drug use, condom use as well as a large number of attitude and socio-demographic questions. Given the non-random sampling methodology it was not possible to say whether the data collected are representative, however the findings are compatible with other studies.

2.3.4 Key Lessons

The surveys carried out in Galway and Midlands highlight the feasibility of conducting school based survey research with young people aged 16-18. The usefulness of the lifestyle approach as a means to tapping into the context of young people’s lives and subsequent sexual knowledge/behaviour is highlighted in the
Midlands research. The AIDS Alliance study provides practical guidance in developing inclusive research to identify the sexual knowledge, attitudes and behaviour of young people outside education settings such as through Youthreach centres and youth settings. New technologies such as the internet may also provide the opportunity to research sexual health of young people outside the school settings although the generalisability of such research may be limited. However, representative data can only be collected via a random probability sample (see Chapter Four) and this requires the use of a sampling frame, either of households or schools so that young people can be selected randomly from the total population.

2.4 UK Surveys of Young People

A number of large scale surveys examining young people's sexual knowledge, attitudes and behaviours have been carried out in the UK. The key surveys are summarized in Tables 3 and 4. Two of the surveys (SHARE: Wight et al 2000 and APAUSE: Mellanby et al 2001) form the baseline for evaluations of school-based sex education projects. These data provide useful information on young people's attitudes and behaviour.

2.4.1 SHARE Baseline Survey

As part of the SHARE evaluation young people aged 13/15 were asked to complete detailed questionnaires on sources of information about sex, and on their sexual behaviour (Wight et al 2000, 2002). The questionnaires were administered to 8430 young people through schools. Parents were informed about the survey and the research and were offered the opportunity to remove their child from the study.

2.4.2 The Health Behaviour of School Children (HBSC)

The HBSC survey is carried out every 4 years across Europe. In most countries, including Great Britain and Northern Ireland, the survey includes a sexual behaviour module, but this was not included in the Irish survey. In the Scottish survey (Todd et al 1999) participating school classes were selected systematically from a list of all classes in the relevant age groups, stratified by education authority. Participating schools were asked to select a mixed ability class in the appropriate year group to take part in the survey (81 schools with Secondary 4 classes - the 15 year old age group participated in 1998). All pupils present in the class on the day of the survey were required to complete a questionnaire anonymously in the classroom under the supervision of a teacher. Pupils were requested to place their questionnaires inside individual unmarked envelopes when they had completed them and to seal the envelope. The questionnaire followed the research protocol for the HBSC cross-national survey. The module included questions on sex education, relationships, sexual behaviour and knowledge and attitudes relating to HIV and AIDS. The questionnaire also included questions on smoking, alcohol and drug use, physical activity, nutrition and eating habits, leisure activities and dental health. Questions on psychosocial aspects of health, family, peer, school and socio-economic context were also included.

The benefit of the HBSC survey is the ability to analyse trends over a four-year period, and to compare behaviours across countries.
2.4.3 Sexual Health Research in Northern Ireland

In January 2000 the fpaNI and the University of Ulster began a 3-year research project to collect and analyse information on the sexual attitudes and lifestyles of young people aged 14-25 living in Northern Ireland (Schubotz et al. 2002). The study employed both qualitative and quantitative research methods. A self-completion survey was administered across schools, colleges, youth centres, residential homes and workplaces across Northern Ireland. In total 2910 questionnaires were handed out. Of these 460 were distributed to intermediaries but were not forwarded to young people. Based on the successfully distributed questionnaires, a response rate of 52% was achieved (but based on the total distributed the response rate was 43%). The questionnaire was detailed and focused on the social backgrounds of respondents, their general health including drug and alcohol use, their views on sexual relationships and sexual health, their knowledge about sexually transmitted infections, as well as their sexual attractions and behaviour. Unfortunately, the non-random sampling method used makes it difficult to assess the representativeness of the sample.

In 2001, some sexual health questions were included in the Northern Ireland Health and Lifestyle Survey (NISRA 2002). As part of this survey, 2116 adults aged 16-44 were asked about knowledge of sexual matters, first sexual intercourse, contraception, sexual lifestyle and pregnancy. The findings from the FpaNI Towards Better Sexual Health Survey were broadly similar to the findings for the same age group from the NISRA survey which is based on random sampling procedures.

2.4.4 Contraceptive Surveys of Young People in the UK

Coleman (1999) reviewed a number of surveys of young people’s contraceptive use conducted in the UK from the late 1980s to late 1990s. The review presents a detailed analysis of different measures of contraceptive used in surveys and argues that accurate measure is needed to reflect the consistency of contraceptive use among young people and to allow cross-survey comparisons. Table 4 presents a summary of the studies reviewed. Coleman notes that many surveys are limited in their assessment of patterns of contraceptive use, and only five of the 11 studies in the review used the same measure of condom use. Coleman puts forward broad recommendations for future surveys:

• use similar sampling strategies
• target comparable age groups (or at least provide detailed age breakdowns) to allow cross-survey comparisons
• attempt to use standardized questions or measures which can be interpreted accurately by young people.

Coleman’s final recommendation with relevance to a national survey is that measures of non-use of condoms with one or more partner be considered as an indicator of STI risk, and that condom use should be measured with each sexual partner.
Chapter Three: Findings from Review of International Surveys

The rise of AIDS in the mid to late 1980s gave renewed importance to research on sexual behaviour and led to national KAB surveys being carried out in a large number of countries. Since 1985 there have now been over forty KAB studies carried out in developed countries, the largest of which were the two NATSAL surveys carried out in the UK in 1990 (Wellings et al. 1994) and 2000 (Johnson et al. 2001). Whilst the HIV epidemic was the main reason for the increased interest in sexual behaviour, in more recent years interest in sexual behaviour and attitudes has extended to social networks, sexual dysfunction and lifestyles.

These surveys have used different methodological approaches and have asked questions on a variety of issues, thus in this chapter we attempt to provide a summary of each that will allow comparison across studies. Given the large number of studies across countries, outside of Ireland and the UK we only list national KAB surveys.

3.1 International Surveys – Approach

Table 5 provides summary tables of the main national surveys of sexual behaviour and lifestyle and shows that across countries three main types of methodologies are used – face-to-face interviews, telephone questionnaires and mail questionnaires. However, no one of these techniques is dominant. Of the 26 surveys summarised, half used face-to-face (FTF) interviews as the data collection method. Of the 13 using face to face, a number also used self-administered questionnaires (SAQ) at the end of the interview. The most recent British survey – NATSAL2 employed computerised self interview (CASI) as well as face-to-face interviews. Just under half of the surveys used telephone interviews as the data collection method – the majority of which used computerised telephone interviews (CATI). Only two surveys used postal questionnaires.

The age of the research population has implications for the data collection method, as written parental consent may be required for those under 18 years of age. The majority of the surveys included 18 year olds as the lower age limit. The upper age limit varied from 40 to 74 years. The lower age has both benefits and limitations. Using 18 as the lower age limit allows for the inclusion of more sensitive and detailed questions on sexual behaviour that may not be appropriate for younger age groups. The limitation of this age limit is that information on the teenage years is retrospective for the vast majority of respondents.

The sizes of the surveys in terms of the number of respondents also differ substantially with only four surveys having more than 10,000 respondents and only two (the 1990 NATSAL in Britain and the 2001 Australian survey) having more than 15,000 respondents. Most surveys had more than 3000 respondents with six having between 4000 and 5000, but there have been Greek and Spanish surveys with less than 2000 respondents.
3.2 International Surveys – Scope

The surveys varied in their size and scope. The sample size of the surveys varied from just over 1000 respondents in the Dutch survey to over 20,000 in the French ACSF 1992 study, 19,307 in the Australian ASHR 2001 survey and 18,876 in the British (NATSAL1) survey. The most recent British survey (NATSAL2) included 11,161 individuals – a reduced sample size to permit the collection of urine samples to test for chlamydia. The US NHSLS study initially planned to include 14,000 interviews but the budget allowed only 3,432 interviews and was limited to the English language.

The smaller sample size of the many of the European studies precluded detailed analyses of individuals reporting uncommon practices. In contrast, the large British, French and Australian samples allow for analyses of sufficient statistical power of infrequent behaviours and those behaviours reported by few people.

It is important to note that the British NATSAL surveys provide a unique opportunity for a 10-year follow-up on sexual attitudes and behaviours using large scale general population surveys. In addition NATSAL 2 was the only national survey to gather physical samples by means of urine tests to test for chlamydia infection. These data can be compared with epidemiological data but also provide a more detailed understanding of the sexual lifestyles (including sexual health service use) of populations with positive tests.

3.3 International Surveys - Content

Routine epidemiological data provides important information on the nature and spread of sexually transmitted infections, pregnancies and terminations, although these data provide limited information on the characteristics of individuals such as age and geography. In order to develop appropriate sexual health promotion programmes and to tailor sexual health services it is important to understand sexual lifestyles and practices. Over the last two decades national surveys have included questions about sexual behaviour that cannot be answered through epidemiological studies such as: how often do people have sex? What do they do when they have sex? How often do they use condoms? How often do they change partners or have concurrent relationships with more than one person? How many people engage in homosexual activity?

The impetus for earlier national sex surveys was the need for reliable information about sexual behaviour to predict and control the spread of HIV/AIDS. However, many of the research teams were also interested in the broader social context of sexual behaviour. For example the NHSLS survey used a life-course approach to gather information about HIV-risk behaviour but also examined behaviours such as masturbation, sexual fantasy, and use of pornography in order to gather a complete picture of adults’ sex lives. The aim of the French (ACSF) study was to describe in detail respondents’ most recent episode of sexual intercourse, and then to place this behaviour in broader analytical parameters to allow the development of models to predict the spread of HIV/AIDS. Most of the other studies had more limited agendas, and concentrated on HIV/STI risk behaviour.

1 The full version of the survey was only administered to 4829 respondents.
A summary of the content of the European and English language national surveys is presented in Tables 6 and 7. More detail on content is available for the English language surveys as copies of the questionnaires were available. Less detail is available in English for the European countries but Hubert and colleagues (1998) provide a summary of the key questions. Box 1 provides a summary of 7 aspects of sexual lifestyles and behaviours included in national surveys in GB, Australia and the US.

<table>
<thead>
<tr>
<th>Box 1: Content of National Surveys of Sexual Attitudes &amp; Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Learning about sex e.g. main sources of information about sex, preferred sources of information about sex, additional information/education needs</td>
</tr>
<tr>
<td>2. First sexual experience e.g. age of first intercourse, willingness, use of protection, feelings of regret</td>
</tr>
<tr>
<td>3. Sexual partnerships and practices e.g. sexual attraction, heterosexual partnerships and practices, homosexual partnerships and practices, injecting drug use, paying for sex, sex abroad</td>
</tr>
<tr>
<td>4. Risk reduction practices e.g. condom/contraceptive use, actual &amp; preferred sources of protection supplies, HIV/STI testing</td>
</tr>
<tr>
<td>5. Service use and outcomes e.g. actual &amp; preferred sources of sexual health services</td>
</tr>
<tr>
<td>6. Adverse outcomes e.g. pregnancy under age 20, (intended or unintended), abortion, sexually transmitted infections, sexual violence/abuse</td>
</tr>
<tr>
<td>7. Knowledge &amp; attitudes to sex &amp; relationships, abortion, to risk reduction behaviours etc</td>
</tr>
</tbody>
</table>

3.3.1 Background Characteristics

Most surveys of sexual knowledge, behaviour and attitude commence with the collection of respondent’s background characteristics. Among the English language surveys background details included demographic information including age, marital status, family structure, ethnicity, education status, social economic status as well as questions on general health status (example NATSAL1, NATSAL2), preventive and general health (Australia ASHR) and physical health (US NHSLS).

Religion and religiosity has been included in a number of surveys in order to explore differences in attitudes, knowledge and behaviour. Most surveys include questions on religious background and church attendance.

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Not all surveys included questions on each of the areas
3.3.2 Learning about Sex

While most surveys included adult populations, many questioned respondents on their main source of information about sex. The US and British surveys include questions about school-based and family based sex education. In general, questions into sex education in national surveys tended to cover the following:

- Sources of information about sex e.g. schools, family, peers, media, internet
- Main source of information about sex
- Sex education in school e.g. age, and content
- Gaps in sex education
- Communication with parents/carers

3.3.3 First Sexual Experience

A number of surveys included questions on age of first sexual intercourse and the context in which this took place such as use of contraception. Some surveys have explored willingness and coercion within the context of first sexual intercourse. This was explored in the NATSAL 1&2 and NHSLS surveys through a series of questions included feelings of regret. The NHSLS survey included questions on the reasons for first sexual intercourse. The survey also included questions on childhood sexual victimisation including forced sexual intercourse. In general, questions around the first sexual experience tend to cover the following:

- Age of first sexual intercourse
- Context of first sexual experience
  - Age of partner
  - Protection – contraception/condom
  - Willingness/Coercion
  - Regret

3.3.4 Sexual Partnerships and Practices

Indicators on sexual behaviour are at the core of most surveys. Most surveys include questions on lifetime sexual experience as well as most recent sexual experiences. A number of surveys request details on sexual practices such as same sex partnerships, anal and oral sex, as well as lifestyle questions such as alcohol and drug use (including injecting drug use). Surveys question sexual partnership and practices in different ways. In the US NHSLS survey respondents are questioned on partnerships in the previous 12 months, in previous 5 years and since 18th birthday. Questions on sexual partnerships and practices tended to include:

- Sexual attraction
- Heterosexual partnerships – in previous month, year, five years and lifetime
- Heterosexual practices – vaginal, oral and anal
- Homosexual partnerships – in previous month, year, five years and lifetime
• Homosexual practices – vaginal, oral and anal
• Unsafe sex – unprotected vaginal, oral or anal intercourse
• Concurrent partnerships
• Intravenous drug use or unprotected sex with intravenous drug user
• Paying for sex – generally males only
• Sex when abroad or unprotected sex with someone from abroad
• Drug/alcohol use and sex
• Masturbation, fantasy and sex toys

A number of national surveys (NHSLS and AHSR) have attempted to build a picture of ‘social networks’ by asking detailed questions about recent sexual partners.

3.3.5 Risk Reduction Practices

Risk reduction encompasses a diversity of behaviours including abstinence, avoiding certain types of partners or behaviours or meeting places, talking to partner about sexual past, finding out partners status re HIV/STI, having STI/HIV tests or using condoms. As such researchers have devised a multiplicity of questions for collecting questions on risk reduction including the following:

• Use of protection & contraception (including emergency contraception)
• Faithfulness or abstinence
• HIV/STI testing of self or partner
• Personal perceptions of risk of HIV/STI – awareness of HIV status of partner
• Changed behaviours because of fear of HIV/STI – e.g testing, abstinence, condom use, avoidance of high risk behaviours, reduced number of sexual partners or concurrent partners.

3.3.6 Contraceptive & Sexual Health Services

The more recent surveys such as the NATSAL2 and ASHR surveys include questions on sexually transmitted infections, use of sexual health services and preferred services. Also included were questions on contraceptive use, preferred and actual use of advice and supplies.

• Preferred and actual sources of contraceptive advice and supplies
• History of STIs
• Preferred and actual sources of treatment for sexually transmitted infections

3.3.7 Adverse Outcomes

As already stated a number of the surveys were developed to gain insight into HIV related behaviour but more recent surveys have included questions on broad sexual and reproductive issues. Included in such surveys are questions on:

• Unintended/unplanned pregnancy
• Abortion

17
• Sexually Transmitted Infections/HIV
• Infertility
• Miscarriage & stillbirth
• Sexual violence (childhood sexual abuse)
• Sexual dysfunction – use of medication e.g. viagra

3.3.8 Knowledge and Attitudes

Questions on attitudes to sex and relationships within the surveys are quite broad. The earlier European surveys had a primary focus on assessing knowledge and attitudes rather than a focus on behaviour. The large-scale surveys such as the French (ACSF), British (NATSAL), US (NHSLS) and Australian (ASHR) surveys include a number of questions exploring social attitudes and knowledge. Questions cover views on underage age, sex outside marriage, extra-martial relations, same sex relations:

• Attitudes to sexual relations e.g. underage sex, sex outside marriage extra-martial relations, same sex relations
• Attitudes to sexual practices e.g. oral sex

Most of the surveys include a question about attitudes to abortion. The NHSLS survey included questions on views towards abortion under different circumstances such as rape.

• Attitudes to abortion
• Attitudes to abortion after rape

A number of surveys include questions to access respondent perception of risk of HIV. Questions in the NATSAL2 survey include

• Perceived risk of HIV/STI among groups of people e.g. people with high numbers of sexual partners, men who have sex with men, injecting drug users, people who have sex outside their stable relationship
• Perceived risk of HIV/STI in other countries compared to own country

Indicators on knowledge and misconceptions are included in some surveys. For example the ASHR study includes questions to assess knowledge of sexually transmitted infections and routes of transmission.

• Knowledge of sexually transmitted infections
• Knowledge of HIV prevention

3.4 Conclusions from Review of International Surveys

The review of national surveys in the developed world highlights the complexity of research in the area of sexual attitudes and lifestyles. The overview provided in the earlier section provides a flavour of the content of the more recent surveys – including the British NATSAL surveys, the Australian ASHR survey and the US NHSLS
survey. Some key themes emerge from the surveys with important implications for policy and practice. The surveys have attempted to answer four broad questions – that is, when do people start to have sex; whom do they have sex with; what do they do when they have sex, and how many people do they have sex with? Analyses of the findings of the surveys reveal that the answers to these questions depend on a variety of factors such as gender, age, level of education, place of residence, ethnicity, level of sexual interest, cohabitation status to mention a few.

In order to collect data that can be compared with findings from other national surveys it is important to ensure that content and approach of the surveys are broadly similar, where possible using similar questions. The themes covered in most surveys include – sexual initiation, sexual partnerships and practices, risk-related behaviours (e.g. multipartnership/concurrent relationships, paying for sex, condom use, history of STIs), behaviour change and testing, knowledge about HIV/AIDS and STIs, and attitudes to sexual behaviour.
Chapter Four: Review of Operational and Methodological Procedures

Introduction

In the year 2000, the National AIDS Strategy Committee (National AIDS Strategy Committee 2000) recommended that Ireland carry out a national survey of sexual knowledge, attitudes and behaviour (KAB) to provide the benchmark information required for national health policy. Over the past fifteen years over 40 national surveys of this type have been carried out in different countries and the information they have gathered has been invaluable both for increasing our understanding of patterns of sexual behaviour and informing policy makers in the area of sexual health. These surveys have shown that if we understand patterns of sexual behaviour in a population we are in a better position to understand the spread of sexually transmitted diseases such as HIV, as well as understanding conception rates and other sexual health outcomes. This understanding provides the basis for more effective health and social policy.

In this chapter of the scoping study we examine the numerous methodological and operational issues associated with carrying out a KAB survey and attempt to exclude some of the myriad choices available. The overall aims of a KAB study are to provide representative and valid information on the sexual knowledge, attitudes and behaviours of the population of the Irish Republic. This information should also be comparable with data collected in other countries so that the situation in Ireland can be compared to that elsewhere. The best way of achieving both these aims is through a national probability survey which would ensure that data are representative and provide known sample errors. Doing a national survey would not however preclude the use of smaller scale, qualitative methods to investigate specific sub-groups or infrequent behaviours, or to investigate more complex and beliefs and attitudes.

The chapter begins with an examination of the sampling frames that can be used to select respondents for a study and the financial and technical difficulties presented in getting representative information for the Irish population, both nationally and locally. The section also examines the key question of whether the KAB should aim to cover the general population as its primary aim, or whether it should look to achieve reasonable samples of particular sub-groups. The choice made on this issue has major ramifications for the use to which data can be put and the resources required for the study.

The second section outlines the merits of different types of surveys that can be used for a KAB survey. Here we outline the pros and cons of mail, telephone and face-to-face surveys and their numerous sub-types and focus particularly on the specific difficulties that a KAB survey faces in terms of the sensitivity of the material that is being collected.

In the third section we discuss the subjects of interviewer training, respondent back-up and counselling. The fourth section outlines the key systems that need to be in place.
after data has been collected to provide a clean, user-friendly database to researchers and policy makers. This includes the issue of the weighting of data. In the fifth and final section we discuss the importance of having ethical approval for a KAB study.

4.1 Achieving Representativeness

4.1.1 General Populations and Sub-Groups

A crucial question when designing a KAB survey is how to gain scientifically valid information on a representative sample of the population that can form the basis for sound health and social policy development. Although this question initially sounds quite straightforward, it entails making some crucial choices about the underlying rationale of the study and has long-term implications for the uses to which the gathered data can be put.

KAB surveys are large surveys of a representative sample of the population of a country which attempt to gain an overview of different types of sexual behaviour, the context in which it takes place and the attitudes and knowledge of those engaged in it. Such information allows the researcher and health policy analyst to gain a descriptive picture of the incidence of particular behaviours or attitudes and the factors that are associated with it. For example, a sample which was representative of all groups in the Irish Republic would be able to give the average age at which the sample first had sexual intercourse, how this age varied for those from different age cohorts and what proportion of these events happened without contraceptive or barrier protection. Such information would be invaluable, inter alia, for understanding the high rates of births to women in Ireland aged less than 20 and would help policy analysts design interventions to bring this proportion down.

However, although this information can be extremely useful in describing the behaviour of the general population, it may not be so useful for describing the behaviour of particular sub-groups of the population because these groups do not make up a large enough proportion of the population to allow reliable conclusions to be drawn from those who appear in the KAB survey. For example, it is highly likely that refugees arriving in Ireland are likely to have important and distinct sexual health issues, yet although the number of refugees arriving in Ireland has increased greatly in the last decade (from 39 applications in 1992 to over 10,500 in 2002), the maximum number of refugees in the country does not exceed 48,000, even if all applicants remained. This is roughly 1.2% of the Irish population and though we would expect to gain information on asylum seekers in a nationally representative survey, the number obtained is unlikely to be large enough to be able to come to any reliable conclusions about their behaviour vis-à-vis the general population.

This is shown well in Table 8 that gives the 95% confidence intervals that might be expected from a simple random sample of varying sizes and also from a statistical sample with a design effects factor of 1.6 (this adjusts the standard errors to take account of a clustered sample design – a sample design described later). The sample size for a statistical survey determines the degree of confidence which one can have in

5 We return to the issue of how recall error effects the accuracy of data on subjects such as first intercourse in section 4.2.
the results of the survey. Thus, as Table 8 shows the larger the sample, the smaller the ‘confidence interval’. If, as suggested refugees make up 1.2% of the national population at present then a national sample of 10,000 people would yield around 120 refugees. Table 8 shows that one could derive estimates of statistical certainty of ±11.4% which would make any generalizations almost impossible. Such large confidence intervals mean that analyses on this group alone would be subject to a large amount of error and any disaggregation, for instance into sex or age groups, would simply compound this problem.

<table>
<thead>
<tr>
<th>Size of sample</th>
<th>Design effects of:</th>
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<tbody>
<tr>
<td></td>
<td>95 per cent confidence interval</td>
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<tr>
<td>20</td>
<td>21.91</td>
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<td>10000</td>
<td>0.98</td>
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</tbody>
</table>

Gaining information on sub-groups is often achieved by ‘over-sampling’ the group in question by identifying the relevant individuals before the study begins and designing the sample in such a way that more of this group will be contacted and interviewed. This entails carrying out a ‘sift’ survey before the main survey to identify possible respondents which can add considerably to the resources required for the study. For instance, if we wanted a sample of 1000 refugees for interview we would have to contact over 83,000 individuals (1000/0.012). It is clear then that as the proportion of the subgroup in the population decreases, the costs of the screening survey rise rapidly.

One method that has been proposed for reducing the costs of sift surveys is ‘multiplicity sampling’. While the sift approach discussed so far simply involves the collection of information from a householder about the characteristics of other members of the household, in principle, there is no reason why information should not also be collected about other people, such as close relatives or neighbours. This approach, known as ‘multiplicity sampling’, must have clear ‘linking rules’ so that probabilities of inclusion are not biased – for example, in the case of asking about neighbours, the same number of addresses to either side of the respondent’s address must be screened. The critical point is whether the respondent is able to provide the necessary information and to do so accurately.

'Focused enumeration', a form of multiplicity sampling, was developed jointly by the National Centre for Social Research (formerly SCPR) and the Policy Studies Institute for the Third National Survey of Ethnic Minorities. It has since been developed and used on a number of major surveys in England & Wales, including the Fourth
National Survey in the mid-1990s and successive sweeps of the British Crime Survey. The aim of focused enumeration is to reduce the cost associated with sifting addresses for minority ethnic households by seeking information about the ethnic origin of those living not just at visited addresses but also of those living at n-1 addresses to either side. Where positive identifications are made at non-visited addresses, interviewers are instructed to visit them in person in order to complete the sift process.

It should be clear however that focused enumeration would only really be an option where the population sub-group were geographically clustered and where the characteristic in question were sufficiently public that neighbours would be able to identify them.

Sift surveys can also only be carried out if a sampling frame is available which includes the groups in question and thus the problem of surveying sub-groups in a population becomes particularly problematic when the groups are not listed in any easily available ‘sample frame’ from which individuals or households can be chosen at random. We deal with the issue of sampling frames in the next section.

The alternative to using a sift survey would be to contact members of a specific sub-group through a representative body, or by using some form of ‘snowball’ sampling where an initial contact is used to reach other members of the subgroup. The latter option is not available if the members of the sub-group do not necessarily know each other. The central problem with all three of these methodologies however, is that it is very difficult to know whether the sample attained is representative of the underlying population itself and so it is difficult to be certain of the sample errors involved.

These problems mean that important decisions need to be made early in the sample design process as to whether acquiring practical samples of certain sub-groups is feasible and cost effective. If it is not, then it may be more sensible to survey a general sample of the population and then develop a rationale for the phased evaluation of these groups, perhaps using more qualitative methods.

4.1.2 Sampling Frames

To be certain of getting representative data on the general population surveyors use a random probability sample where units of analysis have a calculable and positive chance of being chosen for inclusion. However, before selection can take place, the surveyor needs a sampling frame that covers the entire population of interest. The most commonly used sample frames are lists of residential homes and this can present real problems when trying to reach groups such as the homeless who by definition do not have a usual address.

4.1.2.1 Face-to-Face and Mail Questionnaires

The choice of sampling frame will depend upon the interview technique selected. For face-to-face interviews or for mail questionnaires, the standard sampling frame used

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6 To partially pre-empt the discussions of the next section – the only nationally available sampling frames are of residential households and these, but their very nature, will not include such groups as the homeless.
by many research agencies is the electoral register, although this will not be available in its full form for research after 2004 due to restrictions under the Data Protection Act. The only other alternative national sampling frame will then be the GEO Directory from An Post which lists all residential addresses, but at present is known to under-represent multiple household addresses and single persons. As discussed earlier, private household addresses as listed in the Electoral Register and the GEO Directory and covers around 97% of the population, excluding Travellers, the institutionalised population (prisoners, those in care homes etc) as well as those who are homeless. One solution to this problem may well be better to design specific studies for such groups rather than trying to integrate them into a general survey.

Using this general sampling frame the list of possible respondents needs to be both stratified and clustered for a face-to-face survey or simply stratified for a mail questionnaire. Sample stratification occurs for two main reasons. The first is that factors such as socio-economic status may not be evenly distributed across the country geographically and thus a random selection may be biased. The second reason for stratifying is so that the sample includes enough cases for analysis from certain geographical areas. For example, it would be useful in an Irish KAB survey to be able to carry out analyses at the level of Health Boards. A random sample across the country may not provide a large enough sample in each Health Board area for that authority to be able to carry out analyses that will be of use for planning and policy purposes, thus the sample design ensures an adequate number by explicitly using Health Board region as a stratifying variable. Stratification is achieved using the District Electoral Divisions (DEDs) and dedicated software (RANSAM) developed and available at the ESRI. This links socio-demographic information from the Census to polling districts in the electoral register and allows the sampling frame to be pre-stratified according to any combination of census variables. A sample of DEDs is then selected from this list. From this individual respondents can then be drawn in the final stage of sample selection. This procedure, as the steps suggest, produces a ‘two-stage’ sample design.

The sampling frame should also be clustered so that the individuals selected for interview live in ‘clusters’ of addresses rather than evenly across the country as this makes large-scale social survey research more practical and less costly by cutting down on the travel time for interviewers. Interviewers may well travel to addresses three or four times before achieving a successful interview or marking the address as a non-respondent and the costs of this travel, particularly in rural areas is considerable (though urban travel in cities such as Dublin and Galway is also increasingly time consuming).

4.1.2.2 Telephone Questionnaires

For telephone questionnaires, a system called random digit dialing (RDD) is used which allows all telephone numbers, including newly allocated numbers and ex-directory numbers to be called. As yet this system does not allow mobile phones to be contacted. However, recent research from the UK suggested that most mobile users also had a landline in their home. Coverage of landlines in Irish homes is now comparable with US and UK households at around 95% (Living In Ireland Survey 2000) which means that contact by telephone is at least as efficient as by address listing.
Using software such as the ESRI's RANSAM system, area codes are randomly selected from among possible Irish codes and possible 'stems' are identified. The 'hundred bank' method is then used whereby local telephone numbers are generated and the last two digits are used to create a full set of 100 numbers from XXXXX00 to XXXXX99. Depending on the size of the sample desired, the appropriate number of sample points (i.e. unique numbers) is generated and the hundred bank method applied.

4.1.3 Sample Size and Composition

Survey sample size depends on two factors: the incidence of particular groups or behaviours that need to be surveyed and the budget for the project, but the overall aim should be to have a large enough sample that the data can be disaggregated to a sufficient extent. More interviews are always regarded as better, but the marginal value of each additional interview after a particular point becomes debatable once a minimum size for each sub-group has been reached. The overall aim of the sample design is to achieve a representative sample of the population with enough respondents in each important sub-group to be able to make reliable generalizations about their attitudes, knowledge and behaviour.

As argued earlier however, it may not be possible (because of the absence of a suitable sampling frame) or practical (because of the absolute size of the sub-group) to be able to carry out analyses of particular sub-groups or of behaviours that occur infrequently. One answer to this problem may be to attempt to over-sample certain groups, but this is only feasible on a limited basis given the expense of carrying out filter surveys. Given this, the prime aim should be to create a sample which has sufficient numbers in broad sex/age groups in the population to be able to allow analyses of these sub-groups. Going back to Table 8, we can see that a sample of 10,000 for the Irish Republic would allow estimates of +/-1.24%, but assuming five age groups of roughly equal size, a cross-tabulation of age and sex groups would produce sub-samples of around 1000 respondents each where the confidence interval including design effects is +/-3.92%. As confidence intervals increase it becomes increasingly difficult to separate random differences between groups from substantive differences and this has important implications for policy analysis.

Surveys in other countries have varied widely in the size of the samples used with most European surveys using samples of between 2000 and 5000, though British and French samples have been larger. In France the ACSF survey contained 20,055 respondents (1992) and the two British samples drawn for the two NATSAL studies in 1990 and 2000 contained 13,765 and 11,161 respectively (Johnson et al. 1994). It is important to note that the larger British and French samples have given researchers the statistical power to investigate behaviours reported by few people or engaged in infrequently (Johnson et al. 2001).

4.1.3.1 Health Board Coverage

Within an Irish KAB study it may be beneficial for localised sexual health policy development if the sample was designed with health board level analyses in mind. As already discussed in section 4.1.2.1, to build in health board analyses into a national
sample the health board needs to be one of the stratifications applied before sampling begins. Creating viable numbers within health boards would also mean collecting what is practically a national sample in each health board if sufficient respondent numbers are to be achieved that allows disaggregation of the data. As explained in section 4.1, the standard error of the sample and associated confidence intervals depends on the size of the disaggregated groups. To return to the example used above (of the 10,000 person national sample), if we assume that the sample is divided into ten health board regions of 1000 respondents each, then each sex/age group would now be of 100 people with a confidence interval for each of +/- 12.4% once design effects have been taken into account. This confidence interval is too large to reliably inform policy development. Increasing health board samples obviously has serious cost implications across ten health boards. This could be reduced if some health boards were seen as more homogenous in terms of sexual health behaviour than others. However, given the lack of available evidence at present on the distribution of sexual behaviours in Ireland, there is no simple way in which this sampling decision could be made. Nonetheless, if reliable estimates of behaviour are needed at a health board level for policy purposes, there is no real alternative to collecting sufficient cases within each to allow behaviours to be disaggregated.

One complicating factor when assessing the national sample size is the need for at least one third of respondents to be obtained in the Dublin region if it is to reflect the distribution of the national population. A large sample in Dublin also has the benefit of gaining more interviews with particular population sub-groups who probably have higher levels of more risky behaviours. For example, the NATSAL 2 study carried out in Britain between 1999 and 2001 over-sampled London since the previous national KAB study (NATSAL 1) showed a greater prevalence of many HIV risk behaviours such as homosexual contact and injecting drug use in the Greater London area than in any other area of Britain (Erens et al. 2001). An over-sampling of Dublin would be an efficient way of sampling respondents with higher risk behaviours which are still comparatively rare or of sampling groups such as ethnic minorities who may have differing sexual health attitudes, behaviours or needs and who are more prevalent in the capital.

4.1.3.2 Age Range

One of the crucial questions that needs to be decided in sample composition is the age range to be studied. If the survey aims to interview younger respondents aged less than 18 then this introduces questions of informed consent where prior permission would be sought from parents before the minor could be given the questionnaire. Some have also argued that KAB studies should not include those at the upper end of the age range since these groups may be less sexually active, or if still active are likely to be in permanent monogamous relationships. Surveys in other countries have used different age ranges depending on the focus of the survey. The Finnish FINEX survey in 1992 covered a wide age range from 18 to 74, but avoided interviewing minors whereas two KAB surveys carried out in Greece in 1989 and 1990 have interview those aged 15 upward (to 64 in 1989 and 49 in 1990) and one in Spain in 1990 interviewed those aged 14 or more.

7 The proportions of different respondents in the regions can also be adjusted using weighting of the final data file.
The first NATSAL survey in 1990 in Britain interviewed those aged between 16 and 59, but restricted the upper age range to 44 in the 2000 survey to conserve resources as the 2000 survey also collected a sample of urine for testing for Chlamydia trachomatis. Since 2000, the organizers of the NATSAL 2 have sought additional funding to study those aged over 44.

Gaining information on the sexual knowledge, attitudes and behaviours of young people is of vital importance, but doing so through a national household sample can present considerable problems. Permission must be sought from parents before young people under age 18 can be interviewed and it is likely that a considerable proportion of parents may withhold this consent. If information is sought in each household on the ages and numbers of young people such refusal may be surmountable since the degree of error introduced could be calculated and used to construct sample weights. However a more difficult problem emerges in terms of the influence of parents on the answers of young people if they actually give permission for their children to take part in the study. The presence of parents in close proximity to the young person as they fill out the survey may well influence their answers on sensitive questions to do with sexual experience or alcohol and drug use. Evidence of this effect was found in the British NATSAL surveys when discrepancies were noticed between the responses of young people to the self completion questionnaire and the interviewer administered questionnaire. The factor explaining these discrepancies was the presence of a parent in the room at the same time as the questions from the interviewer were carried out.

One answer to these problems may be to interview those aged between 18 and 20 and ask these respondents to think retrospectively about their behaviour at younger ages. This would keep the recall period comparatively short and would ensure that the age specific findings were not too out of date at the time of survey, but would limit the number of people of this age group that were available for analysis. For example, an attained sample of 10,000 individuals would yield around 370 aged between 18 and 20, which would lead to comparatively large confidence intervals.

In terms of the practical numbers of young people aged less than 18 who could be reached for interview using a household survey, data from the Living in Ireland Panel Survey for the year 2000 (the Living in Ireland Survey is a household survey of over 3500 households that has was carried out each year between 1994 and 2001) shows that a survey which attained an actual sample of 10,000 addresses would yield 3751 young people between 12 and 18, 2830 between 14 and 18 and 1790 young people aged between 16 and 18. Given the restricted age range involved, these attained sample sizes would be more than adequate, but it should be remembered that it becomes increasingly difficult to obtain parental permission as the minimum age gets lower. This may mean that the actual sample size is considerably smaller than these figures and suggests that it may be pragmatic to confine any survey to the upper age limits.

Another sampling setting for children are schools. There have been several school based KAB studies carried out in Ireland in specific counties (see Chapter Two). The success of the regional school KAB surveys shows that this methodology could be used on a national basis and the removal of this younger group from a national survey of individuals in households would simplify the study considerably. Surveying
children in schools has the advantage that gaining permission to interview is simpler and large numbers of children can be sampled at a lower cost than gathering the same sample size through a household sample. It does have the drawback that early school leavers will not be represented in the sample. Research elsewhere suggests that these groups may actually have higher levels of risky behaviour, and other methods would have to be established to survey these groups.

4.1.3.2 Important Sub-groups

In section 4.1.2.1 we discussed the use of sampling frames such as the electoral register or An Post’s GEO directory. As stated there, these sampling frames only cover those in residential properties which is around 97% of the population, but exclude those such as the Traveling community and the homeless (as well as prisoners or otherwise institutionalized). These are important sub-groups with sexual health needs that could differ substantially from the residential population, thus it is important that data be gathered on these groups. The problem is however that this would have to be carried out as part of a wholly separate survey utilizing a different sampling methodology since no sampling frame is available for these groups. This could involve some kind of qualitative research or quantitative research using more complicated sampling techniques, but would need to be organized as a separate survey exercise.

4.2 Data Collection and Survey Types

The choice of data collection methodology used has important implications for the type and quality of information and this is an important area. The methodological problems that trouble all social researchers are even more problematic in research on sexual attitudes and behaviours given the sensitive nature of the subject matter and the social taboos involved. Establishing adequate response rates in KAB surveys and ensuring that the data collected are reliable presents a number of problems.

Three main types of survey techniques have been used in KAB surveys outside Ireland – the face-to-face interview, telephone questionnaires and mail questionnaires. Around half of European KAB surveys in the last fifteen years have been face-to-face with the most notable examples being the two NATSAL studies in the UK (which also used a self-completion component). Telephone interview techniques have also been used to good effect in France (1992), Belgium (1993) and Australia (2001).
Table 9: Strengths of Different Modes of Data Collection

<table>
<thead>
<tr>
<th></th>
<th>telephone interview</th>
<th>face-to-face interview</th>
<th>self-complete questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>moderate</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>Response rate</td>
<td>moderate-high</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>Speed</td>
<td>high</td>
<td>low</td>
<td>low</td>
</tr>
<tr>
<td>Ability to use computer assistance</td>
<td>high</td>
<td>moderate</td>
<td>none</td>
</tr>
<tr>
<td>Respondent motivation</td>
<td>high</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>Anonymity</td>
<td>moderate</td>
<td>low</td>
<td>high</td>
</tr>
<tr>
<td>Interviewer bias</td>
<td>low</td>
<td>moderate</td>
<td>none</td>
</tr>
<tr>
<td>Supervision of interviewers</td>
<td>high</td>
<td>low</td>
<td>none</td>
</tr>
<tr>
<td>Sample quality</td>
<td>high</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>Possible interview length</td>
<td>long</td>
<td>very long</td>
<td>short</td>
</tr>
<tr>
<td>Dependence on respondent</td>
<td>none</td>
<td>none</td>
<td>high</td>
</tr>
<tr>
<td>literacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to clarify and probe</td>
<td>high</td>
<td>high</td>
<td>none</td>
</tr>
<tr>
<td>Control of question order</td>
<td>high</td>
<td>high</td>
<td>none</td>
</tr>
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</table>


4.2.1 Face-to-Face Interviews

The face-to-face interview is the most costly form of survey since interviewers need to be sent into the field, often several times, to interview particular individuals who have been chosen through the sampling procedure. This type of interview can produce high quality data as questions can be more complex than questionnaires and the interviewer can provide a quality check on the information received using secondary queries. Face-to-face interviews also allow the interviewer to use visual aids such as ‘flash-cards’ with multiple response sets which allow answers to be more detailed. As can be seen from Table 9, face-to-face interviews perform well in terms of response rates and the non-reliance of the interview on the abilities of the respondent, but score lower on the respondents anonymity and interviewer bias, as well as being more expensive.

There are a number of difficult issues around ‘interviewer influence’ when using face-to-face surveys with some people being understandably reticent about revealing their true sexual behaviour. Others may exaggerate their sexual behaviour by reporting behaviours never performed, or over-reporting the frequency of particular behaviours (Padian et al. 1995). There is also some suggestion that the longer the recall period involved the more likely it is that the information given will be inaccurate (Catania 1996). Though these effects are not restricted to face-to-face interviews, they can be particularly acute using this method given the proximity of the interviewer to the respondent. One way of getting round these problems has been to use a self-completed component in the face-to-face interview, although this does not remove interviewer effects completely. This was used to considerable success in the NATSAL studies in the UK which used computer assisted self-interview (CASI) for the more sensitive sections of the survey. For the self-completed section, the interviewer handed a laptop to the respondent (which was already used by the interviewer for the
first part of the interview) who was led through the questionnaire by the machine. When the respondent had finished the self-completed section, the interviewer would then show the respondent their information being ‘locked’ into the machine to assure anonymity.

As with mail questionnaires however, self-completion surveys demand a great deal from respondents in terms of literacy and this may lead to poorer response as was found in the 1990 NATSAL study, where those with poorer literacy were less likely to complete the CASI section.

4.2.1.1 Interviewer Matching

Attempts can be made to overcome interviewer effects by matching the characteristics of respondents and interviewers, primarily on dimensions such as age and sex, but others such as ethnicity can also be used. There are many examples of this, such as young people being trained in interviewing skills to carry out surveys into drug use or other sensitive lifestyle issues with other young people. This is done in the belief that the young people will be more likely to take part and to provide accurate information if they are interviewed by their peers. In the US, research has shown (Catania et al 1996) that matching the sex of the respondent with that of the interviewer can increase the reporting of risk behaviours significantly. However, on some subjects such as sexual violence, other procedures, such as increasing respondent control (by giving them choices about how the interview is carried out) may be a better choice.

Against this argument it is also possible that people are more likely to wish to conform to socially accepted views when discussing issues with their peers. For example, young people might exaggerate their use of drugs in order to appear adventurous, ‘streetwise’ etc. Similarly, people from minority ethnic groups might be reluctant to report behaviours that contravene religious teachings or taboos (such as prohibitions on smoking or alcohol consumption) to someone else from that group and may report these more accurately to someone from outside their community. In the UK, it has been suggested that the benefits of ethnic matching are only evident in relation to information given in response to attitudinal questions and that factual questions are not affected by the interviewer’s ethnic origin. [See Tuck, M. and Southgate, P. (1981) Ethnic minorities, crime and policing. Home Office Research Study No70. London, HMSO.]

4.2.2 Telephone Interviews

Using a telephone interview decreases the impact of interviewers as the telephone gives respondents a sense of anonymity once it has been explained that their number was chosen at random. This technique has been widely and successfully used in KAB surveys outside Ireland including large surveys in France (Spira et al 1994) and Australia (Smith et al forthcoming). A recent survey of Sexual Abuse and Violence in Ireland (SAVI) (McGee et al. 2002) found the method to be acceptable in Ireland (a 71% response rate was achieved – this is better than most general household telephone surveys [62-4% is the typical response rate in Ireland]). SAVI also showed that a very sensitive issue could be explored in considerable detail with a telephone survey method in Ireland. As well as producing detailed valid data on sensitive
subjects, telephone surveys are also cheaper to administer than face-to-face surveys as interviewers do not have to travel.

In recent years, computer aided telephone interviewing (CATI) has begun to be used more extensively and has been shown to have real advantages in terms of improving the quality of the data and speeding up the delivery of the final database. CATI ensures that the questions are worded in exactly the same way for all respondents and that responses are automatically entered into a database. CATI also allows complex skip patterns and filters within the questionnaire which means that more questions can be asked of respondents in a shorter amount of time. For example, if a respondent indicates that they have never had sex, all questions about their sexual experiences can be skipped and more pertinent questions asked. CATI also allows for cross-checks to be carried out whilst the interview is in progress thus improving the consistency of the data.

A pilot study conducted for the French ACSF revealed that response rates and data quality were comparable between face-to-face and telephone questionnaires, but that telephone interviews were preferable because a random sample could be generated more easily and at a far lower cost. Furthermore, interviewers could be monitored more easily for both survey quality and safety. The importance of this last point should not be underestimated as interviewers carrying out a KAB survey in the home of respondents about personal issues could find themselves in an unsafe situation. It would be possible to send interviewers in pairs to face-to-face interviews, but this has obvious implications for the costs of the survey and the reliability of the answers to sensitive questions.

As can be seen from Table 9, telephone interviews combine high response rates and respondent motivation and anonymity with low cost. On the other hand, questions asked over a telephone must be less complex than those asked in a face-to-face survey as visual aids are unavailable and respondents will not be able to remember lists of response categories that are read out. Overall, telephone (and particularly CATI) interviews combine a number of characteristics that make them a very attractive option as a technique.

4.2.2.1 Convincing Respondents of the Authenticity of Calls

One of the major benefits of a telephone interview is the anonymity that this affords the respondent. However, this situation can leave respondents unsure of the legitimacy and authenticity of the researcher at the other end of the telephone. A number of measures can be put in place to reassure the respondent about the authenticity of the study and the callers [apart from an explanation of the process of generating the numbers itself]:

- A dedicated free-phone telephone number in place which those called can hang up and call back – this should get them through directly to the research centre. From experience, most people wanting to check study authenticity opt for this strategy.
- Those who would like a more formal check-back contact through an organisation, as a second [from our experience lesser used] option, can contact a number such as the main research organisation's switchboard – they can be given the number and told to ask for the research centre or department. In setting this up, international experts suggest avoiding any unnecessary publicity even within
organisations which could get the nature and format into the public domain while it is ongoing. This is because of other individuals outside the study misrepresenting themselves on the phone as researchers for their own ends. In an organisation, switchboard and similar staff would need to be briefed about the existence and nature of a study and where to transfer calls.

- For those callers unconvinced by either of these options, and since the aim is to preserve their anonymity, an offer can be made to fax a letter of authentication to a police station of the participant's choice [through which they can satisfy themselves of the study credibility and authenticity even if they do not wish to take part in the study]. In our experience, this option is taken up on very few occasions – usually the willingness to offer it is enough to convince potential participants of the veracity of the study.

4.2.3 Mail Questionnaires

Lastly, mail questionnaires also offer a relatively cheap method of collecting a large amount of information. A well-designed mail questionnaire can provide true anonymity and can thus be more successful at collecting sensitive information than both the techniques just discussed, but it has several limitations. First the instrument used must be extremely straightforward and the information collected relatively simple as interviewers are not on hand to guide respondents. Secondly and perhaps most importantly, response rates, particularly on sensitive issues, tend to be very low (c.30%) leading to large sample errors and problems with representativeness, particularly among sub-groups. Such problems mean that apart from Norway and Spain, no other countries have used mail surveys.

4.2.4 Biological Sample Components in Sexual Health Surveys

Recent KAB surveys in other countries have collected biological samples in an attempt to gather information on the incidence of particular diseases. This should be examined as an option in an Irish KAB survey. In Britain for example, the National Survey of Sexual Attitudes and Lifestyles (NATSAL 2000) collected urine samples to test for the prevalence of Chlamydia trachomatis. Similarly a study among gay men in Ontario, Canada collected saliva samples to examine the incidence of HIV and how this was related to behaviour. Adding a biological samples component would add substantially to the cost of the project (it would necessitate face-to-face interviews).

4.3 Interviewer Training and Respondent Counselling

The success of a sensitive survey such as a KAB depends on the calibre of the study interviewers. Staff should be selected from social or health science backgrounds, or from other employment experience settings which would equip them to conduct interviews as both an impartial and sensitive task. Maturity in terms of management of issues of sexual health should be a key recruitment factor. In addition, a tailored training programme should be developed to ensure that all team members have the information and skills necessary to conduct high quality, sensitive interviews and to look after their own well-being as an integral part of the work. Regarding the welfare
of study participants, questions of a sexual health nature may result in reports of unwanted or distressing sexual experiences, for instance persons reporting their first sexual experience to have been one of abuse or one they very much regretted for moral or other reasons. Interviewers should be trained to address these issues sympathetically and have information on other resources [such as Rape Crisis Centre contact details] which can be availed of by distressed participants. A telephone callback system should also operate so that respondents can recontact, with consent, any participant who was judged to have been distressed by the content of the interview in the next day or two [these procedures were used by the Sexual Abuse and Violence in Ireland project (SAVI) where 15 interviewers conducted telephone interviews with 3,120 members of the public about their lifetime experience of sexual violence].

A training programme for interviewers within a KAB study would need to cover a number of issues that could be tackled over five training days in the following way:

Training Programme:

Day 1: Introduction to study [Purpose and nature of research project including rationale for choice of topics. Specific questions and format introduced]
Day 2: Methodology [telephone interviewing – particular challenges]. Study quality issues: response rates and data management addressed. Practice data entry formats
Day 3: Practicing telephone interviews – introductions and routine interview scenarios
Day 4: Study sensitivity: managing participant welfare [emotions and disclosures], language sensitivity and practicing with sensitive role-play scenarios
Day 5: Researcher well-being: responding to issues raised in interviews [debriefing, reporting systems]

4.4 Providing User Friendly and Policy Relevant Information for the Research Community

As already suggested, the collection of national data on sexual knowledge, attitudes and behaviour is essential for evidence-based policies in the area of sexual health. This is also an opportunity to provide benchmark data for future evaluation of policies across a number of complementary sexual health issues. To ensure the final survey provides data relevant for policy analysis, the survey should not only include questions on issues around sexual health, but should also have questions to establish the socio-demographic situation of the respondent and the context within which their behaviour occurs. Such information is integral to any future policy interventions.

A general aim of the KAB survey project should be to lodge any data collected in the Irish Data Archive so that other researchers can access the data at minimal cost and use it for further research. Though basic checks are always necessary to ensure that data is not being used for commercial purposes, the central aim should be to distribute the data to the widest possible audience. It is likely that considerable resources will be spent collecting the data. There is a greater chance that this expenditure will be seen as worthwhile if the data are then used extensively by the research community and the findings used for health policy purposes.
If data are to be lodged with the Irish Data Archive, they will need to be well-documented and ordered. Data preparation tends to be an ad hoc process at the end of the research process, but should be seen as integral to the project and funded as such. Widespread use of the data cannot occur if the data file is difficult to use and the structure undocumented. Therefore a data preparation, dissemination and access plan should be required as part of the original tender specification. The sponsors of the research may also want to investigate the establishment of training workshops where potential users can be given copies of the data and shown techniques for analyzing it first-hand.

4.5 Ethical Approval

Given the sensitivity of the issues in a KAB survey in the area of sexual behaviour it is imperative that the researchers should have clear ethical approval from an ethics committee working in the general area of epidemiology, public health or health services research. This committee would need to assess a number of different aspects of the study and the back-up services that it provided to respondents. Those tendering for the project should specify a research ethics committee to which any tender for the main study should be submitted.

Ethical approval for the study protocol, including approval of provision for the training of staff and ongoing monitoring and support during the study, is an essential prerequisite for a KAB study on sexual health. There is no one body in Ireland with obvious responsibility for providing ethical approval for such a study. A number of options exist. One option is to have the ethics committee system from the grant holders' institution(s) provide this evaluation. Many organisations such as universities, hospitals and health boards now have in-house ethics committee procedures. Since 2002, the Health Research Board requires all grant receivers for human or animal research to get ethical approval for the work funded. There are also some professional body ethics committees, e.g. those of the Irish College of General Practitioners and the Faculty of Public Health Medicine of the Royal College of Physicians in Ireland. In the case of a national study as proposed, where patient or other client lists are not being accessed, it is not appropriate to ask professional groups or organisations not involved in the project, e.g. a particular hospital or health board, to provide ethical approval. Indeed, for reasons including responsibility and burden, many organisations will not consider applications for approval unless the project in question is being conducted by or through their staff members (e.g. Royal College of Surgeons in Ireland).

Applicants in a tender process for a national KAB study should be asked to specify the ethics committee application procedures available to them.
Chapter Five: The Consultation Process

5.1 The Consultative Questionnaire

One of the provisions of the original tender specification for the scoping study was that it should include a plan for a wide-ranging consultation process among relevant stakeholders. The proposal that was accepted by the Education and Prevention Sub-Committee outlined a consultation process based on a questionnaire that would be sent out to stakeholders identified by the researchers in collaboration with the Committee. This was followed by a consultation day (informed by a preliminary draft of the scoping study background research document). Seventy-eight questionnaires were sent out to specific individuals identified as having responsibility for KAB issues for particular organisations. These individuals were asked to canvas opinion and beliefs within their organisation and respond to the questionnaire in the light of these discussions. Questionnaires were also sent to the Chief Executives of the Health Boards in the Republic of Ireland who were asked to identify key personnel in specific departments in their organisation who should respond to the questionnaire for their department. Those responding to the questionnaire came from a diverse group of organisations including many different departments from health boards, GUM/STI clinics, HIV/AIDS organisations, various organisations dealing with specific issues around sex and sexuality, academic departments and health education organisations.

The delegation of the distribution of the questionnaires to Chief Executives means that we cannot be sure of response rates, but forty-seven questionnaires were returned giving us a sample of responses on four general issues:

- From a list of seven areas – which would provide useful information for the organisation and could these be ranked?

- From a list of specific areas, sub-areas and approaches, does the organisation have information needs?

- Has the organisation completed any research with any of a list of specific groups?

- From a list of specific areas – does the organisation have information needs for policy and strategy development?

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8 Some questionnaires were also sent to particular individuals who were seen as having specific expertise in the area such as academics and medical consultants.

9 Responses were received from at least one representative of most types of organisations, though it was clear that in both responses to the mail questionnaire and attendance at the consultation day that those involved in child and adolescent health were represented to a much greater degree and this undoubtedly impacted on the results of both processes.

10 We would estimate conservatively that the response rate was somewhere between 50 and 55% which would be normal for a mailed questionnaire.
In the first section, respondents were asked to focus on seven areas in which they may have information needs and to choose three of these as most important. These areas were:

1. Learning about sex e.g. main sources of information about sex, preferred sources of information about sex, additional information/education needs
2. First sexual experience e.g. age of first intercourse, willingness, use of protection, feelings of regret
3. Sexual partnerships and practices e.g. sexual attraction, heterosexual partnerships and practices, homosexual partnerships and practices, injecting drug use, paying for sex, sex abroad
4. Risk reduction practices e.g. condom/contraceptive use, actual and preferred sources of protection supplies, HIV/STI testing
5. Service use and outcomes, e.g. actual & preferred sources of sexual health services
6. Adverse outcomes e.g. pregnancy under age 20, (intended or unintended), abortion, sexually transmitted infections, sexual violence/abuse
7. Knowledge and attitudes e.g. to sex and relationship education, to contraceptive/condom services, abortion, relationships etc.

The results from this first section of the questionnaire are set out in Figure 1. These show that information on risk reduction practices was the first choice of most respondents, followed by service use and knowledge and attitudes. In terms of second choices, these three reoccur again, but are joined this time by the need for information on actual sexual practices. The third choice subjects were more evenly distributed with information on knowledge and attitudes most common followed by adverse outcomes, risk reduction practices and learning about sex.

Figure 1: Most Important Areas for Development

Rather less interest was expressed in gaining information on first sexual experience, although it should be noted that one of the issues included in the section on first
intercourse was the use of protection. These results suggest that sexual behaviour, what people know about sexual behaviour and its consequences and use of sexual health services are the main information concerns of the respondents to the survey.

In the second section, respondents were asked whether they had information needs around crisis pregnancy and sexual health and if they did, was this for a teenage or adult population and on specific approaches to the problem. About 66% of respondents stated that they had specific information needs about crisis pregnancy among teenagers. Among this 66%, Figure 2 shows that over 90% needed information on approaches to education on the issue, 85% on the provision of contraception to teenagers, 85% on the provision of counselling and 82% on developing support programmes.

Figure 2: Information Needs About Crisis Pregnancy Among Teenagers & Adults

![Bar chart showing information needs about crisis pregnancy among teenagers and adults](image)

Approximately half of respondents had information needs about adults and among these, four fifths needed information on education and support programmes and the provision of contraception and around three-quarters needed information on the need for the provision of counselling. These high figures in terms of information need were replicated for sexual health.

The third section of the questionnaire asked whether the organisation provided any sexual health promotion or services/programmes to specific groups such as homosexual/bisexual groups, IV drug users or sex workers or whether research had been carried out by the organisation on these groups. All the groups listed would be of interest in an Irish KAB survey. Responses to this question showed that a large proportion do have some link with these groups as shown in Figure 3.
Forty percent of the organisations surveyed have dealings with young people in care settings, 30% with sex workers and asylum seekers and 28% with IV drug users.

Lastly, in terms of information needs for strategy development, two-thirds thought that they could not develop adequate public health strategies without more information on STDs and associated behaviour among young people. Nearly 60% were in the same position in terms of adults and 54% needed information for the development of crisis pregnancy strategy among young people.

The responses in the more open sections of the questionnaire very much mirrored those in the closed, although more specific issues were highlighted. The issue of knowledge and attitudes to sex was mentioned by many respondents in terms of the role of the media in providing information about sex and about setting norms, as was the need to identify the preferred source of information about sex. Many were also concerned to investigate the role of alcohol and drugs in sexual behaviour and particularly the role they play in casual sex.

Many of these same issues, but in terms of young people, were mentioned as important by questionnaire respondents with many seeing the role of the media as important for younger age groups in terms of setting expectations and attitudes. Questions on the preferred source of information on sex for young people were seen as important, as were questions on the factors stopping young people using sexual health services.

A positive finding of the consultation process was that none of the question areas highlighted by the consultation documents were seen as superfluous or inapplicable to the Irish context. It is clear from the results from the consultative questionnaire that there is a dearth of information available in the public domain on these issues and that this must, to varying degrees impact on the ability of organisations, including health boards, to develop coherent and effective interventions and public health strategies. In this situation, the collection of survey data that reveals the pattern of sexual health
behaviours and the factors that are associated with them is essential for the future development of policy in the area of sexual health.

5.2 The Consultation Day

The second aspect of the consultation process was a 'consultation day' of presentations and discussions held at the Royal College of Surgeons in Ireland on December 5th 2002. After presentations on important substantive and methodological issues in a future KAB survey and a review of the findings of the consultative questionnaire, those attending the day (N=2511) were divided into three groups, each with a facilitator. These groups were then asked to discuss and arrive at a group understanding of five general questions:

- Which population should be investigated?
- Which areas of sexual behaviour and practices should be investigated?
- What aspects of beliefs and attitudes are important?
- What aspects of knowledge/information are important?
- Which aspects of current and future service use should be investigated?

After approximately four hours of discussion, working groups presented their conclusions to the larger group. The following discussion distils the main outcomes from the facilitated discussion using the five question areas set out above.

Which population should be investigated?

Groups were asked to discuss the age range that a national survey should study and the population sub-groups that should be included as special interest groups. There was consensus that an upper age limit for a study was ageist and inappropriate. There were various views about the lower age limit. All groups wanted to see younger age groups included in the study, although not necessarily as part of a national sample. The lowest age suggested was twelve, although this was stated in the context of a separate survey of children in schools being carried out with two groups feeling that the youngest age group that should be addressed being 15 to 16 years. One of the groups expressed an interest in exploring age of consent issues for the younger age group.

Across the groups different population sub-groups were mentioned as in need of special attention in a national study, with three sub-groups emerging across the discussion as important: the homeless, the Travelling community and refugees/immigrants. In the final discussion it was generally agreed that the study of these three sub-groups should not occur (specifically) as part of a national sample, but as separate complementary studies, perhaps utilizing different methodologies.

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11 Roughly half of those attending the consultation day were from health boards, a quarter from organisations with an interest in AIDS and the rest a mix of organisations with interests in women’s, child and traveler health.

12 Other groups suggested were the disabled, intravenous drug users, prisoners and gay/lesbian.
Which areas of sexual behaviour and practices should be investigated?

Five areas of behaviour and practice were suggested within the facilitator guidelines, which groups could accept, amend or delete:

- First sexual experience e.g. age of first intercourse, willingness, use of protection, feelings of regret.
- Sexual partnerships and practices e.g. sexual attraction, heterosexual partnerships and practices, homosexual partnerships and practices, injecting drug use, paying for sex, sex abroad.
- Risk reduction practices e.g. condom/contraceptive use, actual and preferred sources of protection supplies, HIV/STI testing.
- Adverse outcomes e.g. pregnancy under age 20, (intended or unintended), abortion, sexually transmitted infections, sexual violence/abuse.
- Sexual dysfunction and infertility.

Across the groups there was a general consensus that all these areas were of importance, but some notable additions were suggested. One of the major themes that emerged from these discussions was that of the role of alcohol and other drugs in initiating sex and increasing the likelihood of unprotected sex. Alcohol and recreational drug use were also seen as a distinct, but contributing factors to risk behaviour. Concurrent sexual partners (i.e. more than one partner over a relatively short time span) were also viewed as an important indicator of risk behaviour. On the other hand there was also a view common across the discussions that the study should not just concentrate on adverse outcomes and regret, but should also seek to understand enjoyment and other positive outcomes associated with sex.

In terms of additional information on risk reduction practices, one group felt that an emphasis should be placed on understanding access to, or limits on access to condoms and whether condoms were used correctly. The location of where sex occurred was also suggested as an important dimension in understanding sexual behaviour. The exploration of mutual consent (or lack of coercion) both at initiation and during intercourse was seen by one group as an important issue that could be included in a survey.

What aspects of beliefs and attitudes are important?

Under this heading, two main areas were suggested by facilitators:

- Attitudes to sexual relations e.g. underage sex, sex outside marriage, extra-marital relations, same sex relations.
- Beliefs about risks associated with certain behaviours; degree of sexual competence.

One additional theme which emerged from discussions on these questions was the pattern of attitudes toward who had responsibility for the provision of both
contraception and barrier protection and when this subject should be broached before and during sex. One group also felt that attitudes toward celibacy and abstinence, particularly among younger groups should be investigated, as this area had not received much attention.

One interesting idea suggested was that a survey should try to elicit the extent to which people had personal knowledge of adverse outcomes of sexual behaviour among their peers; their understanding of this and its impact on their own attitudes and behaviour. Another idea was that attitudes toward what constituted a stable relationship should be investigated since this structured sexual relations to a considerable extent. Attitudes to alcohol and drugs, religious affiliation, pornography and masturbation were also identified as important issues.

What aspects of knowledge/information are important?

The following areas were suggested by facilitators:

- Learning about sex
  - Main sources of information about sex - the role of parents, school, peers, media (including the internet)?

- Experiences of school based sex education
  - Who delivered sex education?
  - What age?
  - Quality of education received?

- Individuals' preferred sources of information about sex; current sources and possible other sources of information.

- Additional information/education needs.

Across the discussions of the groups, the role of the media in setting norms about sexual behaviour and providing education on sexual health matters was highlighted as an area that should be covered within a questionnaire for a national sample. Similarly, groups also felt that gaining insight into respondents' knowledge and awareness of STIs and contraception, and their main sources of information would be of prime importance. The growing importance of the internet as a source of information, particularly for young people was suggested as a question that could be included.

One group suggested that information should be sought about what context or other factor would help people and particularly young people seek information on sexual health and related matters. This group also suggested that the survey should include questions on the real availability of contraception and how this may differ for urban and rural populations. Going back to the theme of examining the positive factors about sex, it was also suggested that the survey should investigate the factors that led to satisfaction with one's sex life and perhaps partnerships more widely.

Which aspects of current and future service use should be investigated?

In this final question area a single set of issues were offered by facilitators:
• Service use and outcomes e.g. actual & preferred sources of sexual health services
  o Contraceptive services
  o Sexual health services – e.g. screening, testing/ treatment of STIs
  Other?
  o Cost of services?

Discussion within the groups centred on how people find out about services (STI, contraception, counselling etc), their knowledge of what is available and barriers to service use. One group was particularly concerned about the geographical availability of dedicated sexual health services and the difficulty that the availability of generic services alone presented to users who may be concerned with anonymity. This was complemented by discussions in another group about finding out the extent to which people do and would in future travel for sexual health services and the cost, quality and timeliness of services in the respondent’s area.

One major strand of discussion across groups centred on investigation of people’s preferences for services. An extension of this discussion was the need for questions on the extent to which services were ethnically appropriate at present and the extent to which this might constrain people’s use of these services.

One suggestion for the survey was that it should include questions on use of healthcare and sexual health services following symptom experiences, e.g whether the respondent had ever experienced any symptoms (perhaps providing a list of particular symptoms) and then asking whether the respondent sought advice/help on this symptom and if not?

5.3 Conclusions from the Consultative Process

The consultation process provided a wealth of information about the present availability of information for those organisations who are working in the general area of sexual health and the large gap that exists between what is currently available and what is required for coherent and strategic policy making. This message emerged from both the questionnaire and the consultation day and arose repeatedly in discussions over the whole period of the consultation process. This strongly suggests that a national survey would contribute a great deal to the improvement of services both at a national and local level and would contribute to improved public health and the attainment of the aims of the national health strategy.

In terms of the substantive issues to be studied and the methodology to be employed, the consultation process has produced a large input from a range of practitioners, policy makers and researchers that is important for both raising new issues for a possible survey and orientating the scoping study to the Irish context.

A positive finding the consultation process was that none of the question areas highlighted by the consultation documents were seen as superfluous or inapplicable to the Irish context, although there were many additions that were suggested. Therefore, using the information drawn from the consultation questionnaire and the discussions
on the consultation day, as well as reviews of international KAB surveys, the next section outlines the substantive issues that should be included as specific questions, or sets of questions in any forthcoming Irish KAB survey.
Chapter Six: The Terms of Reference for a National Sexual Survey of Sexual Knowledge, Attitudes and Behaviour

In this final chapter we draw from the information and discussion of the last five chapters the preferred aims, content and methodology of a national survey of sexual knowledge attitudes and behaviour and set these out here as a terms of reference. It should be acknowledged here that these terms of reference are not based solely on the deliberations of the research team, but draw more widely from discussions of early versions of the Scoping Study within the Education and Prevention Sub-Committee of the National AIDS Strategy Committee. However, although the Sub-Committee are in general agreement with the position set out in this chapter, the recommendations are those of the study consortium.

This chapter is set out as follows: In the first section we use the conclusions from the consultation process in concert with the deliberations of the Education and Prevention Sub-Committee (using the evidence set out in earlier chapters of this study) to set out the substantive issues that should be covered by any future KAB survey. In the second section of the chapter we then outline the most appropriate methodological form that a future KAB should have including the population that should be studied and the types of methodology that should be employed as well as some more specific issues that would be of importance in an Irish KAB survey.

6.1 Substantive Issues for an Irish KAB Survey

In this section we attempt to distil the findings from Chapters Two and Three of this report and the deliberations from the consultation day and questionnaire feedback to provide a list of substantive areas that should be covered by an Irish KAB survey. In doing this it should be noted that one of the recommendations of the National AIDS Strategy (NASC) Sub-Committee was that the questions used in an Irish survey should be comparable with those collected in other countries and particularly the UK so that meaningful comparisons can be made on specific issues and some context for Irish results supplied. This should not mean that an Irish survey cannot explore areas that have not been included in surveys in other countries, or that specific Irish issues cannot be addressed, but it does mean that where the same issue is to be studied, the questions used should be compatible with those used elsewhere.

6.1.1 Social and Demographic Characteristics

It is important when collecting KAB information that social and demographic covariates are also collected so that variations in knowledge, attitudes and behaviour across the population can be studied. The following list should be seen as the minimum to be included:

- Sex
- Date of birth
• Partnership status and living arrangements
  - Partner's age if living with partner
  - Partner's activity status and social class
  - Ever lived as a couple if single
• Highest-level education achieved and age completed education
• Activity status
  - Employment, unemployment and other status information
  - Get last employment status if not currently employed
  - Get constituents for a social class measure
• Ethnicity and country of origin if not Irish
• An urban/rural indicator

The following variables would be extremely valuable for research purposes, although their inclusion would depend on the resources available and the practical constraints of the questionnaire instrument:

• Religion
• Degree of religiosity
• Church attendance
• Sex role attitudes
• Liberalism/conservatism scale
• Health status and disability
• Household register
• Partnership history (a full event history of marriage and cohabitation events)
  - Including questions on why partnership broke down
• Fertility history (a full history of all pregnancies and live births)
• Housing tenure
• Whether school attended was single sex or co-educational
• Whether have given blood and when
• Locus of control

The following substantive areas are listed in order of importance for inclusion, but their ordering and placement within the final questionnaire would depend on a number of practical issues such as question flow.

6.1.2 Risk Reduction Practices

• Use of protection & contraception (including emergency contraception)
  - Access to and costs
  - Preferences
  - Role of alcohol/drugs
  - Whether behaviour planned
• Monogamy, abstinence and celibacy
• HIV/STI testing of self or partner
• Personal perceptions of risk of HIV/STI – awareness of HIV status of partner
• Changed behaviours because of fear of STI/HIV – e.g. testing, abstinence, condom use, avoidance of high risk behaviours, reduced number of sexual partners or concurrent partners
• Changes in behaviour of those who have tested positive for HIV or other STIs
• Personal perceptions of the risk of pregnancy/contracting STIs during unprotected sex

6.1.3 Knowledge and Attitudes

• Attitudes to sexual relations e.g. underage sex, sex outside marriage extramarital relations, same sex relations, paying for sex
• Beliefs about what makes a successful, marriage or long-term relationship
• Attitudes to sexual practices e.g. oral sex, pornography, masturbation
• Attitudes to abortion
• Attitudes to abortion after rape
• Perceived risk of HIV/STI among groups of people e.g. people with high numbers of sexual partners, men who have sex with men, injecting drug users, people who have sex outside their stable relationship
• Perceived risk of HIV/STI in other countries compared to own country
• Knowledge of sexually transmitted infections
• Knowledge of HIV prevention
• Ease with which can talk openly about sex with partner
• Ideal partnership and sexual lifestyle at this point in life
• Ideal partnership and sexual lifestyle in five years time
• Beliefs about the risk reduction practices of peers

6.1.4 Contraceptive & Sexual Health Services

• Preferred and actual sources of contraceptive advice and supplies
• History of STIs including HIV & Hepatitis testing.
• Preferred and actual sources of screening and treatment for sexually transmitted infections
• Whether ever had HIV or Hepatitis test, when this was, where it was and reason
• Previous use of sexual health services
• Routes through which people found services
• Appropriateness of services
• Barriers to service use, e.g. confidentiality
• Extent of travel to use services
• Whether travel to use sexual health services rather than use local services
• Attitudes to quality of sexual health/contraception services in area/nationally

6.1.5 Sexual Partnerships and Practices

• Sexual attraction
- Sexual orientation
- Heterosexual partnerships – in previous month, year, five years and lifetime
- Heterosexual practices – vaginal, oral and anal
- Homosexual partnerships – in previous month, year, five years and lifetime
- Homosexual practices – vaginal, oral and anal
- Where/how met sexual partners
- Location of sex
- Unsafe sex – Unprotected vaginal, oral or anal intercourse
- Concurrent partnerships
- Length of current sexual relationships
- Intravenous drug use or unprotected sex with intravenous drug user
- Paying and being paid for sex
- Sex when abroad or unprotected sex with someone from abroad
- Consumption of alcohol and drugs
- The consumption of drugs and sex
- Alcohol use and sex
- Masturbation, fantasy and sex toys
- What aspects people like/dislike about sex
- Behaviour which enhances the experience of sex
- Belief in ability to say no to sex

6.1.6 Learning about Sex

- Sources of sex education, information and norms
  - Family
  - School
  - Peers
  - First sexual partner
  - Doctor, nurse or clinic
  - Television
  - Radio
  - Videos
  - Books
  - Newspapers
  - Magazines
  - Internet
- Main source of information about sex
- Preferred sources of information about sex
- Sex education in school e.g. age, and content
- Gaps in sex education
- Communication between parents/carers and children

6.1.7 First Sexual Experience

- Age of first sexual intercourse
- Age of first sexual experience
• Estimate of proportion of peers who had had sex by this time
• Main reason for sex at this point
• Context of first sexual intercourse
  • Age of partner
  • Planned/unplanned
  • Protection – contraception/condom
  • Willingness/Coercion
  • Feelings at the time and subsequently
  • Location of sex
  • Role of alcohol in first sexual intercourse
  • Extent to which pleasurable

6.1.8 Outcomes

• Unintended/unplanned pregnancy
• Abortion
• Sexually Transmitted Infections/HIV
• Infertility
• Miscarriage & stillbirth
• Sexual violence (including childhood and adult sexual abuse)
• Sexual dysfunction, whether sought help for the problem and kind of help
• Positive outcomes from sex – sexual satisfaction, pleasure, affection, enjoyment.

6.2 Methodological Choices

In this section we use the findings from Chapter Four, deliberations within the Education and Prevention Sub-Committee and discussions on the consultation day to arrive at some concrete proposals for the methodology that should be employed in any Irish KAB study.

6.2.1 The Population to be Studied

In discussions within the Education and Prevention Sub-committee and among the wider consultation group it was generally agreed that the prime focus of an Irish KAB survey should be to gather a representative sample of the population. This then should be the position taken in the Terms of Reference. This does not rule out the collection of information on specific sub-samples of the population using other smaller surveys, perhaps using different methodologies. Within the Terms of Reference then, the position held would be that a representative national survey should be undertaken and separate funding and proposals should be sought for separate surveys on important subgroups³.

³ Consideration could also be given to allowing interested organisations to pay for the over-sampling of certain population groups who can be sampled as part of the main study.
In terms of the upper age group to be interviewed, the consultation process, plus the experiences of researchers in the UK suggests that no upper age limit should be used since it is important to have information on in older age groups including those in retirement. This group would be particularly important for questions on sexual dysfunction which tend to be more common in this age group either because of the physical changes associated with age, the greater prevalence of chronic illness and poorer health generally.

It was clear from discussions on the consultation day that many groups would like to have large-scale representative information on a sample of young people given the importance of this group for future developments. Options for this have been examined including collecting a sample of young people at school, or interviewing young people as part of the household survey. Collecting information from young people at school is not being recommended because it excludes young people out of school and it involves a second methodology being added to the study. The approach being proposed is to add a sampling arm to the main population survey that interviews sixteen and seventeen year old respondents in the home as part of the main survey. This requires planning to maximise consent and minimise the effect of adult presence on the answers given (see Appendix 1).

Sampling sixteen and seventeen year olds will allow researchers access to an age group who are on average just beginning to experience sexual relationships, but should also limit the consent problems that might face an attempt to sample a younger age group.

6.2.2 The Survey Methodology

The review of the methods used in KAB surveys in other countries in Chapters Three and Four showed that the two main survey methodologies used were the face-to-face survey (with or without a self-completion component and use of computer aids [CAPI]) and the telephone interview (with or without computer aids [CATI]). Both methods yielded high quality data and in different ways, both circumvented the problem of anonymity which would be vitally important in a survey on such a sensitive subject. It was clear though that the face-to-face interview was considerably more costly than the telephone interview primarily because interviewers would need to travel to the home of the respondent, perhaps on more than one occasion. Given that research using telephone surveys (most recently in Australia in 2002) has shown that this technique delivers reliable and valid data, it would be possible to carry out a far larger telephone survey, with all the implications that this has for the precision of the data and one's ability to focus on sub-groups/infrequent behaviours, for the same level of resources used in a face-to-face survey.

For these reasons and those outlined in table 9 page 29 it is suggested that telephone interviewing will be considered as a first option when designing the questionnaire and pilot for any future study. Some concerns were expressed by the research sub committee about the length of the questionnaire and whether this might have an impact on co-operation over the phone. The pilot should be used to check this and the validity this method of interviewing in an Irish context given the subject matter.

14 This does not preclude also doing a school based survey of younger age groups.
It should be noted that using a telephone survey for this type of subject matter implies that steps be taken to ensure that either respondents are alone when answering the questions, or that the questions asked can be answered using either a 'yes' or a 'no' response. In the SAVI survey, which could largely be used as the model for a future Irish KAB survey, respondents were asked on first contact whether they were alone and if not, whether there was a time when they were and the interviewer could call back.

### 6.2.3 The Sampling Method

Telephone interviewing requires the use of a sampling procedure that samples randomly from all possible telephone numbers in the State. In Chapter Four we described the ‘hundred bank’ method used in the SAVI survey and this would produce a random sample of household addresses at which interviews could be carried out. However, because the sample would be of households rather than individuals (whereas the KAB survey would be a survey of individuals), the sampling method would have to include a quota control element. Each address contacted may have a number of people present who have different characteristics. The person answering the phone may not necessarily be random (calls made during the afternoon for instance are likely to reach middle and older age women who happen to be home at this time), thus data representativeness should be ensured by attempting to interview certain categories of people at each address contacted. This would tend to happen in the final stages of the study as it became clearer that certain types of individuals were under-represented, e.g. if young men aged between 25 and 35 who were working were under-represented, interviews with these types of people would be requested first.

The choice to interview sixteen and seventeen year old individuals adds another dimension to the sampling procedure since access to these individuals is dependent on getting permission from an adult in the household. Moreover, to gain interviews with enough individuals of this age group also requires over sampling using the age criterion. To achieve this we propose asking each private household contacted how many individuals aged sixteen or seventeen there are in the household and then aiming to interview each person of that age group that is available to speak and for whom consent is given. This should yield 1790 individuals based on a sample of 10,000 attained interviews, but more importantly, also means that if possible respondents of this age group are present, but consent is refused, the degree of non-response can be quantified and used when constructing weights using the characteristics of responding adult individuals in the household.

### 6.2.4 Sample Size and Geographical/Health Board Coverage

The sample size for a survey is often dictated by the budget available. We would argue strongly that an Irish KAB survey should endeavour to have the size of sample gathered in the UK, France and Australia. Sample size is not a function of population size, but of the prevalence of certain characteristics and forms of behaviour and it is clear that surveys such as the UK NATSAL survey have been able to far more precise in their estimates and have enough respondents in particular sub-groups to allow in-
depth research of certain important sexual health issues such as use of condoms among homosexual men. We suggest that an attained sample of 10,000 individuals should be seen as the minimum required as this would produce reasonable age/sex sub-groups for analysis and also be sufficiently large that groups or behaviours with prevalence rates as low as 1% would still yield 100 cases for analysis. This would mean for example (using figures from the 2000 NATSAL survey in Britain) that the sample would yield around 190 homosexual men of all age groups for analysis. This group are especially important in terms of risk reduction practices and 190 should be seen as close to the absolute minimum number for reliable analysis.

Given the dominance of the Greater Dublin area as a proportion of the total population of the State, it is clear that a large proportion of interviews will be clustered in this area if the data are to be seen as representative. This does mean however that sample sizes in other geographical areas outside Dublin would be smaller than would be the case if the same number were interviewed in each number stem. The disadvantage of this is that analyses below regional level will be unreliable (with implications for the analysis of health boards -- see below), but it does have the advantage that high risk behaviours and sub-groups such as those from ethnic minorities will be more prevalent in Dublin and this will aid analysis of a number of issues.

It was argued in Chapter Four that gaining enough cases for analysis in each health board would entail substantially increasing the sample gathered since the minimum sub-group size requirement would have to be replicated within each health board. This would have major implications for the resources necessary to carry out the survey. It is also becoming less certain that the present health board structure will remain in the long, or even medium term. We argue given these points, that the survey should not set out to be representative of health boards.

6.2.5 Important Sub-Groups

The consultation process highlighted four population sub-groups that were seen as important enough to warrant national studies. These were the homeless, the travelling community, asylum seekers and young people under 16. In the case of travelling community, they are a substantial grouping in Irish society with a very different culture and lifestyle which may shape their sexual health needs and this should be studied. The homeless on the other hand are a very vulnerable grouping who have specific sexual health problems such as high levels of abuse that should be understood more clearly. Immigrants, asylum seekers and refugees, and particularly those from countries with high rates of HIV infection may require further research.

Collecting information on homeless people and the travelling community is difficult because, as discussed in Chapter Four, by their very nature these groups will not be present in the settled private households which are reachable through a telephone survey. This means that these groups could not be sampled as part of the main study and would require a separate survey if data is to be gathered. It may be possible to sample from the populations of these two groups in Ireland, but given the absence of any sampling frame and the difficulty of finding respondents initially, it would probably be simpler to attempt a census approach and interview all respondents that could be located. Given the expense of carrying out such an exercise nationally, it
may be simpler to adopt a qualitative approach and get a more in depth understanding of the sexual knowledge, attitudes and behaviour of these groups, especially since the issues for each are substantially different than for the main population.

A study of immigrants, asylum seekers/refugees presents different, though certainly not simpler problems. To be an asylum seeker, individuals need to have registered as such and so there should, at least notionally, be a list of all applicants, their age and sex and an address where they can be reached, but this is not true of the wider community of immigrants. The register of asylum seekers would provide an ideal sampling frame from which to study refugees as it would enable a sample to be stratified by the respondents characteristics before contact was made. In practice, data protection legislation may make it difficult to gain access to the information on asylum seekers held by the Department of Justice, Equality and Law Reform and asylum seekers themselves may be a very mobile grouping and not be at all easy to reach.

6.2.6 Biological Samples

There are a number of research and public health issues such as rates of chlamydia trachomatis understanding of which would be greatly enhanced if we could gain an estimate of their real incidence and the characteristics of those individuals with such infections. However, gathering the biological samples necessary to carry out the appropriate tests is both costly, problematic when using a telephone survey and adds a new layer of complexity to the sensitive nature of the main survey. The cost of collecting and testing in the Irish context should not be underestimated. Overall it would seem prudent not to attempt to collect biological samples during the first national survey so that resources can be focused on gaining a reliable and representative sample of individuals and other baseline information.

6.2.7 Interviewer Training and Study Authenticity

In Chapter Four we discussed in detail the high level of interviewer training required before they would be able to undertake an Irish KAB survey given the sensitivity of the issues and the possibility that respondent counselling may be required. Similarly, procedures would also need to be put in place to guarantee the authenticity of the study to respondents. It is worth reiterating the importance of these issues here and underlining the fact that the set up costs of any future national KAB survey would have to take these factors into account. It will also be important before and during a KAB survey to keep publicity on the project to a minimum given the sensitivity of the area and the possibility of fake calls which could damage the project as a whole.

6.2.8 Ethical Approval

Ethical approval for the study protocol, including approval of provision for the training of staff and ongoing monitoring and support during the study, is an essential prerequisite for a KAB study on sexual health. As we have stated repeatedly in this study, a KAB survey would cover some very sensitive subjects in detail and thus the
protocols and methods of the project need to be legitimated by an appropriate ethics committee. Some of the core issues that should be dealt with here are: is the anonymity of the respondent being protected? Are procedures in place to protect and counsel respondents who reveal abuse or are upset by the survey? Is parental consent for minors correctly sought? In Chapter Four we outlined the different possible routes that could be taken to gain ethical scrutiny and approval, but made it clear there that the choice of ethics committee would depend to a large extent on the make up of the research team and the organisations involved in the successful research proposal. For example, should the successful researchers work at the Royal College of Surgeon's in Ireland, they would be able to avail of the ethic committee at the College, but this would not be an option for researchers outside of the College. Similarly, if the successful research team has members who belong to the Royal College of Physicians in Ireland or the Faculty of Public Health Medicine, the committees of these professional bodies could be used.

6.2.9 From Data to Research

As part of the Terms of Reference, we also stress that survey design and data collection should not be seen as the end of the process. First of all, this implies that data should be available for research in a timely fashion, and should certainly be available for research purposes within a year of the commencement of data gathering if the data are to be most effective.

The resources spent on a national KAB survey will be substantial and should be seen as an investment not just in the present but for future research and health policy. Data need to be used extensively by both policy makers and researchers to be fully effective and this post-data collection aspect of the survey needs to be an integral and costed part of future tenders.

The contract for the KAB survey should specify that the data are to be lodged with a respected national archive such as the Irish Data Archive at UCD, and thus will need to be well-documented and ordered. The cost of this data preparation should be part of the tender proposal and consideration should be given to the establishment of training workshops where potential users can be given copies of the data and shown techniques for analyzing it first-hand. Similarly, consideration should also be given for the development of more limited databases, perhaps with a user-friendly interfaces that can be used by non-researchers to extract information from the data.

Programmes of research using the data which establish an in-depth technical and substantive understanding of the data are, however, unlikely to be established without a source of funding, even if the data are widely available for free. Given this, it would be optimal if experienced researchers were encouraged to apply for extended sources of funding, possibly from the Health Research Board, to establish a centre for the study of sexual knowledge, attitudes and behaviour using the KAB data.

6.2.10 Questionnaire Length

One central concern in survey research is the maximization of response rates since non-response increases the degree of error in the sampling and through question non-
response can lead to bias. Given this, the research team working on an Irish KAB would need to balance the desire for greater numbers of questions in the survey with the fact that increasing questionnaire length increases non-response. As a general guide, telephone surveys rarely last longer than 30 minutes, although greater involvement of respondents can increase interview time. For example, the Sexual Abuse and Violence in Ireland survey (SAVI) which was also carried out by telephone had 88 core questions which took respondents 20 minutes on average, but if they answered ‘yes’ to either child or adult abuse, they answered 191 questions which took approximately 40 minutes (if they answered yes to both child and adult abuse they answered 381 questions, but this was only in a small number of cases). The researchers involved found that if respondents were reporting something serious they were more willing to spend longer answering questions. The average interview should thus be kept under 30 minutes.

6.2.11 From Research to Policy

A national programme of research into the area of sexual health in Ireland is overdue. This scoping study has highlighted the absence of good quality research to inform national policy and local practice. The benefits of a national survey of sexual attitudes and behaviour are evident from the experience of the UK NATSAL surveys. For example, the first NATSAL survey highlighted the role of reliable information (from schools or home) in terms of limiting adverse sexual health outcomes, thus adding evidence for the need for good quality school based sex education. NATSAL 1 & 2 have contributed to the understanding of the role of family structure, deprivation, and general education and aspirations on subsequent experience of teenage pregnancy and sexually transmitted infections. This research has informed government policy in the UK, particularly the work of the Teenage Pregnancy Unit (TPU), whereby a cross departmental approach was adopted to address broad health, social and educational inequalities in order to reduced teenage pregnancy (see www.teenagepregnancyunit.gov.uk).

The NATSAL research continues to inform policy across the UK. In 2002, the Scottish Executive together with the Health Education Board of Scotland commissioned the NATSAL team to undertake a secondary analysis of the Scottish sample of NATSAL2 (MacDowall et al 2002). This report has formed the basis for the work of the National Sexual Health Strategy Expert group.

In short, an Irish survey of sexual knowledge, attitudes and behaviour would:

- Provide a large amount of currently unavailable data on a range of important issues
- Provide information for the development of more effective health policies and strategies
- Greatly help the efficient allocation of resources
• Provide quality baseline data for future surveys of sexual knowledge, attitudes and behaviour and thus show change over time and important trends in society on these issues

The collection of national information on sexual knowledge, attitudes and behaviour would thus be an important first step in the development of evidenced based policy in this area that would be effective, strategic and cost efficient.
References


Sheerin E (1998) *Life as it is: Values, Attitudes and Norms from the Perspective of Midland’s Youth* Midland Health Board

Smith A et al (forthcoming) *Sex in Australia: the rationale and methods of the Australian Study of Health and Relationships* Submitted


**Relevant Websites**

GSS codebook http://www.icpsr.umich.edu:81/GSS/index.html


NATSAL http://qb.surrey.ac.uk/surveys/nssal/nssalintro.html

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Table 1: Summaries of Irish National surveys with relevance to sexual knowledge, attitudes & behaviour

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Geography</th>
<th>Population Group</th>
<th>Methods</th>
<th>Sample Size/Response Rate</th>
<th>Content</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Statistics Ireland (Carroll et al 2002)</td>
<td>Ireland (North &amp; South)</td>
<td>Gay, Bisexual &amp; Homosexually active men living in Ireland (aged over 16)</td>
<td>Self completion questionnaire distributed at Gay Pride Events (summer 2000) throughout the main cities on the island of Ireland via Outreach Workers.</td>
<td>1500 questionnaires distributed 1420 returns 1290 eligible responses</td>
<td>Background info (age, education, residence, sexual identification) Partnership HIV testing history Current status belief Sex with men Numbers of partners Sources of new partners Anal intercourse (protected and unprotected) Knowledge of HIV status of UAI partners Condom use Hepatitis B vaccination STI checkups Recreation drug use Sexual assertiveness (access to condoms, condom use confidence, HIV knowledge)</td>
<td>The research builds on previous research completed by the Gay Health Action (1989) and the Gay Men’s Health Project (EHB 1989). The questionnaire was developed in collaboration with the Gay Health Network &amp; was piloted in the GMHP drop in centre &amp; 2 gay bars in Dublin. Non-probability sampling (but difficult to assess the representativeness of sample as no profile of gay/bisexual population in Ireland is available) Similar data are available from England &amp; Scotland carried out by Sigma Research <a href="http://www.projectsigma.co.uk">www.projectsigma.co.uk</a></td>
</tr>
<tr>
<td>SAVI (McGee et al)</td>
<td>Ireland</td>
<td>General Population</td>
<td>Telephone Interview</td>
<td>3120 interviews; response rate of</td>
<td>Sexual Abuse and Violence in Ireland</td>
<td>See section 2.2.2.</td>
</tr>
<tr>
<td>Author(s) Year</td>
<td>Geography</td>
<td>Population Group</td>
<td>Methods</td>
<td>Sample Size/Response Rate</td>
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<td>Comments</td>
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<tr>
<td>2002) European Values Survey Halman (2001)</td>
<td>Ireland and 32 other countries across Europe</td>
<td>General population</td>
<td>Face to face questionnaire</td>
<td>At least 1000 respondents in each country, 1112 in Ireland 1999</td>
<td>Attitudes to: Homosexuality Abortion Underage Sex Prostitution Casual sex</td>
<td>The questions in the EVS are attitudinal. No knowledge or behaviour questions are included. Provides example of the usefulness of collecting data to compare attitudes across Europe.</td>
</tr>
<tr>
<td>Sex &amp; Health Survey 2002 Lansdowne Market Research (unpublished)</td>
<td>Not clear</td>
<td>18 to 30 year olds</td>
<td>Not provided</td>
<td>N=400 51% males 57% 18-24 years 43% ABCI 69% Employed 17% Student</td>
<td>School based sex education Assessment of school based sex education Topics discussed at home Age of first intercourse Contraceptive use at first intercourse Numbers of sexual partners Incident of one night stand Frequency of contraception use Current contraception Ever had STD tests Source of STD test</td>
<td>High refusal rate on key questions for example source of STD tests (50% refusal)</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Geography</td>
<td>Population Group</td>
<td>Methods</td>
<td>Sample Size/Response Rate</td>
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<tr>
<td>International Social Survey Project (ISSP) March 1994</td>
<td>Republic of Ireland</td>
<td>General Population</td>
<td>Face-to-face interview with self-completion survey</td>
<td>938 main questionnaires and 502 responses (54%) from self-completion survey</td>
<td>Socio-demographic info, sexual practices (number and sex of partners; sex outside marriage; paying for sex) and attitudes to sexual issues</td>
<td>The only large-scale national survey of sexual practices in Ireland although the results are marred by high non-response. Completely unused for research and would form benchmark for a future survey</td>
</tr>
</tbody>
</table>

UAI Unprotected Anal Intercourse
Table 2: Summaries of research into sexual behaviour among young people in Ireland

<table>
<thead>
<tr>
<th>Author(s) Year</th>
<th>Geography</th>
<th>Population Group</th>
<th>Methods</th>
<th>Sample Size/Response Rate</th>
<th>Content</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Alliance 1996 (Dunne M., Seery, D. 1997 – What On Earth Are They Doing?)</td>
<td>Cork</td>
<td>Young people aged 15-24</td>
<td>Self completion questionnaire across a range of settings including schools, FE &amp; HE colleges, Vocational training centres, Programmes for early school leavers, Youth groups etc</td>
<td>Approx 800 – self selectors</td>
<td>2 questionnaires Shorter questionnaire for younger (under 18 age group) Long questionnaire included Sources of information about AIDS Knowledge of HIV Perceived risk of AIDS Alcohol &amp; drug use Sexual behaviour &amp; practices Condom use Risk reduction behaviour</td>
<td>The schools and youth organisations chose to send a letter to parents for parental consent. Only two parents excluded their children from the survey. The study does not employ random sampling methods but highlights the importance of seeking to access young people in a range of settings. Qualitative research using focus groups were carried out to inform the development of the questionnaire.</td>
</tr>
<tr>
<td>Athlone Institute of Technology Lifestyle Survey (Duggan 2000)</td>
<td>Athlone</td>
<td>FE college Year 1 to Year 4 (Age 18-21)</td>
<td>Self completion survey of 20% sample of college population</td>
<td>N=487 (86% Response rate)</td>
<td>General health behaviour including smoking, alcohol &amp; drug use, stress, diet &amp; nutrition, &amp; physical fitness. Questions on sexual behaviour included levels of sexual experience, protection during intercourse, sources of contraception/advice, methods of</td>
<td>Very detailed survey of students lifestyle including sexual behaviour. Provides a context to sexual behaviour among this population group. Limited to third level students but provides useful insight into this groups behaviour &amp; sexual health information needs.</td>
</tr>
<tr>
<td>Author(s) Year</td>
<td>Geography</td>
<td>Population Group</td>
<td>Methods</td>
<td>Sample Size/Response Rate</td>
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<tr>
<td>Midlands Survey Bonner (1996)</td>
<td>Midlands</td>
<td>Post primary school pupils</td>
<td>Self completion survey of 16-18 year olds from 12 randomly selected schools</td>
<td>( n=1645 ) (males and females)</td>
<td>contraception, reasons for using contraception, concerns about pregnancy, &amp; sources of advice on pregnancy options.</td>
<td>32% sexually active by age 17 (38% males 26% females) 70% used contraception at 1st intercourse</td>
</tr>
<tr>
<td>FE Colleges (Condon et al 1993)</td>
<td>Cork</td>
<td>University students 17-33</td>
<td>Self completion survey</td>
<td>200 undergraduates selected at random 192 returned (15 blanks)</td>
<td>Background characteristics (Age, sex, living with parents) Sexual activity (frequency) Contraceptive use</td>
<td>35% sexually active 58% had sex at least once weekly 66% used some form of contraceptive Weak study – not representative of student population Limited questionnaire No mention of ethics</td>
</tr>
<tr>
<td>Dempsey et al (2001)</td>
<td>South East of Ireland</td>
<td>Young mothers 16-24</td>
<td>Qualitative study</td>
<td>70 interviews</td>
<td>To explore the experience of pregnancy from teenagers' perspectives</td>
<td></td>
</tr>
<tr>
<td>Mc Hale &amp; Newell</td>
<td>Galway City</td>
<td>School going teenagers</td>
<td>Self completion questionnaire</td>
<td>40 of the 47 schools participated</td>
<td>Sex education Knowledge</td>
<td>21% had sexual intercourse 72% had reported using condom at first</td>
</tr>
<tr>
<td>Author(s) Year</td>
<td>Geography</td>
<td>Population Group</td>
<td>Methods</td>
<td>Sample Size/Response Rate</td>
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<tr>
<td>(1997)</td>
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<td>15-18 years (mean age 16)</td>
<td>47 Schools Pre-leaving cert class</td>
<td>in the survey (85%) Q’naire completed by 2754 pupils (98%)</td>
<td>Sexual behaviour, Condom use, Drugs and alcohol use</td>
<td>intercourse 20% had regular sexual intercourse</td>
</tr>
<tr>
<td>Authors</td>
<td>Population</td>
<td>Methods</td>
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<tr>
<td>Teenage Pregnancy Unit (1999- Ongoing) (<a href="http://www.teenagepregnancyunit.gov.uk">www.teenagepregnancyunit.gov.uk</a>)</td>
<td>Teenagers</td>
<td>Household survey Face to face interview Self-completion questionnaire</td>
<td>Awareness of media campaign Experience of sex education Use of contraceptive services Awareness of and use of support services for teenage parents</td>
<td>The survey is part of the continuous evaluation of the teenage pregnancy strategy. A similar survey has been developed for parents.</td>
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<tr>
<td>Health Behaviour of School Children (HBSC) Ongoing – 4 yearly (most recent data collected 2002) Todd et al (1999)</td>
<td>School children aged 15 (across 17 countries including Ireland but Ireland has not included module on sexual behaviour)</td>
<td>Self-completion administered within school setting</td>
<td>Lifestyle survey including module on sexual behaviour. 1998 questionnaire included data on Sex education &amp; communication about sex Sexual experience Attitude to condoms HIV/AIDS education in schools Knowledge about AIDS and HIV Attitudes to AIDS and HIV Beliefs about risk of infection Educational needs Attitudes to people with HIV/AIDS AIDS and relationships</td>
<td>Data on sexual behaviour were gathered in Northern Ireland but not in the Republic of Ireland. The HBSC provides the opportunity to collect information about sexual behaviour together with information on other lifestyle behaviours. The survey also presents the opportunity to compare behaviour across a number of European countries using the same research protocol.</td>
<td></td>
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<tr>
<td>FpaNI Towards Better Sexual Health: A Survey of Sexual Attitudes and Lifestyles of Young People in Ireland (Schubotz et al 2002)</td>
<td>Survey of Young People aged 14-25 (n=1049) Response rate 41%.</td>
<td>Self completion survey 5 sections – four sections to be completed by all respondents and a section to be completed by sexually active respondents</td>
<td>The study also included qualitative research with young people across Northern Ireland</td>
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<td>Authors</td>
<td>Population</td>
<td>Methods</td>
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<tr>
<td>SHARE Baseline Survey (Wight et al 2002 &amp; Wight et al 2000) (Questionnaire available on request)</td>
<td>Scottish school children Aged 13-15 in 1997 Follow-up two years later part of SHARE evaluation.</td>
<td>Part of ongoing evaluation of SHARE school based sex education programme. Baseline survey N=8430 aged 13-15 From 47 non-Catholic schools in Scotland Q’naires were administered by researchers in exam conditions. Pupils completed questionnaires and returned in sealed envelopes</td>
<td><strong>Content</strong>&lt;br&gt; (including religion)&lt;br&gt;Type of school&lt;br&gt;General health&lt;br&gt;Alcohol &amp; drug use&lt;br&gt;Learning about Sex&lt;br&gt;Actual and preferred source of information&lt;br&gt;Attitudes to sexual behaviour &amp; relationships&lt;br&gt;Attitude to abortion&lt;br&gt;Sexual Behaviour&lt;br&gt;First sexual experience&lt;br&gt;Sexual attraction&lt;br&gt;Use of contraception</td>
<td>Poor response rate (41%)&lt;br&gt;Two versions of questionnaire available – one for males &amp; females. Parents were informed about the survey &amp; programme and were given opportunity to withdraw child Pupils given the option to withdraw or to omit questions Nine schools objected to questions about experience of pregnancy</td>
<td></td>
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<tr>
<td>Authors</td>
<td>Population</td>
<td>Methods</td>
<td>Content</td>
<td>Comments</td>
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<tr>
<td>APAUSE Evaluation Mellanby A et al (2001)</td>
<td>Survey of young people attending schools in the Exeter area (age 15-16) (Part of evaluation)</td>
<td>859 before and after questionnaires</td>
<td>Perceptions of sexual activity among peers Knowledge of STIs Assertiveness skills Attitudes to teenage sexuality</td>
<td>No data on sexual behaviour are presented in this paper</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breakwell &amp; Fife-Shaw (1992)</td>
<td>Survey of 16-20 year olds in Nottingham area</td>
<td>Four cohorts of fifth form students. Local education authorities provided addresses of students. Respondents’ names were drawn at random. 6400 were sent letters describing the study – a response rate of 37% (n=2171) from corrected contacts was achieved</td>
<td>Full details of questionnaire not available Study reports on section concerning sexual behaviour which covered 14 activities including penetrative sex and masturbation</td>
<td>One school declined to give addresses of students One church-aided school refused due to the nature of the research</td>
<td></td>
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</tbody>
</table>
Table 4 Summary of UK Surveys Examining Contraceptive Use among Young People (Extract from Coleman (1999))

<table>
<thead>
<tr>
<th>Author</th>
<th>Survey Year</th>
<th>Survey site</th>
<th>Sampling strategy</th>
<th>Sampling frame</th>
<th>Data Collection</th>
<th>Age Group</th>
<th>Sample size</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrams et al 1990</td>
<td>1987</td>
<td>Dundee</td>
<td>Random</td>
<td>Postal</td>
<td>SAQ</td>
<td>16-18</td>
<td>n=690</td>
<td>64%</td>
</tr>
<tr>
<td>Bowie &amp; Ford 1987</td>
<td>16-21</td>
<td>400</td>
<td>95%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ford &amp; Morgan 1988</td>
<td>1988</td>
<td>Bristol</td>
<td>Quota</td>
<td>Household</td>
<td>SAQ + Interview</td>
<td>16-21</td>
<td>400</td>
<td>94%</td>
</tr>
<tr>
<td>Galt et al 1989</td>
<td>1989</td>
<td>Doncaster</td>
<td>Random</td>
<td>Postal</td>
<td>SAQ</td>
<td>18-19</td>
<td>766</td>
<td>58%</td>
</tr>
<tr>
<td>Ford,1993</td>
<td>1989/1990</td>
<td>S West UK</td>
<td>Quota</td>
<td>Household</td>
<td>SAQ + Interview</td>
<td>16-24</td>
<td>3777</td>
<td>70-90%</td>
</tr>
<tr>
<td>MORI 1990</td>
<td>1990</td>
<td>England</td>
<td>Random</td>
<td>Household</td>
<td>Interview</td>
<td>16-19</td>
<td>4436</td>
<td>63%</td>
</tr>
<tr>
<td>Galt &amp; Gillies 1990</td>
<td>1990</td>
<td>Derbyshire</td>
<td>Random</td>
<td>Postal</td>
<td>SAQ</td>
<td>18-49</td>
<td>1175</td>
<td>61%</td>
</tr>
<tr>
<td>West et al 1993</td>
<td>1990</td>
<td>Glasgow</td>
<td>Random</td>
<td>Household</td>
<td>Int</td>
<td>18</td>
<td>908</td>
<td>90%</td>
</tr>
<tr>
<td>Ford et al 1987</td>
<td>1996</td>
<td>Somerset</td>
<td>Quota</td>
<td>Household</td>
<td>Int &amp;SAQ</td>
<td>16-24</td>
<td>498</td>
<td>92%</td>
</tr>
</tbody>
</table>

SAQ – Self Administered Questionnaire
Table 5: Summary of International KAB Surveys

<table>
<thead>
<tr>
<th>Language</th>
<th>Year</th>
<th>Age</th>
<th>Collection Method</th>
<th>Sampling Method</th>
<th>Sample Size</th>
<th>Response Rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>America GSS (Smith 1998, Davies &amp; Smith 1998)</td>
<td>English</td>
<td>1988-1998</td>
<td>18+</td>
<td>SAQ at end of Interview</td>
<td>Probability Sample</td>
<td>2832 (most recent survey completed in 1998)</td>
<td>Supplementary section part of general social survey (GSS) Includes questions on attitudes and beliefs. Questions on first intercourse and numbers of partners but not actual behaviours such as vaginal, oral, anal intercourse (1996 survey included condom use)</td>
</tr>
<tr>
<td>America Janus Survey (Janus &amp; Janus 1993)</td>
<td>English</td>
<td>1990</td>
<td>18+</td>
<td>Self completion Postal</td>
<td>Non-random</td>
<td>2795</td>
<td>61%</td>
</tr>
<tr>
<td>America Leigh et al (1993)</td>
<td>English</td>
<td>1990</td>
<td>18-70</td>
<td>FTF &amp; self completion</td>
<td>Multi-stage area probability samples of adult household population in 48 states</td>
<td>2058</td>
<td>70%</td>
</tr>
<tr>
<td>Language</td>
<td>Year</td>
<td>Age</td>
<td>Collection Method</td>
<td>Sampling Method</td>
<td>Sample Size</td>
<td>Response Rate</td>
<td>Comments</td>
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<tr>
<td>America NHSLS (Laumann et al 1994)</td>
<td>English</td>
<td>1992</td>
<td>18-59</td>
<td>FTF interview lasting 90 minutes</td>
<td>Stratified clustered sample of households. Hispanics were oversampled</td>
<td>3,432</td>
<td>78%</td>
</tr>
<tr>
<td>Language</td>
<td>Year</td>
<td>Age</td>
<td>Collection Method</td>
<td>Sampling Method</td>
<td>Sample Size</td>
<td>Response Rate</td>
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<tr>
<td>America</td>
<td></td>
<td></td>
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<td></td>
<td>Pilot work preceded the development of full survey (comprehension of difficult terms were assessed during the interviews)</td>
</tr>
<tr>
<td>National AIDS</td>
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<td></td>
<td>Described as an AIDS survey rather than a sex survey.</td>
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<tr>
<td>Behavioural</td>
<td></td>
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<td></td>
<td>The focus was particular populations – men, people with multiple partners or ‘risky’ sex partners.</td>
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<tr>
<td>Survey (NAPS 1)</td>
<td></td>
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<td>2 waves – first wave national survey second wave follow-up of High Risk Cities (HRC)</td>
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<tr>
<td>Dolcini et al (1993)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Questions include attitudes, beliefs and behaviours)</td>
</tr>
<tr>
<td>America</td>
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<td></td>
<td></td>
<td>Pilot work preceded the development of full survey (comprehension of difficult terms were assessed during the interviews)</td>
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<td>National AIDS</td>
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<td>Described as an AIDS survey rather than a sex survey.</td>
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<tr>
<td>Behavioural</td>
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<td></td>
<td>The focus was particular populations – men, people with multiple partners or ‘risky’ sex partners.</td>
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<tr>
<td>Survey (NAPS 11)</td>
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<td></td>
<td>2 waves – first wave national survey second wave follow-up of High Risk Cities (HRC)</td>
</tr>
<tr>
<td>(Dolcini et al 1993)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Questions include attitudes, beliefs and behaviours)</td>
</tr>
<tr>
<td>Country</td>
<td>Language</td>
<td>Year</td>
<td>Age</td>
<td>Method</td>
<td>Sampling Method</td>
<td>Sample Size</td>
<td>Response Rate</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>-----------------</td>
<td>----------------------------------</td>
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<td>---------------</td>
</tr>
<tr>
<td>Australia Study of Health and Relationships (ASHR)</td>
<td>English</td>
<td>2001</td>
<td>16-59</td>
<td>CATI</td>
<td>Random digit dialing</td>
<td>19,307</td>
<td>73% (69% males 77% females)</td>
</tr>
<tr>
<td>Belgium*</td>
<td>French/Dutch</td>
<td>1993</td>
<td>15-59</td>
<td>CATI</td>
<td>Multistage stratified random sample (population registry)</td>
<td>3733</td>
<td></td>
</tr>
<tr>
<td>Denmark*</td>
<td>Danish</td>
<td>1989</td>
<td>18-59</td>
<td>SAQ (n=1080 questionnaire only n=360 Card questionnaire)</td>
<td>Random sample</td>
<td>4680</td>
<td>Q’naire only = 52% Card q’naire 73%</td>
</tr>
<tr>
<td>Language</td>
<td>Year</td>
<td>Age</td>
<td>Collection Method</td>
<td>Sampling Method</td>
<td>Sample Size</td>
<td>Response Rate</td>
<td>Comments</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>French * the Analyse des Comportements Sexuels en France (ACSF) (Spira et al.)</td>
<td>French</td>
<td>1992</td>
<td>18-69</td>
<td>CATI</td>
<td>Stratified random sample from telephone directory – based on birthday</td>
<td>Short 20 055 Long 4820</td>
<td>77%</td>
</tr>
<tr>
<td>France * KABP</td>
<td>French</td>
<td>1992</td>
<td>18-69</td>
<td>CATI</td>
<td>Stratified random sample from telephone directory – based on birthday</td>
<td></td>
<td>1927</td>
</tr>
<tr>
<td>Germany* (E)</td>
<td>German</td>
<td>1990</td>
<td>16-74</td>
<td>SAQ</td>
<td>Random selection of households – selection by birthday</td>
<td></td>
<td>1319</td>
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74
<table>
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<tr>
<th>Country* (w)</th>
<th>Language</th>
<th>Year</th>
<th>Age</th>
<th>Collection Method</th>
<th>Sampling Method</th>
<th>Sample Size</th>
<th>Response Rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany*</td>
<td>German</td>
<td>1990</td>
<td>18-69</td>
<td>FTF &amp; SAQ</td>
<td>Quota sample - based on gender, age, marital status, state, townsize</td>
<td>3014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany* (East and West)</td>
<td>German</td>
<td>1993</td>
<td>16-74</td>
<td>CATI in WG FTF in EG</td>
<td>Random - phone numbers selection by birthday</td>
<td>4662</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Britain* (NATSAL1)</td>
<td>English</td>
<td>1990</td>
<td>16-59</td>
<td>FTF &amp; SAQ</td>
<td>Multi-stage random sample of addresses in PAF - selection of individuals using variant of KISH GRID</td>
<td>18876</td>
<td>67%</td>
<td>Qualitative research was completed to inform the development of the research instruments. No incentive. Questions include background characteristics, general health and use of health services, family and learning about sex, age of first intercourse, first sexual experiences, numbers of sexual partners, same-sex partners within past year &amp; over lifetime, vaginal, oral and anal sex, paying for sex (men only), condom use, STD, miscarriage and termination (women only) sources and use of contraceptives, use of services, HIV testing and sexual attitudes.</td>
</tr>
<tr>
<td>Country/Region</td>
<td>Language</td>
<td>Year</td>
<td>Age</td>
<td>Collection Method</td>
<td>Sampling Method</td>
<td>Sample Size</td>
<td>Response Rate</td>
<td>Comments</td>
</tr>
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<td>---------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Great Britain (NATSAL2)</td>
<td>English</td>
<td>2000</td>
<td>16-44</td>
<td>CAPI &amp; CASI</td>
<td>Multi-stage random sample of addresses in PAF – selection of individuals using variant of KISH GRID (oversample in London represent – and booster samples to represent ethnic minorities)</td>
<td>1161</td>
<td>65.4% (response lower in London, and among young men)</td>
<td>Qualitative research explored the experience of completing the survey, the usefulness of ACASI &amp; acceptability of urine sample. Respondents were offered incentives £5, £10, donation to charity. New questions on sexual dysfunction, sexual mixing abroad and preferred sources of contraceptives. Half respondents were asked to provide urine sample for Chlamydia test The follow-up survey provides an update on sexual behaviour over the decade,</td>
</tr>
<tr>
<td>Greece* Athens KABP</td>
<td>Greek</td>
<td>1989</td>
<td>15-64</td>
<td>FTF + SAQ</td>
<td>Two stage clustered: Selection of 150 clusters; random route selection of households – selection of individual according to age and gender</td>
<td>1200</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Athens KABP: Friends of the National AIDS Research Project, Greece
<table>
<thead>
<tr>
<th>Country</th>
<th>Language</th>
<th>Year</th>
<th>Age</th>
<th>Collection Method</th>
<th>Sampling Method</th>
<th>Sample Size</th>
<th>Response Rate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greece • Athens PR</td>
<td>Greek</td>
<td>1990</td>
<td>15-49</td>
<td>FTF</td>
<td>Two stage clustered: 3 area units – 4 clusters Random route selection of household. Selection of one or more according to age/gender</td>
<td>1980</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands*</td>
<td>Dutch</td>
<td>1989</td>
<td>18-50</td>
<td>FTF</td>
<td>Multi-stage random sampling selection based on birthday</td>
<td>1001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>English</td>
<td>1991</td>
<td>18-54</td>
<td>CAT/1</td>
<td>Two stage stratified national sample using RDD</td>
<td>2361</td>
<td>63%</td>
<td>The survey used the WHO/GPA protocol which covered background characteristics, partnerships, sexual behaviour, contraception, STDs, sexual practices, and knowledge and attitudes to HIV and AIDS.</td>
</tr>
<tr>
<td>Country</td>
<td>Language</td>
<td>Year</td>
<td>Age</td>
<td>Collection Method</td>
<td>Sampling Method</td>
<td>Sample Size</td>
<td>Response Rate</td>
<td>Comments</td>
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<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Norway</td>
<td>Norwegian</td>
<td>1992</td>
<td>18-60</td>
<td>SAQ (postal)</td>
<td>Random sample of population registry</td>
<td>4760</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>Portuguese</td>
<td>1991</td>
<td>19-40</td>
<td>FTF &amp; SAQ</td>
<td>Multi-stage stratified</td>
<td>2471</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain*</td>
<td>Spanish</td>
<td>1990</td>
<td>14+</td>
<td>SAQ (postal)</td>
<td>Random sample of population registry</td>
<td>1103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Castilla et al 1998)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland*</td>
<td>German, French,</td>
<td>1992</td>
<td>17-45</td>
<td>CATI</td>
<td>Random selection of households from telephone registry – selection of individuals based on quota sample</td>
<td>2800</td>
<td>87.5%</td>
<td>Baseline survey was carried out in 1987 among 17-45 year olds. The survey was repeated annually until 1992, and then biennially. The most recent surveys cover knowledge and attitudes to HIV/AIDS Perceived risk of HIV/AIDS, sexual activity (age of first intercourse, lifetime no. of partners, frequency of intercourse – last week, no. of partners 6 months, lifetime drug use, use of protection</td>
</tr>
<tr>
<td>(Dubois-Arber et al 1997)</td>
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</tbody>
</table>

*Data extracted from Hubert M (1998)

FTF: Face to Face
CATI: Computerised Assisted Telephone Interview
CASI: Computerised Assisted Self Interview

SAQ: Self Administered Questionnaire
CAPI: Computerised Assisted Personal Interview
Table 6: Content of English Language Surveys

<table>
<thead>
<tr>
<th>Topic</th>
<th>Australia ASHR</th>
<th>US – NHSLS</th>
<th>GB 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health &amp; use of health services</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Family and learning about sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st sexual experience</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Sexual abuse during childhood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual partnerships</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Sexual practices</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Homo-sexual behaviour</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Sexual partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex abroad</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying for sex</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>√</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Alcohol &amp; recreational drug use</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social networks</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. &amp; details of recent sexual partners</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sources and use of contraceptives</td>
<td></td>
<td></td>
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<tr>
<td>Preferred source of contraception</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Miscarriage, stillbirth and termination</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>STIs</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Risk reduction</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Use of pornography/sex aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Attitudes – marriage/relationships</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Sexual Attitudes – risk reduction</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Sexual Attitudes – AIDS/HIV</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

15 Full details of the ASHR survey not available – some details may be omitted
Table 7: Table 1c European Surveys – Content of Questionnaires
Proportion of questions on different topics in the European Surveys

<table>
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Knowledge, perception, attitudes</td>
<td>32</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>46</td>
<td>29</td>
<td>7.5</td>
<td>12</td>
<td>0</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>toward HIV risk &amp; prevention</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Condom use</td>
<td>11</td>
<td>14</td>
<td>8</td>
<td>0</td>
<td>10</td>
<td>8</td>
<td>17</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>8.2</td>
<td>22</td>
</tr>
<tr>
<td>Number of sexual partners</td>
<td>4</td>
<td>10</td>
<td>1</td>
<td>4.2</td>
<td>3.8</td>
<td>2.9</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>17</td>
<td>7</td>
<td>7</td>
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<tr>
<td>Characteristics of partners, meeting</td>
<td>0.5</td>
<td>13</td>
<td>35</td>
<td>9</td>
<td>11</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>24</td>
<td>17</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>places and relations between</td>
<td></td>
<td></td>
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<tr>
<td>partners</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sexual practices</td>
<td>0.0</td>
<td>8</td>
<td>2</td>
<td>9</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>21</td>
<td>21</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Past &amp; current family life</td>
<td>26</td>
<td>3</td>
<td>3</td>
<td>14</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Contraception &amp; abortion</td>
<td>1.0</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0.3</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Data extracted from Hubert M (1998)
Appendix 1: Parental Consent from the NATSAL Survey (Great Britain 2000)
Relevant References – National Sexual Health Surveys (Methodology & Findings)


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