

Contraceptive Needs: The Evidence, A Literature Review

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Abstract

The research in Ireland shows that people are becoming sexually active at a younger age, with estimates of about 70% using contraception at first intercourse. The main methods of contraception in Ireland are the pill and condoms, with only small numbers using other methods. The use of natural methods has declined to very low levels. This pattern is similar to the United Kingdom (UK). In Ireland provision of sterilisation is patchy, with long waiting lists in many areas. Sterilisation rates vary in different countries and are affected by cultural issues and service availability. In Ireland the pill is more popular with younger women than with older women. Estimates for use of emergency contraception (EC) vary but usage seems to be higher among younger women. Women need to know about EC and recognise the need for it in order to use it. Service providers need to be familiar with the indications and contraindications for EC, and make women aware that it is available. Out-of-hours access to this method can be difficult. Apart from differences with age, in Ireland contraceptive method choice varies with marital status, educational attainment, social class and entitlement to a general medical services card (GMS card also known as 'medical card'). Access to (including ability to pay for) services can also affect choice of contraception and this is important for people in rural areas, people on low income and young people.

The findings of research in Ireland on preference for contraceptive service provision are similar to the findings in UK and other international research. Women generally prefer a female practitioner and confirm this by choosing a female when there is one available. However, one study showed that women value listening skills and friendliness, regardless of gender. Overall, women want choice in services, including access to dedicated family-planning clinics (FPCs) and a range of methods available for them to choose from. Reasons for preferring a FPC include feeling embarrassed going to their GP and wanting a confidential and private service.

The needs of younger women are different to those of older women. They tend to prefer nurses to doctors and have higher usage of FPCs. However, ordinary FPCs might not meet all the needs of young people and several specialist clinics are described in the literature. These include clinics in settings familiar to young people, such as schools and youth clubs, that are staffed with same-gender, non-judgmental, approachable personnel in all areas.

Irish and other international studies have shown that people want more information about contraception. Younger people tend to use lay sources of information, such as mothers and friends, whereas older people use health services. Leaflets are acceptable to the public but there has been debate as to whether they are effective in improving knowledge, especially as many of them are written for people with a high literacy level. Women given information in FPCs retained more information than women given information by a GP did.

Services in Ireland are mainly delivered by GPs in a general-surgery setting. FPCs are mainly confined to urban areas with a high concentration of population. Women with medical cards are restricted in their choice because they are tied to one provider, which can be a problem for women in rural areas where many GPs work alone. Also, the majority of GPs are male. Recent studies have shown that the majority of GPs provide the hormonal methods of contraception, but provision of other methods varies.

About three-quarters of GPs have membership of either the Irish College of General Practitioners or the Royal College of General Practitioners, with half having a further qualification in family planning. However, getting practical training to get this qualification and retaining these skills is an issue for doctors and nurses because the majority of women use the pill or the condom. Providing a full range of methods to women at a location convenient to them is a challenge for the health services in Ireland.

1.0 Literature review

This document reviews the literature on sexual behaviour, patterns of contraceptive use and the use of services by women. Literature on the sexual behaviour, contraceptive use and service use of men is very limited, although some research on young people does include men. The document also reviews the literature available on the needs of service providers. Where they are available, Irish research findings are discussed. This information is supplemented by international research.

The aim of the review is to make recommendations about future development of services in Ireland so that they meet the needs of the people who want to use them. Although the document mainly reviews literature from medical, nursing and public health collections, a search of other collections was done. Figures were taken from national and international statistical databases. Hand searching of references was also done. The Crisis Pregnancy Agency made unpublished results from a recent audit of contraceptive services in Ireland available to the author.

1.1 Search strategies

Multiple sources, including Medline (1990-2003), were searched for relevant literature. The main search strategy was 'contraception' or 'family planning' and 'services'. A search using 'contraception' or 'family planning' and 'needs assessment' and one using 'general practice' and 'contraception' were also done. The Cochrane database and Bandolier were searched using 'contraception' or 'family planning' and 'services'. CRD Databases (DARE, NHSEED, HTA) for 1996-2001 were searched via the web site www.york.ac.uk using the search terms 'contraception' or 'family planning' and 'services'. A search of the 'Family Planning collection' on the British Medical Journal website (www.bmj.com) was done periodically, as was a search of the Alan Guttmacher website, which publishes the journal Family Planning Perspectives. Central Statistics Office data was accessed via the Internet.

1.2 Fertility trends in Ireland

The population of Ireland has been increasing steadily since the 1960s. The population at the 2002 census was 3,917,336 (Central Statistics Office 2002). However, although the crude birth rate and total fertility rate in Ireland are the highest in the European Union (EU), they have both been falling in the last thirty years. In 1995, the crude birth rate in Ireland was 13.5 per 1000 and the fertility rate was 1.84 (Central Statistics Office 2001). The marriage rate has also decreased from 6.4 per 1000 in 1978 to 4.5 per 1000 in 1998, so women are less likely to get married now than they were in 1978. This may explain some of the increase in births outside marriage, which have risen from 3,723 (5%) in 1980 to 18,049 (31.2%) in 2001 (NISRA and Central Statistics Office 2003). The EU average for births outside marriage is 23.4%. In 2001 there were 3,095 births (5.3% of total births) in Ireland to women aged less than twenty years. In 1980 there were more births in this age group (3,580) although the percentage of total births was less (4.8%).

1.3 Sexual activity in Ireland

It is difficult to trace the trends in sexual activity in Ireland over time because until the late 1980s most studies did not include unmarried women, so data is not always comparable. In recent years studies have included unmarried women and patterns are beginning to emerge. Also, although questions on sexual health have been included in national surveys (Centre for Health Promotional Studies 2003, Wiley and Merriman 1996), unlike the UK, for example, there has not been a national sexual health survey in Ireland.

In Ireland the age at which women first have intercourse has been decreasing over recent decades (Mason 2003, Smith 1996). This has also been noted in the UK (Ford, Halliday and Little 1999, Wellings, Wadsworth, Johnson, Field, Whitaker and Field 1995). Several Irish studies of women under twenty years have found that, on average, women report having first intercourse between the ages of fifteen and seventeen years (Fitzpatrick, Fitzpatrick and Turner 1997, McHale and Newell 1997, Midland Health Board: personal communication, Smith 1996). Fitzpatrick et al. found nearly 20% of 120 pregnant teenage girls attending a Dublin antenatal clinic had started having intercourse under sixteen years of age. A Midland Health Board (MHB) survey of sixteen to eighteen year olds found that a third of respondents reported having had sexual intercourse (Midland Health Board: personal communication) while McHale and Newell (1997) found that 21% of fifteen to eighteen year olds in Galway schools had had sexual intercourse. Mason (2003) found that 55.2% of a sample of women aged 18-45 years in the North Western Health Board (NWHB) area had had sexual intercourse for the first time in their teens. A study of women using emergency contraception (EC) in the NWHB in 1999 found that 14.8% had had sexual intercourse for the first time when less than sixteen years old and that 93.5% had become sexually active by the time they were 22 years (McCormick 2001: personal communication).

The estimates of sexual activity vary because some studies estimate it by asking participants if they are currently sexually active and some ask if they have ever been sexually active. Sexual activity also varies with age and marital status. The likelihood of ever having been sexually active increases with age, as shown by McCormick (2001) and Mason (2003). In both these studies over half of the women had become sexually active in their teens; with the majority of the rest becoming sexually active by the end of their twenties. Married women are more likely to be currently sexually active than single women (Wiley and Merriman 1996). Depending on the age group chosen, the estimates for sexually active single women varies from about a quarter to a third (Condon, Collins and Jenkins 1993, Wiley and Merriman 1996).

1.4 Patterns of contraceptive use

1.4.1 Europe

Several large international studies, repeated at intervals, have built up a picture of the patterns of contraceptive use in Europe over the last three decades (Dawe and Meltzer 2001, McEwan, Wadsworth, Johnson, Wellings and Field 1997, Spinelli, Talamanca and Lauria 2000). In Europe the main methods used are oral contraception, condoms and sterilisation (Dawe and Meltzer 2001, McEwan et al. 1997, Spinelli et al. 2000). The preference varies between countries and is affected by availability of services, cultural beliefs and the role of women in society (Spinelli et al. 2000). Choice of method also varies with age and marital status (Dawe and Meltzer 2001, McEwan et al. 1997,

Spinelli et al. 2000). Younger women are more likely to use the pill than older women (Dawe and Meltzer 2001). Married women are more likely to use sterilisation than single women are, although this is affected by health policies in some countries, which exclude single women from this service (Spinelli et al. 2000).

In Britain there have been changes in contraceptive usage since 1970. McEwan et al. (1997) compared surveys carried out in England and Wales in 1970, 1975 and 1990-91 on sexual attitudes and lifestyles. Although the results are not completely comparable because of changes in the classification of certain groups, the results do give an indication of the changes in contraceptive use over the period. The most striking change is the decrease in the number of never-married women who have never used contraception: from 59% in 1970 to 1% in 1990-91. The most commonly used methods for single women between 1970 and 1990-91 were the condom and the pill (Table 1.1).

Table 1.1: Percentage of never-married or cohabiting women aged less than 36 years ever using selected methods of contraception. (McEwan et al. 1997)

Method	1970	1975	1990-91*
Pill	14%	49%	61%
Condom	26%	30%	63%
None	59%	40%	1%

*More than one method may have been reported by any respondent

Married women who were not using sterilisation were most likely to have been using condoms or the pill in the last year (Table 2.2). Sterilisation increased in popularity from 11% in 1975 to 29% in 1990.

Table 1.2: Percentage of ever-married women aged 16-41 years using selected methods of contraception in the last year. (McEwan et al. 1997)

Method	1970 (n=2241)	1975 (n=1913)	1990-91 (n=2866)*
Pill	21%	36%	40%
Condom	31%	22%	32%
Withdrawal	16%	6%	5%
None	21%	23%	21%

*More than one method may have been reported by any respondent

Dawe and Meltzer (2001) confirmed that the two main methods used in the UK were the pill (26%) and condoms (23%), although if female (12%) and male (11%) sterilisation are combined they would have been as popular as condoms.

1.4.2 Ireland

Comparisons of studies in Ireland from the 1970s (Wilson-Davies 1975) and 1980s (O'Neill 1986) with studies from 1990 onwards (Bedford 1997, Condon et al. 1993, Mason 2003, Centre for Health Promotional Studies 2003, Wiley and Merriman 1996) show that there has been an increase in the number of women using contraception and a change in the balance of methods used. Three studies in the 1990s found about 30% of sexually active women did not use contraception, with single women more likely to use contraception than married women (Bedford 1997, Condon et al. 1993, Wiley and Merriman 1996). However, a recent study found only about 15% not using contraception (Mason 2003). Wiley and Merriman (1996) found that sexually active women with only primary education were less likely to use contraception than women with a university qualification. The SLAN surveys in 1998 and 2002 (Centre for Health Promotional Studies 2003) showed an increase in regular contraceptive use by women over the four-year period of study: in 1998 31.2% of sexually active women always used contraception whereas in 2002 42.9% of women always used it. However, there was a fall over the same period of sexually active men who always used contraception from 35.6% to 26.3%.

In the 1970s natural methods and withdrawal accounted for 65% of the contraception used by married women (Wilson-Davies 1975). In the 1980s the use of the pill and condoms rose and natural method usage fell (O'Neill 1986). In the 1990s the condom and the pill continued to dominate, especially with younger women (Centre for Health Promotional Studies 1999, Condon et al. 1993, Wiley and Merriman 1996). The pill and the condom are consistently the most commonly used methods in recent years (Table 1.3). The level of usage varies with age (Mason 2003), marital status (Bedford 1997, Mason 2003, Wiley and Merriman 1996), educational achievement (Mason 2003, Wiley and Merriman 1996), social class (Bedford 1997, Mason 2003) and geographical location (Wiley and Merriman 1996).

Nationally, Wiley and Merriman (1996) found that 22% of women used the condom, 17% used the pill and 14% used natural methods. The 1998 SLAN survey (Centre for Health Promotional Studies 1998) found that 48.2% of sexually active women had been on the pill at some time in their life, with a mean usage of 4.8 years. This increased in the 2002 survey to 54.8% of women having used the pill for an average of 5.4 years (Centre for Health Promotional Studies 2003).

Table 1.3: The percentage of women using selected methods of contraception in three Irish studies

	Wiley and Merriman (1996) n=2988	Bedford (1997) n=1002	Mason (2003) n=901	SLAN survey 1998 (women)	SLAN survey 2002 (women)
Pill	22.0%	45.1%	29.5%	25.5%	30.0%
Condom	17.0%	44.3%	24.0%	40.0%	35.7%
Natural Methods	14.0%	10.5%	1.6%		
Sterilisation			5.9%		
Withdrawal			1.1%	7.2%	6.0%

In Bedford's 1997 study of women in the North Eastern Health Board (NEHB), the pill was the most common currently used method (45.1%), followed by condoms (44.3%). Some women used more than one method, with the pill and a condom being the most common combination (8.2%). Natural methods were used by 10.5% of women, and were used more commonly by older women and married women.

Mason (2003) found that the most common methods currently being used were the pill (29.5%) and the condom (24%), with the next most common method being sterilisation (5.9%). Only small numbers of women used each of the other methods, although altogether these methods were used by 13.9% of the sample. Over half of the sample had used the pill at some time and nearly two thirds had used condoms. While only 1.1% of the sample was currently using withdrawal, nearly one in five women (19.1%) had used withdrawal at some time. Natural methods were being used by 1.6% of women and had been used by 7% in the past. A study of 1,200 women aged fifteen and over in Ireland showed the prominence of pill use, with 41% of women having used the pill at some time (Schering A.G. 2001: personal communication). Dissatisfaction with the pill rose with age. The main reason for discontinuing the pill was side effects (26%) although 54% cited 'other' reasons, which included age and the menopause. Of those who were no longer taking the pill 36% were now using no method with 26% using condoms, 12% natural methods, 9% intrauterine device (IUCD), 6% female sterilisation, 6% cap and 3% depo-provera.

Single women are more likely to use the pill or condoms than are married women (Wiley and Merriman 1996). Married women are more likely to use natural methods than single women (Mason 2003, Wiley and Merriman 1996).

Age comparisons are hindered by different definitions of younger and older women, but, generally, younger women are more likely to use the pill and less likely to use withdrawal when compared to older women (Mason 2003, Schering A.G. 2001, Wiley and Merriman 1996). Using logistic regression Mason (2003) showed that at all ages women were more likely to be using the pill than the condom but the difference in usage was greatest for women aged 21-24 years (4.8 times as likely to use the pill). Wiley and Merriman (1996) showed an increasing use of sterilisation with age, with the highest percentage usage being in women aged 40-45 years (13.3%). The increase in usage started in the 35-39 year age group where 9.6% used it compared to only 3.3% in the age

band below (30-34 years). This trend may be due to changing contraceptive needs in older women, but may also be influenced by criteria set by gynaecologists (or urologists for men) for doing sterilisations. Lack of other reliable alternatives in this group may also influence their choice, especially in women who have completed their families.

Educational, socio-economic and geographical factors may also affect choice of contraception. Wiley and Merriman (1996) found condom use is more common in women with third-level education, and Mason (2003) found pill use is more common in women who left education at or before the end of second level. Bedford (1997) found women in socio-economic group 1 (i.e. head of household in a professional or senior managerial grade) were less likely to use the pill, and women with medical cards were more likely to use the pill. Wiley and Meriman (1996) found that unemployed women had the highest level of pill use in their sample. Also, women from urban areas were more likely to use condoms and the pill compared to women from rural areas, who were more likely to use natural methods. This may be a reflection of different attitudes to contraception among couples in rural areas, but it is also likely to indicate the difficulties women in rural areas have had historically in accessing services due to the lack of choice of provider. Mason (2003) identified the problems in rural areas for women and young people who wanted to use contraception using focus groups with women and men. Problems included perceived lack of confidentiality in rural health centres and embarrassment and lack of confidentiality using pharmacies in small towns and villages. Problems also arose from the fact that a lot of general practitioners (GPs) in rural areas work alone; problems such as a lack of choice of a female doctor and a dependence on the personal views and skills of the GP serving their area. People wanted access to specialist services such as FPCs or young people's clinics, but they identified that having these services available locally meant that privacy was compromised: they were worried about people knowing they were using them. Yet having services in larger towns, although this offers greater privacy, also presented problems such as the cost, time and inconvenience involved in travelling. Lack of transport is a particular issue for young people wanting to access services. Some groups suggested providing outreach clinics from a FPC in a main town, and that a neutral premises, such as a women's centre, should be used.

1.4.3 Contraception use at first intercourse

Mason (2003) found that of those who had had intercourse, 71% reported using contraception the first time, with condoms (34%), the pill (27%) and withdrawal (7.8%) being the most commonly used methods. A MHB study found that 70% had used contraception on the first occasion. The most popular methods were the condom (79%) and the pill (12%) (Midland Health Board: personal communication).

1.5 Service providers: Users perspective

1.5.1 Gender of professional

Irish studies, in keeping with international findings, have demonstrated that women prefer to consult a woman doctor (Bedford 1997, Irish Family Planning Association and Board 1997, Mason 2003, Smith 1996). International studies have shown that this is particularly true for women's health issues (Graffy 1990). Explanations put forward to explain this finding have included that women doctors are easier to talk to and have a better understanding of the problem (Nichols 1987). Other explanations are that women

doctors spend more time with patients (Van den Brink-Muinen, de Baaker and Bensing 1994) and that women patients feel less embarrassment with a woman doctor, and feel more at ease during internal examinations (Nichols 1987, Thompson, Skinner and Kirkman 1996).

This preference for a female doctor can also affect utilisation of services and the outcomes of the service (Hippisley-Cox, Allen, Pringle, Ebdon, McPhearson, Churchill and Bradley 2000, Majeed, Cook, Anderson et al. 1994, Ni Riain 1998). Studies have shown cervical smear uptake rate may be higher (Ni Riain 1998, Majeed et al. 1994) and teenage pregnancy rates may be lower if a female doctor is available in a practice (Hippisley-Cox et al. 2000). The lack of opportunity to choose a women doctor may reduce the demand for a female doctor, but given a choice women do choose a woman doctor (Mason 2003, Ni Riain 1998, Ni Riain and Canning 2000, Van den Brink-Muinen et al. 1994). Women doctors see more patients with women's health problems and for longer consultations than male doctors. Younger women are more likely to choose a female doctor than older women are (Bedford 1997, Van den Brink-Muinen et al. 1994).

The perception of women as being easier to talk to might in part explain the preference for a female doctor. Allen (1991) found from interviews with 200 young people that participants rated friendliness and listening skills as more important than the sex of the doctor. Donovan, Mellanby, Jacobson, Taylor, Tripp and members of the Adolescent Working Group (1997), in their school-based survey of 4,481 teenagers in the UK, showed that although female students preferred to see a professional of the same sex, either a doctor or a nurse, those teenagers who consulted frequently were less concerned who they saw. In a NWHB study (Mason 2003) women in the focus groups wanted doctors to be approachable, to be open with them, to be non-judgmental and to make them feel comfortable. Younger women preferred a female doctor, who they saw as being more approachable than a male doctor. In the quantitative part of the study women with a medical card, who are less likely to have a choice, were more likely to prefer a female doctor. Younger women (under 25 years) were nearly twice as likely to choose a male doctor as their least preferred medical professional.

1.5.2 Choice of professional

Younger women tend to prefer to see a nurse (Thompson et al. 1996), who is seen as more approachable, (Mason 2003) than a doctor for women's health-related issues. However, in the study of Thomson et al. (1996) clients were more concerned with the attitude, competency and training of the professional rather than their actual profession. Mason (2003) reported that men felt they would rather see a doctor than a nurse and this appeared to be because of gender stereotypes: they were expressing a preference to see a male professional.

1.5.3 Age of professional

McKinstry and Yang (1994) found only 3.6% of the 479 women in their study thought that age of the professional they consulted was very important. Most were not concerned about the age of the doctor as long as he or she was within the usual age range for GPs in the UK.

1.6 Information

Studies have shown that women want information about contraceptive methods and sexual health (Harper and Ellertson 1995, Hastings, McNeill and Martins 1987, Hughes and Myres 1996, Mason 2003), as well as information about available services (Mason 2003, Newman 2001). Hastings et al. (1987) identified that people can be embarrassed asking for information and advice from professionals face-to-face. Using the media to access information does not cause the same embarrassment. Studies (Harper and Ellertson 1995, Opong-Odiseng and Heycock 1997) have found that younger people preferred to get information on sexual matters from peers because of confidentiality issues. However, they were prepared to use professionals for less sensitive advice.

FPCs and GPs might vary in their ability to meet women's information needs (Brook and Smith 1991, Burton and Savage 1990). Burton and Savage (1990) found that in an inner London borough 90% of FPC doctors and 83% of FPC nurses had leaflets available, but only 33% of GPs did. Brook and Smith (1991) found that women who attended a FPC retained more information about how to take the pill than women who attended a GP did. Most women would like to receive a leaflet from health professionals (Hughes and Myres 1996). However, several studies have shown that whilst recall of information is higher when a leaflet and verbal advice is given, when compared to verbal advice only, it is still only about 20% of women that retain that knowledge a year later (Metson, Kassianos, Norman and Moriarty 1991, Smith and Whitfield 1995). However, Little, Griffins, Kelly, Dickson and Sadler (1998) confirmed that many women have poor knowledge about contraception, but found that leaflets increased women's knowledge of oral contraception.

In Ireland Wiley and Merriman (1996) found that the most common sources of information on contraception were GPs (43.5%), FPCs (25.4%) and health board centres (10.3%), with only 7.1% using non-medical sources such as family, friends and magazines. In Bedford's study (Bedford 1997) the most popular source of information was also the GP (44%). Books and magazines (12%) were the next most common source. However, although only small numbers of women had obtained information from a FPC they were perceived as being a good source of information (31%), second only to GPs. Mason (2003) found that half of the women in the sample considered the GP to be the best source of information, with the other main sources being friends, mother/sister and written media. However, the NWHB area, where this study was carried out, only has one well-woman clinic and two student health clinics, so it is unlikely that many women had had experience of an FPC service: only 3.4% were using a FPC as their current service provider.

Married women (Bedford 1997, Wiley and Merriman 1996) and older women (Mason 2003, Wiley and Merriman 1996) are more likely to use the GP for information than single women (Bedford 1997) and younger women (Mason 2003, Wiley and Merriman 1996). Single women are more likely to have got information from a FPC (Wiley and Merriman 1996), from friends or from their mother or sister (Mason 2003). Wiley and Merriman (1996) found that rural women were more likely to feel that contraceptive advice was not accessible when compared to urban women.

Several studies have found younger people tend to use lay sources of information (Mason 2003, McHale and Newell 1997, Midland Health Board: personal communication). The MHB study (Midland Health Board: personal communication) of secondary school students

found that 95% of female and 82% of male participants had discussed the facts of life with someone, professional or lay, during their lifetime. Girls were more likely to have discussed them with their mothers, and boys with their fathers. Books and magazines were an important source of information for over two thirds of the sample. McHale and Newell's 1997 study found that although 70% of teenagers had received sex education in school, the main sources of sexual information were friends, teachers and parents.

Leaflets were only mentioned by 5% of women in Bedford's study (Bedford 1997). Mason (2003) found nearly one in five women had got information from leaflets but no-one considered these to be the best source of information. However, professionals in the qualitative part of this study felt there was a lack of good quality leaflets to support and reinforce the information they give to women. One barrier to learning from leaflets may be literacy. Hough (2000) tested 30 health information leaflets available in Ireland and found that the reading age required to understand the information leaflet on contraception examined in the study was seventeen years, and the leaflet on AIDS required a reading age of sixteen years. Early school leavers, who may have literacy problems, and those who have lower educational achievement within the school system, tend to have sexual intercourse for the first time at a younger age (Graham et al. 1996). This group is at a higher risk from unplanned pregnancy, yet leaflets can be beyond the literacy level of the young people in this group (Hough 2000). Moreover, the language used in the leaflets can be technical, judgmental and patronizing (Irish Family Planning Association and Eastern Health Board 1997).

In conclusion, the public value information on services and on contraceptive methods (Mason 2003), but it needs to be appropriate to their literacy level, in a medium that is accessible to them and widely available. Information on services needs to highlight that they are confidential. Information from professionals needs to be consistent and be understandable and appropriate to the individual.

1.7 Models and preferences of service provision

In Ireland contraceptive services are mainly provided by GPs and chemists, with only a minority of women having access to FPCs (Bedford 1997, Mason 2003). Services and supplies that are available on prescription are free to people who are entitled to a means-tested 'medical card'. However, they have to pay for non-prescription items such as condoms. People without a medical card pay for their consultation and supplies (up to a maximum amount in a month). Barrier methods and devices to aid natural methods may be obtained from other retail outlets, including the Internet. However, there are other models of service delivery discussed in the literature (Table 1.4) which have been developed in response to the needs of special groups of people (Table 1.5).

Table 1.4: Examples of special initiatives by setting

Setting	Reference to initiative
With women's groups	(Campbell and MacDonald 1996)
At genito-urinary clinics (GUM)	(Queen, Ward, Smith and Woodroffe 1991)
	(Bloxham, Capstick and Greenwood 1999)
In accident and emergency departments (A&E)	(Gbolade, Elstein and Yates 1999)
In commercial premises	(Wilson 1998)

Table 1.5: Examples of special initiatives by client group

Client Group	Reference to initiative
Young people	(Allen 1991)
	(Fullerton 2003)
	(Morrison, Mackie, Elliott, Gruer and Bigrigg 1997)
	(Williams, Kirkman and Elstein 1994)
	(Wilson, Daniel, Peason, Hopton and Madeley 1994)
Homeless people	(Gaulton-Berks 1994)

Women's preference for different services varies with age and marital status (Bedford 1997, Wiley and Merriman 1996), with younger women and single women tending to prefer FPCs (Bedford 1997, Mirza, Kovas and McDonald 1998, Wiley and Merriman 1996), and older and married women tending to prefer the GP (Bedford 1997, Wiley and Merriman 1996). Their choice of method might dictate the services they use, as some preparations are only available on prescription, and there is some evidence that choice of method might be dictated by available services. Mason (2003) found that women wanted more choice in the area of contraception and contraceptive services. In particular they wanted FPCs available and services that met the needs of young people. They wanted a full range of methods to be available from all providers and sufficient information to guide them in their choice of method. However, a Crisis Pregnancy Agency (2003) audit found that FPC service provision tends only to be in urban areas of high population and so is not available to a lot of women.

Wiley and Merriman (1996) found that 31.4% of women favoured the GP for family-planning advice. However, 44% were actually using this service, which implies that about 12% were not able to access their first choice of service. Women who had had a baby were more likely to go to the GP for contraception compared to women who had not had a baby. There was no difference between women in rural and urban areas on their first preference but there was a difference in the second preference: the rural women favoured the health centres whereas the urban women favoured the FPCs. The authors

noted that this variation might be explained in part by the lack of provision of FPCs in rural areas. Bedford (1997) found a similar pattern in the North Eastern Health Board (NEHB) region. There was an overall preference for the GP, with older women and married women most likely to prefer the GP. Women eligible for a medical card, who might be unable to use services other than their GP because of financial constraints, were less likely to prefer the GP compared to non-medical-card holders. Mason (2003) found nearly half of the women in the study preferred to go to their GP, with 14% preferring the chemist and 12% a FPC. However, the qualitative part of this study found that although a lot of women felt they could manage with the existing services, they wanted more choice to be available to women, with a range of service options including dedicated FPCs and the option of female doctors in the GP surgery. Participants also felt the needs of young people are difficult to meet through existing arrangements, and that special services were needed that were tailored to the specific needs of young people.

Younger women tend to use FPCs (Mirza et al. 1998). However, as noted above, in Ireland the provision of FPCs is patchy and tends to be in the larger urban centres (Crisis Pregnancy Agency 2003) making it difficult for women in smaller urban towns and rural areas to access them. Also, women with medical card may have to pay for this service. Younger women might prefer a FPC because of difficulties they have with using GP services. Donovan, Ryan and Donovan (1992) studied 100 women attending a FPC and found that the most common reason they were attending was that their GP was not 'sympathetic, competent or interested' enough. FPCs are perceived as services that are anonymous (Mason 2003), confidential (Smith 1996), convenient (Smith and McElnay 1994) and offering a specialist service (Allen 1991, Donovan et al. 1992, Graffy 1990, Smith 1996) which is comprehensive and where women have time to discuss options (Mason 2003). However, a study of a sexual-health help centre for young people (Morrison et al. 1997) suggested that FPCs still need to tailor their service to meet the needs of young people in order to provide a wide range of contraceptive and sexual health services in a non-judgemental, non-threatening environment.

Another service that is used by women that might be acceptable as a contraceptive provider is GUM clinics. Thompson (1998) found women were willing to accept contraceptive services in a GUM clinic. Bloxham et al. (1999) describe a clinic for young people in Morecambe, UK. It is a combined FPC and GUM clinic in a multi-agency youth project premises in a town-centre location, staffed by women. The service includes free pregnancy testing, contraceptives and treatment of sexually transmitted infections (STIs).

Other settings are becoming increasingly important in providing contraceptive supplies. In Ireland pharmacists have provided condoms since the early nineties, when the law was changed to allow sale in pharmacies, but in recent years condoms have also become available from general stores, supermarkets, vending machines and by mail order from magazines and the Internet. However, there is little research on the satisfaction of consumers with these outlets. Some of the barriers to using pharmacies are the same as barriers to using other services, especially for young people (Mason 2003). These include embarrassment, lack of confidentiality, concern about meeting people they know in the pharmacy and the cost.

1.8 Young people

The term 'young people' is used to mean different age ranges by different researchers and healthcare professionals. It usually refers to people under twenty years of age

but can include people up to 25 years old. Another term used is adolescent, which is favoured over teenager because it can include those under thirteen years old. There are specific legal issues pertinent to people under seventeen years old, particularly in relation to providing information and services. However, because of individual variation in maturation of cognitive and decision-making processes the issues affecting interaction with services continue to be relevant to young people into their late teens and beyond.

Young people have specific health needs (The Intercollegiate Working Party on Adolescent Health 2003), which include but are not confined to sexual health needs (Bewley, Higgs and Jones 1984, Epstein, Rice and Wallace 1989, Kari, Donovan, Li and Taylor 1997). It is a challenge to service providers to design services that meet these needs and are attractive enough that young people use them regularly and consistently (Allen 1991). Some young people do not use existing services because they feel uncomfortable or find them unfriendly (Smith and McElroy 1994). Studies have found where sexual health clinics have been established for younger people they use them for wider health problems than were originally intended (Little 1997, Morrison et al. 1997). These services should be responsive to the expressed needs of the users (Little 1997).

Young people are perceived as being infrequent users of general practice services but they do consult for general health services (Kari et al. 1997) and contraceptive services (Donovan et al. 1997, Seamark and Pereira Gray 1995). However studies have shown that meeting the needs of young people is hard in general practice (Johnson and Madeley 1995, Lo, Kaul S., Kaul R., Cooling and Calvert 1994, Mason 2003). The consultations tend to be shorter (Jacobson, Wilkinson and Owen 1994) than with other patients but young people themselves feel a five-minute consultation is not sufficient to discuss personal matters and how to use a contraceptive method effectively (French 2002, Irish Family Planning Association and Eastern Health Board 1997). Young people report feeling a lack of respect for their health concerns when using primary care, not being listened to (Irish Family Planning Association and Eastern Health Board 1997), poor communication skills from GPs and a poor understanding of confidentiality issues (Jacobson, Richardson, Parry-Langdon and Donovan 2001). Practice nurses might be a way of addressing the needs of young people (Dowell 2000), but they appear to be an underused resource in Ireland (Mason 2003).

For contraceptive needs FPCs are a specialist service, and might be better placed to meet the needs of young people (Searle 1995) and be more effective (Brook and Smith 1991). However, several studies have identified that young people prefer to have the option of a dedicated service for young people (Allen 1991, Jones, Finlay, Simpson and Kreitman 1997, Little 1997, Mason 2003, Williams et al. 1994), of which there are several different models (Campbell and MacDonald 1996, Morrison et al. 1997, Smith 1999, Williams, Kelly, Carvalho and Feely 1998). The youth advice clinics that have an associated doctor-led clinic have better attendance than those without (Campbell and MacDonald 1996).

1.8.1 Confidentiality

Confidentiality is particularly important to young people (Allen 1991, Jacobson et al. 2001, Little 1997, Mason 2003, Smith 1999, Williams et al. 1994) and goes beyond concerns that doctors might share information with their parents or other agencies. The fear that doctors might inform their parents is a barrier to accessing services for young people (Brooke Advisory Centres 1996), but they are also concerned about

confidentiality when seeking to use a service (Jacobson et al. 2001, Allen 1991, Mason 2003, Morrison et al. 1997, Smith 1996). Jacobson et al. (2001) term this phenomenon 'community confidentiality': young people wanting anonymity when accessing services. It is important to them that they can enter services unseen and go unrecognised by the staff and other clients of the service. The fear is that people will know why they are there and that others, including their parents, will get to hear of their visit. This is one of the reasons young women choose to use FPCs (Smith 1996). However, it creates a dilemma for health service planners who want to provide local services (Irish Family Planning Association and Eastern Health Board 1997), especially in rural districts (Mason 2003). People attend GPs for many different reasons and Ni Riain and Canning (2000) argue that there is some anonymity for young people entering GP surgeries, whereas if they attend a local youth clinic it is more obvious what they are consulting about. However, Mason (2003) found that generally young people preferred services to be convenient and on their own territory, including within a school setting for the younger ones. This would imply that they are not so concerned about their peers knowing why they are using a service but that they are suspicious of the assurances given by providers about confidentiality within mainstream services.

1.8.2 Characteristics of doctors

As discussed earlier, young women are more likely to prefer to see a woman doctor and this is also a reason why young women choose to go to a FPC (Smith 1996). Young women see the GP as a family doctor and this can be a barrier to them consulting their GP for contraception (Ni Riain and Canning 2000, Smith 1996). Jacobson et al. (2001) found that teenagers considered that GPs have difficulty communicating with them. Young people also feel shy and embarrassed (Oppong-Odiseng and Heycock 1997) consulting their GP about contraception.

1.8.3 Accessible and appropriate services for young people

Several studies have looked at the preferred service provision of young people (Allen 1991, Irish Family Planning Association and Board 1997, Mason 2003, Nwokolo, McOwan, Hennebry, Chislett and Mandalia 2002). There are common themes in many of these studies:

1. Services should be in an environment that is used by young people in their leisure time (Allen 1991, Searle 1995) but the access should be discrete (Nwokolo et al. 2002). Young people need services available at times convenient to them (Allen 1991, Mason 2003, Williams et al. 1994) such as outside school hours and at weekends (Irish Family Planning Association and Eastern Health Board 1997, Nwokolo et al. 2002).
2. Clinics should mainly be on a 'drop-in' basis (Irish Family Planning Association and Eastern Health Board 1997, Jones et al. 1997, Kari et al. 1997), but some young people might have difficulty getting away from home or might be dependent on transport so some clinics might need to have appointments (Irish Family Planning Association and Eastern Health Board 1997).
3. Young people are very price sensitive and need the services and the supplies to be free (Irish Family Planning Association and Eastern Health Board 1997, Mason 2003, Nwokolo et al. 2002). They want a broad range of services to be available

- (Irish Family Planning Association and Eastern Health Board 1997, Little 1997, Williams et al. 1994), including on-the-spot pregnancy testing and counselling (Irish Family Planning Association and Board 1997).
4. Young people want to see someone who is non-judgmental, knowledgeable (Jacobson, Mellanby, Donovan, Taylor, Tripp and members of the Adolescent Working Group 2000, Mason 2003, Oppong-Odiseng and Heycock 1997) and who does not appear to be 'clinical' (Allen 1991). They want all the staff to be able to communicate easily with them (Little 1997) and to be highly motivated, well trained and young (Irish Family Planning Association and Eastern Health Board 1997, Mason 2003). Staff should also be casually dressed but not scruffy (Jones et al. 1997, Nwokolo et al. 2002).
 5. They want the staff to respect their right to confidentiality (Finlay 1998, Irish Family Planning Association and Eastern Health Board 1997, Jones et al. 1997, Nwokolo et al. 2002) and have what has been termed 'community confidentiality' (Jacobson et al. 2001, Mason 2003). Community confidentiality includes the concept of anonymity in using services.
 6. They want friends and partners to be welcome (Irish Family Planning Association and Eastern Health Board 1997, Little 1997, Nwokolo et al. 2002, Williams et al. 1994).
 7. They want the reception area to be immediately identifiable and welcoming (Jones et al. 1997).
 8. They want age-appropriate posters and magazines in the waiting room (Morrison et al. 1997).
 9. The service should be advertised widely at venues and through media that are used by the young people which it targets (Allen 1991, Morrison et al. 1997).
 10. The name of the service should be unambiguous and appropriate for young people, who do not recognise 'family planning' as relevant to them (Allen 1991).

There is little Irish literature on the availability of these types of services. A recent audit carried out by the Crisis Pregnancy Agency (Crisis Pregnancy Agency 2003) identified ten FPCs or well-woman clinics in Ireland but there was no information available as to whether they provided specific services tailored to the needs of young people. Mason (Mason 2003) identified a gap in specialist services for young people in the NWHB area.

1.8.4 Information needs of young people

Apart from information about the services available (Smith and McElnay 1994), young people need information about how their body works and contraception (Mason 2003). The main reasons young people delay seeking advice on sexual health is a lack of information about the available sources of contraception and a failure to identify a service appropriate to their needs (Brooke Advisory Centres 1996). Young mothers feel they do not have enough knowledge of their bodies and tend to be more concerned about the side effects of the pill prior to their pregnancy (Irish Family Planning Association and Eastern Health Board 1997, Mason 2003). School sex education projects should be a source of information for young people but Mason (2003) found that young people themselves feel that they are not of much use. They wanted a holistic approach, which

included discussion of relationships but also included specific information about how their bodies work and contraception. They also felt that the programmes needed to be started at a younger age – probably around eleven years old. Peer education was seen as useful, especially if it included an input from young parents.

1.9 Emergency contraception (EC)

Until recently EC was not licensed for use in Ireland, even on prescription. Ovran 50 had been used for EC but was not licensed for this use. However, the manufacturers withdrew Ovran 50 from Ireland in early 2003. Levonelle was licenced for use in Ireland in May 2003 by the Irish Medicines Board and has been available on prescription since June 2003.

1.9.1 Use and effectiveness of EC

There is very little research on use of EC in Ireland. Estimates of incidence of EC use in other countries vary with the population studied and age group. General practice-based estimates (Rowlands 1991, Seamark and Pereira Gray 1997) tend to be lower than estimates derived from population studies (Dawe and Meltzer 2001, Graham, Green and Glasier 1996) and younger women tend to have used it more than older women have (Graham et al. 1996, Rowlands 1991). Younger women are more likely to use FPCs for EC than older women are (Mirza et al. 1998), so the highest users of EC are less likely to be counted in GP studies.

Rowlands (1991), in a general practice-based study, found that the annual incidence of requests for EC was eleven per 1,000 for women aged 15-44 years, and over half of these came from teenagers. In another general practice-based study of fifteen to nineteen year olds in an English market town (Seamark and Pereira Gray 1997), only 16% (59) of the sample had consulted for EC but a third of these had consulted more than once. George, Turner, Cooke, Hennessy, Savage, Julian and Cochrane (1994) in a school-based Scottish study found 9.7% of the sample had used it, with one third of sexually active girls under sixteen having used it.

1.9.2 Awareness of and knowledge about EC

In order to use EC women need to be aware that it exists, know where it is available and know the indications and time limit for using it. Also, professionals need to be aware of the indications, contraindications and time limit and inform women that it is available. There is little Irish data in this area. Mason (2003) found that GPs were concerned about the lack of legal clarity about prescribing EC (at the time of that study there was no licensed EC preparation available), which may affect them being open about the availability of this method.

In the UK Burton and Savage (1990) highlighted poor knowledge of EC among professionals and women as a barrier to increased usage, with GPs being less knowledgeable than the FPC doctors and nurses. In an audit of EC requests in a general practice, Rowlands (1991) showed the number of requests increased two fold over two years, which was attributed to women becoming more aware that the method was available (often through word of mouth). More recent studies have shown good awareness of EC among women, including teenagers (Pearson, Owen, Phillips, Pereira Gray and Marshall 1995), with 80% or more having heard of it (Dawe and Meltzer 2001,

George et al. 1994, Hughes and Myres 1996). Men are less likely to have heard of EC (Graham et al. 1996, Whitlow, Desmond and Hay 1995). Several studies found the main source of information was friends (Bell and Millward 1999, Whitlow et al. 1995). Pupils attending schools with academic achievement ranked higher than the national average were more likely to have heard of EC (Graham et al. 1996).

However, indications for use and time limits are not so widely known (Harper and Ellertson 1995). A study of women attending for termination of pregnancy found 55% had recognised a method failure at the time of conception, 30% of these knew about EC, the time limit and where to get it but only 12% had used EC (Bromham and Cartmill 1993). The women who attended the GP were less knowledgeable about EC than those who attended FPCs. In a study of women with an unplanned pregnancy (Randall and Lewis 1995) the main reasons given for not using EC were underestimating their fertility, not thinking about it at the time and not being aware of EC.

1.9.3 Service delivery of EC

After discussion in the medical journals (Drife 1993, Glasier 1993), Levonelle, a progesterone-only EC preparation, was deregulated in the UK in 2001 and is available from pharmacists in the UK to women aged sixteen years and over (Harrison-Woolrych, Duncan, Howe and Smith 2001). Pharmacists receive training to sell Levonelle and are expected to be familiar with the criteria for supplying it. There have been concerns that deregulation does not allow for discussion of the risk of sexually transmitted infections (STI) or counselling on future contraceptive use at the time of dispensing (Stammers 2001), and that it is too expensive for women on low incomes. However, deregulation overcomes some of the difficulties women have in accessing EC when they need it (Harrison-Woolrych et al. 2001). Deregulation has met with approval from service users in the UK, although there have been concerns among the public and professionals that easier access and prior prescription will encourage excessive use and unsafe sexual practices (Harper and Ellertson 1995, Newman 2001). Glasier and Baird (1998) studied women given EC by their FPC to keep at home and found that 47% of women had used it at least once at follow-up. There were no serious adverse effects in those who used it and they were not more likely to use it repeatedly than the control group. In the control group, who did not have a home supply, 27% had used EC at follow-up.

In the UK women might get EC from GPs or FPCs free of charge during normal surgery hours but can experience difficulty out of hours. A general practice audit in the UK showed that there is greater demand for EC after the weekend (Rowlands and Dakin 1993) so GPs need to allocate more time to emergency work on Mondays and Tuesdays to cope with this demand. However, not all GP surgeries have flexibility in their appointment systems and women may have to wait, or even have to reveal the nature of the emergency to the receptionist to get seen (Bell and Millward 1999). Women may also have no choice about which doctor they see.

1.10 Services available in Ireland

The Crisis Pregnancy Agency recently carried out an audit of services in Ireland (Crisis Pregnancy Agency 2003). Health boards were asked to supply information on provision of contraceptive services in their region. Well-woman clinics and the Irish Family Planning Association (IFPA) were also contacted to establish the service they provided. Nine of the

ten health boards responded to the audit, but the amount of detail in the responses from each health board varied. Seven boards provided lists of GPs that were registered for or known to provide family planning/women's health services. Two of these lists gave an indication of the services that the GPs provided. Two boards only provided a full list of all GPs in the area with an indication as to whether they provided contraceptive services or not. Five health boards provided additional information on other service providers. Thirteen initiatives were identified. Ten of these provided contraception services either through a FPC or a well-woman clinic, two of which were based in hospitals. One other facility taught natural family planning, one was a primary care-based vasectomy clinic and one was an outreach programme that provided sessions from health nurses once a week to practices with a male GPs and no practice nurse. Informants reported that recruitment of trained staff and funding of the facilities was problematic. There was no information on the cost of these services to women and particularly young people. Mason (2003) highlighted that women with a medical card are often unable to afford alternative facilities and so are tied into the services offered by the GP to whom they have been allocated. This audit confirms the finding from other research (Bedford 1997, Mason 2003, Ni Riain and Canning 2000) that contraceptive services in Ireland are mainly delivered by GPs. Most GPs provide these services during general clinics although some do have dedicated clinics within their practice (Ni Riain and Canning 2000).

In recent years in Ireland there have been two health board reviews of contraceptive services (Bedford, Howell and Lynsky 1995, Mason 2003) and an Irish College of General Practitioner's (ICGP) study of services (Ni Riain and Canning 2000), looking at what contraception services GPs provide. The vast majority of GPs provide hormonal contraception (Howell, Bedford, Lynn and Bonner 2001, Mason 2003, Ni Riain and Canning 2000), including EC. Howell et al. (2001) and Ni Riain and Canning (2000) found similar percentages of GPs providing instruction on natural methods (over 80%), fitting caps (approximately a third) and fitting IUCDs (between 14% and 17%). Mason (2003) found less than half provided instruction on natural methods, a quarter fitted the IUCD, a quarter fitted mirena coils and just over a quarter fitted caps. The majority also gave advice about sterilisation (Mason 2003, Ni Riain and Canning 2000). However, Mason (2003) found a significant difference between the counties in the percentage of women using sterilisation, implying inequitable access to services across the health board areas.

Mason (2003) found that about half of GPs offered STI services. Ni Riain and Canning (2000) found that 13% of GPs did not provide some contraception because of their moral principles and older GPs were more likely to identify moral principles as the reason for not providing some services. Mason (2003) found that nearly a quarter of GPs had personal objections to at least one method of contraception. In both studies the commonest methods that doctors objected to were EC and IUCDs. Mason (2003) found that the majority of GPs were willing to give advice to under-sixteen year olds and over 80% would prescribe to this group in certain circumstances. The majority of GPs were willing to be on a contraceptive service providers' register and half were prepared to have details of what services they provide included on this register. The public may not know which GPs have personal objections and whether this affects the services they offer.

The Crisis Pregnancy Agency has recently undertaken a survey of sterilisation services in Ireland (CPA 2003: personal communication) which showed that there is inequality of service provision across the country. In the 38 out of 60 hospitals that replied (63%) the waiting time for female sterilisation varied from no wait to 60 months. Waiting times for

male sterilisation also varied from no wait to 60 months. At the time of this study there were 478 women and 13 men waiting for a sterilisation operation in Ireland. In 2000 and 2001 there were 3036 women and 643 men sterilised in these 38 hospitals. However, the Department of Health figure for the whole country for the same period was only 3785 women and 717 men, implying that there is under-reporting of sterilisation operations to the Department.

1.11 Profile of service providers in Ireland

As discussed in sections 1.6 and 1.10, the main contraception service providers in Ireland are GPs. There is no published literature on the profile of providers working in family planning/well-woman clinics in Ireland. About 70% of GPs are male and 30% female (Mason 2003, Smith 1999), which has changed from earlier in the 1990s when over 80% of GPs in a NEHB study were male. However, in both Ni Riain and Canning's (2000) and Mason's (2003) studies about two thirds of the practices had a female doctor available, although Ni Riain and Canning (2000) found that rural practices were less likely to have a female available. About half of Irish practices have a practice nurse (Mason 2003, Ni Riain and Canning 2000). The percentage of single-handed GPs in the NEHB fell from just over half to about a quarter between 1994 and 2001 (Bedford et al. 1995, Howell et al. 2001). Nationally in 2000 37% of GPs were single-handed (Ni Riain and Canning, 2000) and in the NWHB in 2001 (Mason 2003) 43% were single-handed.

About three-quarters of doctors working in general practice in Ireland have Membership of the Irish College of General Practitioners (MICGP) or Membership of the Royal College of General Practitioners (MRCGP) (Howell et al. 2001, Mason 2003). About half of GPs have a further specialist qualification in family planning (the Family Planning (FP) certificate) (Howell et al. 2001, Mason 2003, Ni Riain and Canning 2000), which has risen from about a third in 1994 (Bedford et al. 1995). Ni Riain found that doctors aged 40 years or under were more likely to have a FP certificate than those over this age. Doctors with a FP certificate are more likely to fit caps, IUCDs (Mason 2003, Howell et al. 2001) and mirena (Mason 2003). However, Mason (2003) found that less than half had had training in contraception in the last five years, although over three-quarters were willing to participate in training if it were available.

1.12 Service providers' needs

The main dilemmas for service providers in Ireland are acquiring and maintaining specialist skills and providing a comprehensive service, especially to scattered rural areas (Mason 2003, Ni Riain 1998, Ni Riain and Canning 2000). Training is also an issue for nurses (Mason 2003).

1.12.1 Training

Training to provide contraceptive services is a big issue for GPs in Ireland (Mason 2003, Ni Riain 1998, Ni Riain and Canning 2000). Because of the popularity of the pill and condoms, it is difficult for GPs to get experience in fitting other methods of contraception such as caps and IUCDs. If they do acquire these skills it is hard to maintain them, especially in rural areas. It is even harder for GP trainees to get this experience. GPs participating in Ni Riain's and Canning's 2000 study were concerned that the career progression of female GPs would be restricted by male-only practices employing them just to do women's health. Also, because of the preference of women to see a woman

doctor, if a woman joins a practice the male GPs see even fewer women for contraception and become deskilled. Male GPs are also concerned that they need a chaperone to examine a woman.

Mason (2003) found that although half the GPs had a family planning certificate, less than half of GPs in the NWHB had had training in contraception in the previous five years, although the majority was willing to attend training if it was available. Less than half of the GPs in this study provided methods such as IUCDs, mirenas and caps, but GPs with a FP certificate are more likely to provide these methods. Doctors who had had training in the last five years were more likely to fit mirena. Lack of provision of these methods affects older women particularly as they are more likely to need a reliable alternative to the pill. Ni Riain and Canning (2000) found only half of GPs were satisfied with family planning training and suggested that there be two levels of training: basic contraception and then specialist training for those who wished to offer a wider range of methods. Those with specialist training might see women referred to them by other GPs.

The need expressed by women that professionals should be non-judgmental and approachable (Jacobson et al. 2000, Mason 2003, Oppong-Odiseng and Heycock 1997) with good listening skills (Allen 1991) highlights an area that could be improved by a more holistic training package for professionals. For some of the issues identified in section 1.7.3 to be addressed, especially confidentiality, there also needs to be training available for receptionists and other people who have direct contact with clients, especially young people.

1.12.2 Remuneration

Ni Riain and Canning (2000) highlighted that the remuneration to GPs from the General Medical Services (GMS) does not adequately reflect the time necessary to give contraceptive advice to women. While there was support for inter-referral, only 7% of GPs had ever claimed the fee this attracts from the GMS scheme. In addition, GPs were not paid for taking a smear for women with a GMS card.

1.12.3 Time constraints

GPs, especially single-handed ones, can find it difficult to find time to run a dedicated contraception clinic. However, if they see women in the general clinic they cannot give a full contraceptive consultation in the time allowed by a general clinic appointment slot (Ni Riain and Canning 2000). Ni Riain and Canning (2000) found that three-quarters of GPs were in favour of providing services both through routine surgeries and dedicated clinics, but only a third of GPs provided this combination.

1.12.4 Co-ordination of services

Mason (2003) found that GPs in the NWHB were open to FPCs being sited in their area but they had concerns about co-ordination of services for women who visited the clinics and who would take overall responsibility for women's contraceptive and sexual health care.

2.0 Conclusions

Although there are some gaps in the literature relating to contraceptive services in Ireland, a picture of the services available and the needs and wants of women in Ireland can be built up from the available international and Irish literature. A national sexual behaviours and attitudes survey would be useful to supplement this and set a baseline from which to evaluate future interventions. It is also less clear what the needs and expectations of men are for contraceptive and sexual health services. There is research on the profile of GPs and the services they offer, but there is little known about who provides services in the FPCs in Ireland. There is also little information about the role practice nurses play in providing advice and information on contraception.

The literature shows that different women have different needs from contraceptive services and that they want a range of options available to them so they can exercise a choice. They want to have a choice of service provider, choice of service provision and a range of methods to choose from. They also need accurate and understandable information available to help them make the choice that is right for them.

Providing local services and providing choice is a challenge, particularly in rural areas. The main contraceptive providers in Ireland are GPs, supplemented by a small number of dedicated FPCs in some areas. This arrangement does meet the needs of a lot of women but because of the inequitable access to services, women in some areas are denied a choice. Having to pay for contraceptive services and supplies also acts as a barrier to some women (particularly young women) accessing services and methods appropriate to their needs.

The main contraceptive methods used in Ireland are the pill and condoms. The majority of GPs provide the pill, and condoms are sold in commercial outlets. However only about 15% of GPs provide IUCDs and caps. Clear inter-referral arrangements, including reimbursement would help utilise the skills of appropriately trained GPs, but will still not allow women to have choice of service provision and provider.

In the UK there is some evidence that FPCs are more effective in providing information than GPs are, although this has not been shown in Ireland, possibly because only a small proportion of the population has access to a FPC. Women perceive FPCs as providing a specialist, confidential service with time to discuss the options with a female doctor in a non-judgmental environment. These attributes are particularly important to young people, but continue to be important to women as they grow older. It is possible to provide this type of a service in primary care, although GPs have identified time constraints on providing dedicated clinics and they have legal concerns about seeing under-sixteen year olds for contraception. However, this arrangement alone will not meet the needs of women who want 'community confidentiality' and a separate specialist clinic in a more comfortable setting. If contraceptive service provision is to be expanded in Ireland then the professional governing bodies need to consider how professional staff working in this area might be trained, accredited and revalidated, particularly those who want to work solely in a FPC setting. Only about half of GPs in Ireland have a family planning certificate but doctors with a family planning certificate are more likely to provide methods such as IUCDs and caps. GPs have identified that it is difficult to get practical training in contraception. It is also hard to maintain skills such as fitting IUCDs in a typical general practice.

It is likely that GPs will continue to be important providers of contraception, but they should work within a network of services to offer choice to women. This needs to include FPCs and initiatives for young people. In rural areas, FPCs might need to offer outreach services. However, staffing of FPC clinics in these areas might be difficult, especially employment of doctors. Ideally, dedicated personnel should staff FPCs to give continuity of care and be an information resource for other people working in the network. In rural counties FPC doctors are likely to be local GPs with specialist training, but the advantages to some women of attending a FPC should not be disregarded. The role of nurses in provision of contraception services both in primary care and FPCs needs to be examined, as well as their access to appropriate training.

There are other models of service delivery reported in the literature, particularly for young people. The majority of these have been developed in response to local needs assessment and this is an approach that could be taken in Ireland.

The future provision of contraceptive services in Ireland is an important part of addressing crisis pregnancy and improving the sexual health of the population. However many other initiatives need to be put in place in parallel to these services, such as school sex education. Also, other services, such as GUM clinics, are important to sexual health. In order to develop these different strands in the most effective way it might be appropriate to develop a national Sexual Health Strategy.

3.0 Recommendations

3.1 Developing a choice of service provision for women:

1. Consideration should be given to developing a national sexual health strategy to allow a co-ordinated and evidence-based development of services and initiatives to improve the sexual health of Ireland.
2. Contraceptive services should be available free of charge.
3. People with medical cards should be able to consult a doctor of their choice for contraceptive services free of charge.
4. The ICGP should consider the issue of inter-referral between GPs. Protocols may be useful to facilitate this system. Self-referral should be considered. Mechanisms for remuneration for GPs also need to be considered.
5. GPs could consider providing services through a combination of dedicated clinics and general clinics.
6. Dedicated FPCs should be provided. Each health board will need to consider how best to deliver dedicated clinics based on local assessment of needs.
7. The needs of older women should be addressed by accessible provision of non-hormonal methods.

3.2 Areas for further research:

1. A national sexual attitudes survey should be undertaken to give baseline data from which to evaluate any future interventions.
2. This review identified that further research is needed to explore the health beliefs and behaviours of men and their needs from contraceptive and sexual health services. The Crisis Pregnancy Agency has recently commissioned research to address these issues and findings will be available in Autumn 2004.
3. Research is needed to establish the service provided by FPCs and the staffing arrangements, as well as what the personnel working in these clinics perceive to be the threats to and opportunities for providing these services. This research will assist in future development of contraceptive services in Ireland.
4. Local circumstances might affect the needs of the population and the options available to meet those needs. Health boards should develop services that are tailored to local needs, including the needs of young people and men. Tailored services should be developed based both on local needs assessment and on the insights provided by existing research.

5. There is a need for further research with practice nurses to establish:
 - their expertise and qualifications
 - their current contribution to contraceptive services
 - the role they might play in providing contraceptive services
 - their training needs.
6. There is evidence that access to sterilisation services has been inequitable in the past. Newer methods, such as Mirena, may reduce the demand for sterilisation. A national audit of sterilisation services (male and female) which establishes current protocols for sterilisation, referral and payment arrangements as well as usage rates would be helpful in developing appropriate services for the future.
7. Further research is needed on the use of emergency contraception in Ireland. Currently there are only a few small studies on selected populations such as users of FPCs. The findings from these studies may not be applicable to the general population. The research should be on a more representative sample and include an assessment of the incidence of EC usage in Ireland, the reasons for use and the barriers to use.

3.3 Training and accreditation

1. Health boards, in conjunction with primary care units, should develop local training and updating arrangements for GPs and nurses. As new methods become available, training will be needed.
2. Nationally the issue of an accredited training scheme needs to be revisited to allow doctors and nurses to undertake general basic contraceptive/women's health training as well as a higher level of 'specialist training'. Specialist training could allow doctors to train other doctors.
3. The professional governing bodies should consider accreditation and re-validation paths for doctors and nurses who want to specialise in contraception and women's health.
4. Training and education of other staff, such as receptionists and pharmacists, on ensuring privacy in public settings should help improve the services available.
5. Monitoring arrangements and evaluation should be built into any training programmes that are established.

3.4 Information

1. In the development of services, consideration should be given to how and where to publicise the services available. The confidential nature of these services should be highlighted. It might be useful to develop local directories of services that include the names and contact details of those providing the service and the services they offer.
2. Initiatives to provide information on contraception and sexual health should be evidence-based. Consideration should be given to supporting skills development in key communicators such as parents, teachers and health care practitioners.

3. There is a need to develop good quality information resources on contraception in a range of formats. Information should be disseminated widely. These measures should allow accessibility to all people including young people, people in different ethnic groups and people with literacy difficulties. Information resources should be accurate, clearly written and readable, taking into account the range of literacy levels of people using the information. Some information needs to be targeted at particular groups to achieve this, for example information for young people.
4. The national and local provision of information needs to be co-ordinated and evaluated.

3.5 Young people

1. Although there are guidelines about providing services to under-sixteen year olds, GPs continue to feel vulnerable in consultations with this group. Legal clarity about this issue would be helpful in supporting doctors and other practitioners.
2. Health boards should develop services for young people based on local needs assessment.
3. As recommended in Section 3.1 contraceptive services should be available free of charge. If a phased approach is needed priority should be given to young people.
4. It is especially important that good quality accessible information is developed for young people, that targets their needs and addresses barriers to accessing sexual health services e.g. confidentiality, and/or perceptions of existing services.

3.6 Emergency contraception

1. Deregulation of EC should be considered to increase access to women in rural areas and reduce the pressure on out-of-hours services, as in the UK.

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