LEADING AN INTEGRATED APPROACH TO REDUCING CRISIS PREGNANCY

2007-2011

crisispregnancyagency

Formulating & Implementing a National Strategy

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The Crisis Pregnancy Agency was established in October 2001 under the Health (Corporate Bodies) Act, 1961, and is governed by the Crisis Pregnancy Agency (Establishment) Order 2001 (S.I. No. 446 of 2001) as amended by the Crisis Pregnancy Agency (Establishment) Order 2001 (Amendment) Order 2007 (S.I. No. 175 of 2007).

The purpose of the Crisis Pregnancy Agency is to bring strategic focus to the issue of crisis pregnancy and so to add further value to the work of existing service providers.

The primary function of the Agency is to prepare and implement a strategy to address the issue of crisis pregnancy, in consultation with relevant Departments of State and with such other persons as are considered appropriate.

The Agency has three mandates, which are set out in the Statutory Instrument:

Mandate A: a reduction in the number of crisis pregnancies by the provision of education, advice and contraceptive services;

Mandate B: a reduction in the number of women with crisis pregnancies who opt for abortion by offering services and supports which make other options more attractive;

Mandate C: the provision of counselling services, medical services and such other health services for the purpose of providing support, after crisis pregnancy, as may be deemed appropriate by the Agency.

Foreword by the Minister for Health and Children

I am very pleased to welcome the Crisis Pregnancy Agency's second Strategy.

I thank the Board of the Agency and in particular its Chairperson, Ms Katharine Bulbulia, the Agency's Director, Ms Caroline Spillane, and staff for the timely development of this comprehensive plan. I also express my appreciation to the Consultative Committee and the interested groups, organisations and individuals who contributed to its development.

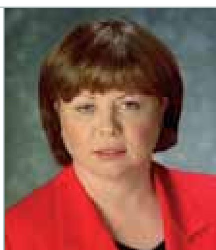
In driving the implementation of its initial Strategy, the Crisis Pregnancy Agency has proven to be a successful, efficient and forward-looking Agency and I compliment it on the very significant progress it has made to date. The work of the Agency, in partnership with many statutory and non-statutory organisations, has made a very effective contribution to reducing the incidence of crisis pregnancy and to ensuring that women who experience crisis pregnancy are responded to in a caring and supportive way.

I commend the Agency also on its innovative and effective communications programmes and on its success in building up a much needed and valuable body of research on crisis pregnancy in Ireland. This research has contributed significantly to shaping this new Strategy and will enable the Agency to ensure that its work continues to be underpinned by appropriate evidence about sexual health and crisis pregnancy in Ireland.

This new Strategy builds on the experience gained by the Agency in the course of implementing its first Strategy. It takes account of the changing nature of Irish society, ongoing developments in the field of sexual and reproductive health and also changes in the way people communicate with each other and access information. It will guide policymakers and service providers concerned with promoting positive sexual health and preventing and managing crisis pregnancy over the next four to five years.

The Strategy's central objectives are to achieve a reduction in the number of crisis pregnancies, a reduction in the number of women choosing abortion as an outcome of crisis pregnancy and the safeguarding of women's physical and mental health following termination of pregnancy. It sets out seven strategic priorities to help deliver these objectives, with projects for change under each of these headings.

The efficient and effective implementation of this plan will require an intersectoral and multi-disciplinary approach. I look forward therefore to the Agency and its partners building upon the achievements of the last five years in addressing the issue of crisis pregnancy in Ireland.



Mary Harney T.D.

Minister for Health and Children

November 2007

Introduction by the Chairperson and Director of the Crisis Pregnancy Agency

This is the Agency's second Strategic Plan. It was developed through a collaborative process involving the Crisis Pregnancy Agency's Board and staff, and through consultation with Government departments, State bodies, voluntary groups, young people and private sector representatives. The 2007-2011 Strategy is also informed by an evaluation of the previous strategic plan. We thank everyone who has contributed.

This Strategy consolidates and continues the work of the Crisis Pregnancy Agency and builds on the Agency's impact in the realms of research, communications and service provision:

- Crisis Pregnancy Agency research has contributed significantly to a greater understanding of the contributory factors and solutions to crisis pregnancy at the individual, community, policy and societal levels. The findings from this research have informed the approaches the Agency is taking to addressing crisis pregnancy in this plan.
- Through its communications campaigns the Agency has brought the issue of crisis pregnancy into the open, informed and empowered sexually active people to protect themselves and equipped parents, teachers and other influencers to assist young people who are entering the sexually active stage of their lives.
- With its statutory and non-statutory partners the Agency has significantly improved supports for women by increasing crisis pregnancy counselling services nationwide by nearly 50%, introducing quality standards and actively publicising the range and availability of counselling services for all.

The following themes will guide the Agency in building on this progress:

- Keeping the woman experiencing a crisis pregnancy at the centre of all decision-making; the woman's partner and her family must also be kept in the Agency's focus.
- Developing partnerships with key organisations to deliver shared projects, to raise awareness, to change behaviours and to provide key services and supports.
- Valuing the influence that strong leadership and imaginative communications initiatives can have on shaping behaviours and attitudes towards relationships and sexuality education for young people.
- Supporting the vital role of parents in shaping their children's sexual development.
- Recognising that the core competencies required to be effective are those the Agency has developed in the areas of research, service development and communications.
- Ensuring value for money and best deployment of resources.

The Agency is mandated to lead a process of information, education, research and advice. With evidence and knowledge as its foundation, the Agency seeks to influence both policy and action. It also seeks to develop strategic partnerships to achieve improvements in sexual health behaviours and outcomes as they relate to crisis pregnancy.

Katharine Bulbulia, Chairperson

Caroline Spillane, Director

Executive Summary

Since its establishment in 2001 the Crisis Pregnancy Agency has published 23 research reports related to crisis pregnancy prevention and support. This places the Agency in a very strong position to reliably profile crisis pregnancy in Ireland. This research allows the Agency to identify the antecedents of crisis pregnancy and effectively plan strategies to address the issue of crisis pregnancy over the next five years. The research programme has established a number of baseline indicators to track key measures related to crisis pregnancy and to evaluate the impact of the Agency's work.

The Establishment Order of the Crisis Pregnancy Agency defines crisis pregnancy as "a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her". The Agency understands this definition to include the experiences of those women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances.

The Strategy for the Crisis Pregnancy Agency 2007 – 2011 focuses on three central objectives, derived from its mandates:

- Reduce the number of crisis pregnancies.
- Reduce the number of women choosing abortion as an outcome of crisis pregnancy.
- Safeguard women's physical and mental health following termination of pregnancy.

Seven strategic priorities will help the Agency deliver these objectives.

Seven strategic priorities

I. Knowledge about Relationships and Sexuality for Adolescents

Achieve measurable improvements in knowledge about relationships and sexuality among adolescents through home-, school- and community-based education

Projects for Change

- Achieve measurable improvements in the delivery of Relationships and Sexuality Education (RSE) in post-primary schools, to enable 100% of schools deliver an RSE programme in the context of Social, Personal & Health Education (SPHE), over the next five years.
- Achieve effective delivery of SPHE/RSE by outside facilitators as appropriate.
- Build systems and processes to capture the views of young people in programme and resource development.
- Assist parents to provide relationships and sexuality education in the home. Develop new resources to equip parents with relevant information and communication skills.
- Improve teacher (including principal) training in RSE/SPHE by developing opportunities for accreditation.

II. Contraception

Improve access to and information on contraception and contraceptive services – particularly for groups at risk of crisis pregnancy

Projects for Change

- Finalise three sub reports of the Irish Study of Sexual Health and Relationships (ISSHR).
- Use findings from ISSHR and other research to develop an evidence-based proposal to support the inclusion of contraceptive service development in Department of Health and Children and Health Service Executive sexual health plans. Support national sexual health plans related to the Agency's mandates.
- Fund pilot models of service delivery to improve access to services, increase take-up of services, and promote consistent and correct contraceptive use among at-risk groups. Evaluate these pilots with a view to mainstreaming.
- Develop policy proposals for the Department of Health and Children and the Department of Finance on how cost of contraception can be minimised in order to facilitate consistent contraceptive use by sexually active young men and women.

III. Communications

Conduct effective and innovative communications campaigns to promote positive behavioural and cultural changes regarding sexual attitudes, choices and behaviour

Projects for Change

- Develop a three-year integrated marketing campaign on consistent and effective contraceptive use. The campaign will have a particular focus on those with lower educational attainment and lower socio economic status (SES). Target groups will include young men, young women and women aged 35–55.
- Run a campaign aimed at delaying early sexual activity in adolescents.
- Extend the Positive Options campaign for a further three years to promote access to crisis pregnancy services and address the stigma of crisis pregnancy.
- Promote the availability of free post-abortion medical and counselling services.
- Develop partnerships with statutory and voluntary bodies to improve sexual health information for asylum seekers.
- Execute a national and regional public relations programme to communicate the strategic objectives of the Agency.

IV. Crisis Pregnancy Services

Improve access to and delivery of crisis pregnancy counselling services and post-abortion medical and counselling services

Projects for Change

- Quantify the need for crisis pregnancy and post-abortion services nationally, comparing this to the level of services delivered. Provide grant funding to ensure that service provision meets demand.
- Develop a commissioning toolkit to guide and assist those establishing new crisis pregnancy counselling services.
- Plan the development of a self-assessment Quality Assurance Framework for crisis pregnancy counselling and post-abortion counselling.
- Develop a National University of Ireland (NUI) accreditation programme on crisis pregnancy counselling skills for counsellors in State-funded agencies.

V. Continuation of Pregnancy

Improve the range and nature of supports central to making continuation of pregnancy more attractive. Ensure that women, their partners and families are fully informed about these supports

Projects for Change

- Develop a workplace project to improve the experience of working women (and men) facing crisis pregnancy. The project will centre on managing statutory leave entitlements (e.g. maternity leave) and providing information on benefits, rights and entitlements.
- Fund pilot initiatives to increase the engagement of men in the support of their partners during crisis pregnancy, in coping with the experience of crisis pregnancy and parenting.

- Fund pilot initiatives aimed at women - particularly young women - who need a high degree of support and assistance in progressing with their pregnancy and coping with parenting.
- Develop and disseminate good-practice guidelines on addressing and presenting the choice of adoption and on the development of referral pathways to adoption.
- Complete a review of demand for initiatives such as supported accommodation and short-term fostering.
- Support the inclusion in the Domestic Adoption Framework of the natural mother's central role in the selection of prospective adoptive parents.

VI. Research

Strengthen understanding of the contributory factors and solutions to crisis pregnancy; use research findings to promote evidence-based practice and policy development

Projects for Change

- Improve the Agency's evidence base: identify knowledge gaps and commission new research to address them. Publish annual statistical reports to monitor base-line indicators. Place Crisis Pregnancy Agency quantitative databases in data archives.
- Build research capacity on topics related to crisis pregnancy by commissioning research and by establishing research scholarships and awards schemes.
- Publish good-practice guidelines, in partnership with professional bodies, to improve professional practice in areas related to crisis pregnancy and ensure practice is informed by sound evidence.
- Increase awareness of the Agency's research programme by extending the current series of research summaries to include new national and international user groups.
- Conduct periodic reviews to ensure the evaluation framework underpinning the work of the Agency is informed by best practice.

VII. Policy Influence

Influence policy makers and key players regarding prevention of crisis pregnancy, reproductive decision-making and crisis pregnancy outcomes

Projects for Change

- Publish policy reviews on key topics related to crisis pregnancy.
- Participate in and organise policy fora on key issues.
- Implement a system for monitoring policy change nationally to assess the impact of the Agency's contribution, and disseminate the findings.

Background to the Strategy

The Crisis Pregnancy Agency

Vision

Through the Strategy the Agency will work to achieve its vision for a future where:

> Pregnancy and parenting are a welcomed and positive experience for women, their partners and families.
>
> Crisis pregnancies are experienced less often, but when they do occur, women can face and manage the crisis without fear for the future because appropriate support is available no matter what choice they make.

Mission

The Crisis Pregnancy Agency was established by the Minister for Health and Children to:

- Develop and support the implementation of a national Strategy to address the issue of crisis pregnancy, in consultation and partnership with Departments of State and relevant agencies.
- Work in partnership with appropriate agencies to promote and co-ordinate the attainment of the objectives contained in the Strategy.
- Promote the development - by the Departments of State and appropriate agencies - of an operational plan to implement the Strategy in its own sphere of responsibility. Monitor and review the attainment of the objectives of such operational plans.
- Produce periodic reports on progress and propose remedial action where required.
- Take such measures and engage in such activities as it considers necessary to address the issue of crisis pregnancy.
- Draw up codes of good practice for consideration by agencies and individuals involved in providing services to women with crisis pregnancies.
- Promote and commission research into aspects of crisis pregnancy as considered necessary.
- Furnish, whenever it is so required by the Minister or on its own initiative, advice to the Minister or other Ministers of the Government on issues relating to crisis pregnancy.
- Perform any other functions in relation to crisis pregnancy that the Minister may from time to time assign to it.

Working principles

In implementing its Strategy the Agency will continue to be guided by the following set of working principles:

People centred

While the woman experiencing crisis pregnancy is at the heart of all the Agency's decision-making, the woman's partner and her family are also central. This is shown in the effectiveness of the Agency's communications campaigns - particularly those promoting crisis pregnancy services - and the non-judgmental stance taken by the Agency regarding the choices women make in crisis pregnancy.

Evidence based

All the Agency's actions and activities are underpinned by research, which allows the Crisis Pregnancy Agency to have an authoritative voice in the field of sexual health, reproductive decision-making and crisis pregnancy. This is shown in the quality of the outputs from the research and policy function and in how these have been used, applied and adopted by the Agency itself and by other organisations.

Solution focused, innovative and courageous

The Agency believes that it must be bold, insightful and imaginative in order to challenge and inform, and that its messages need to be solution focused. This is shown in the mix of channels and methods used to communicate contraception and crisis pregnancy messages to particular target groups.

Objective

The Agency works in an area where people have deeply-held, passionate convictions; the Agency maintains its objectivity as a State agency by adhering to its mandates, utilising evidence and promoting good practice. This is shown in the spread and scope of the Agency's funding programme, the rigour applied in developing education and information resources and in the way the Agency communicates.

Value partnership and consultation

The Agency values the expertise and experience of others. This is shown in the range and scale of consultation the Agency engages in and in the variety of partnerships it has formed.

Accountable

As a publicly funded body, the Agency is very conscious of the need to combine effectiveness with transparent decision-making, providing value for money and ultimate accountability to the public through the Minister and Department of Health and Children. The Agency seeks to learn from experience; therefore it invests in evaluation in order to continously improve. This is shown in the systematic approach the Agency has taken to governance and evaluation.

The context for the new Strategy

Since 2003 the Agency has published 23 research reports related to crisis pregnancy prevention and support. This research has been both quantitative and qualitative in nature and has been conducted with a diverse range of participants.

The Agency is now in a very strong position to reliably profile crisis pregnancy in Ireland. The research findings allow the Agency to identify the antecedents of crisis pregnancy and effectively plan strategies to address the issue of crisis pregnancy over the next five years. The research programme has established a range of baseline indicators to track key measures related to crisis pregnancy and to evaluate the impact of the Agency's work.

Definition of crisis pregnancy

The Establishment Order of the Crisis Pregnancy Agency defines crisis pregnancy as

> *"a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her".*

The Agency understands this definition to include the experience of those women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances.

Prevalence of crisis pregnancy

Crisis pregnancy is a common experience in Ireland.

The ISSHR report found that over 1 in 5 women aged between 25 and 34 reported experiencing a crisis pregnancy[1]. Similarly, the Irish Survey of Contraception and Crisis Pregnancy (ICCP) found that 28% of women (with experience of pregnancy over their lifetime) aged between 18 and 45 had experienced a crisis pregnancy[2]. Some 23% of men in the same survey reported experience of a crisis pregnancy.

Based on these findings and CSO figures from 2004, it is possible to estimate that 136,000 women in the present population have experienced crisis pregnancy. Of those women who reported experience of a crisis pregnancy, 14% had had more than one.

Crisis pregnancy is not a phenomenon other countries measure or track and so international comparisons are not possible. Other countries do not attempt to gauge the proportion of women who opt to continue with a crisis pregnancy. Internationally, comparative data is available for figures such as teenage fertility and abortion rates, but not for crisis pregnancy.

Prevalence of parenting as an outcome of crisis pregnancy

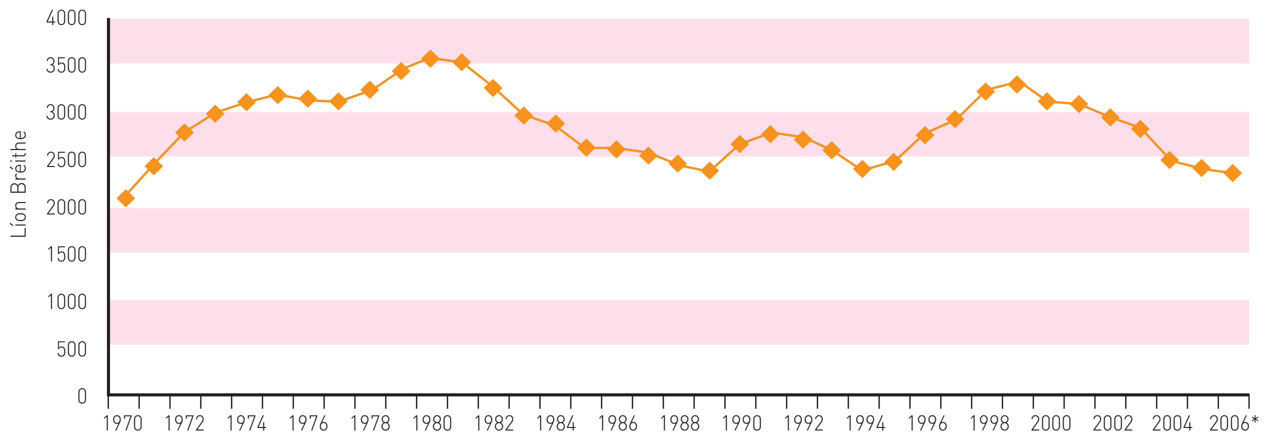
Parenting is by far the most common outcome for Irish women following crisis pregnancy.

The ICCP survey shows that approximately three-quarters of women experiencing crisis pregnancy choose to give birth and parent the baby. Over half will parent with the baby's father (57%) and approximately 40% will parent the baby alone[3].

Teenage birth data and teenage abortion figures when combined show that approximately three-quarters of teenage conceptions will result in birth/parenting[4]. Traditionally, the number of teenage births was used as an indicator of crisis pregnancy. It is evident, however, that not all teenage births are interpreted as a crisis by the young person involved. Some teenagers respond positively to the news of being pregnant and see it as a positive development in their lives[5]. Teenage births and birth rates in Ireland have been relatively stable over the last 30 years[6] (see Figure 1). In 2005 there were 2420 births to teenagers, compared to 3106 in 2000. The abortion rate for teenagers (15-19) giving Irish addresses in UK clinics has also decreased from 6.0 in 2001 to 4.5

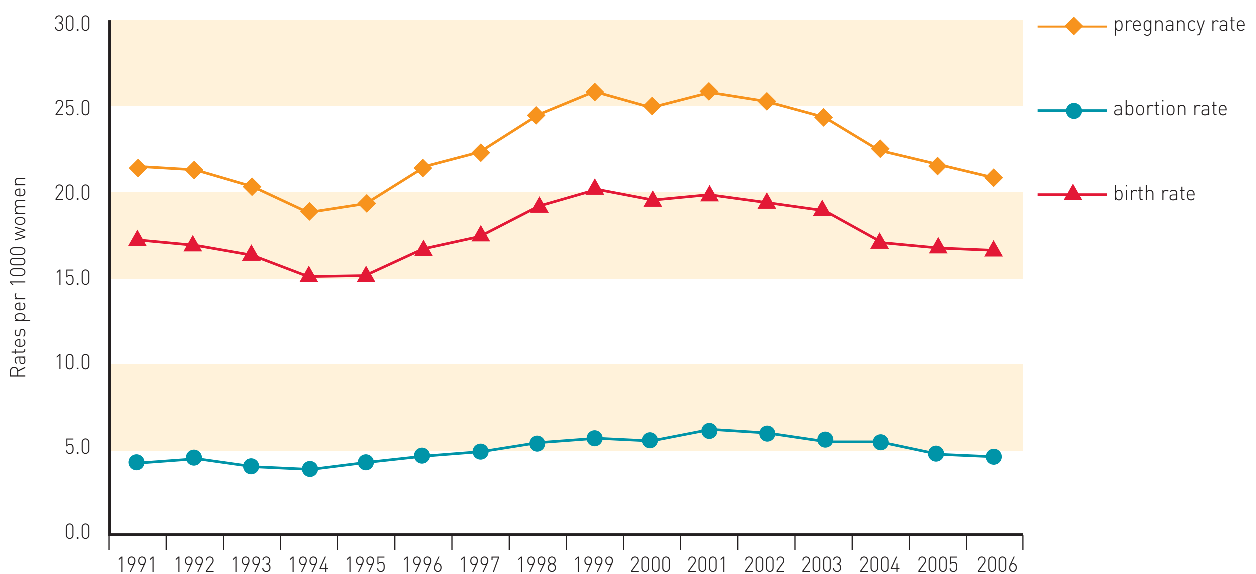
1 Layte, R., McGee, H., Quail, A., Rundle, K., Cousins, G., Donnelly, C., Mulcahy, F. & Conroy, R. (2006). The Irish Study of Sexual Health and Relationships. A Crisis Pregnancy Agency and Department of Health and Children report. Dublin.
2 Rundle, K., Leigh, C., McGee, H. & Layte, R. (2004). Irish Contraception and Crisis Pregnancy [ICCP] Study. A Survey of the General Population. Crisis Pregnancy Agency Report No. 7. Dublin.
3 Rundle et al. (2004). Irish Contraception and Crisis Pregnancy [ICCP] Study. A Survey of the General Population. Crisis Pregnancy Agency Report No. 7. Dublin.
4 Department of Health, UK. http://www.dh.gov.uk/en/index.htm. Teenage abortion numbers from those teenagers giving an Irish address at UK abortion clinics.
5 O'Keeffe, S. (2004). Crisis Pregnancy Decision Making: An Outline of Influencing Factors. Crisis Pregnancy Agency Report No. 1. Dublin.
6 O'Keeffe, S., McGrath, D. & Smith, M. (2006). Crisis Pregnancy Agency Statistical Report: Revised Teenage Pregnancy Data, CPA Statistical Report, Dublin.

Figure 1: Numbers of births to mothers aged 15–19 years, 1970 – 2006



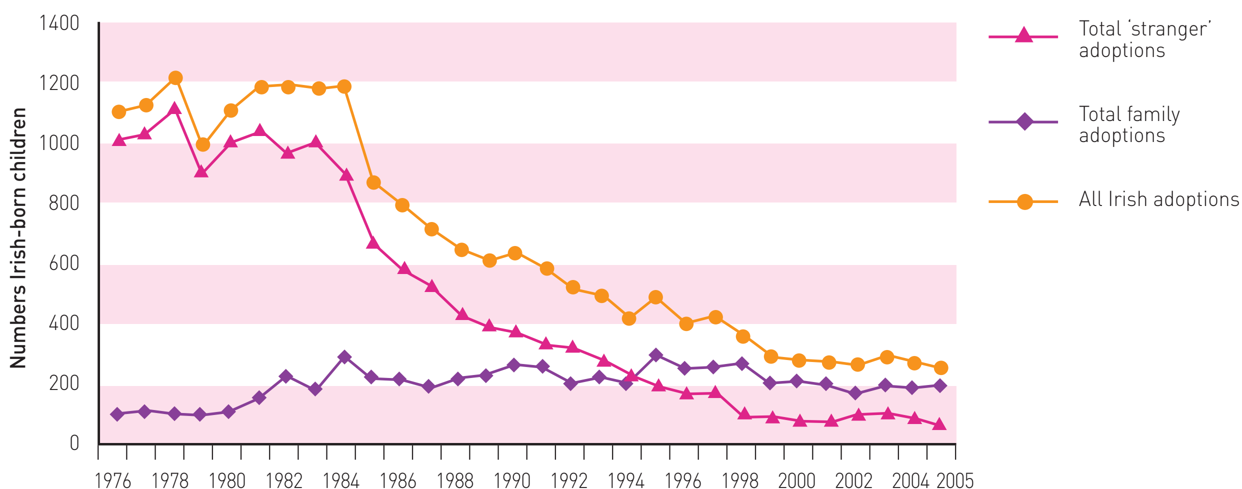
Source: *CSO: Vital Statistics Annual Report 2004*
** 4th Quarter and Yearly Summary, 2005 and 2006*

Figure 2: Pregnancy, birth and abortion* rates (per 1,000) to women aged 15–19 years



Source: *based on data from CSO Vital Statistics; UK Department of Health*
** Abortion rates are calculated based on the numbers of teenagers giving Irish addresses at UK abortion clinics*

Figure 3: Trends in adoption in Ireland 1976-2005



Source: Adoption Board
Note: 'Stranger' adoption is the term used to describe non-family adoptions; family adoptions are relatively common and involve, for instance, a mother's partner within a new union, adopting her child of a previous union, or a relative adopting the child of deceased parents.

in 2006 (see Figure 2). (The abortion rate is the number of abortions to 15 – 19 year old teenagers per 1,000 in the population.)

Prevalence of adoption as an outcome of crisis pregnancy

Very few women choose to place their baby for adoption.

The number of women placing their babies for adoption has decreased significantly in recent decades and continues to fall on an annual basis.

In 2005, 62 babies were placed for adoption[7], compared to 88 in 2004, 99 in 2002 and 1,005 in 1976. The decline in the number of women having their babies adopted suggests that more and more unmarried women who experience crisis pregnancy are choosing to keep their babies. Adoption is now less likely to be viewed by women as an expected or realistic solution to crisis pregnancy (see Figure 3). Issues contributing to the poor presentation and perception of adoption will be addressed by the Agency through this Strategy.

Prevalence of abortion as an outcome of crisis pregnancy

Approximately 15% of women experiencing a crisis pregnancy choose to have an abortion.

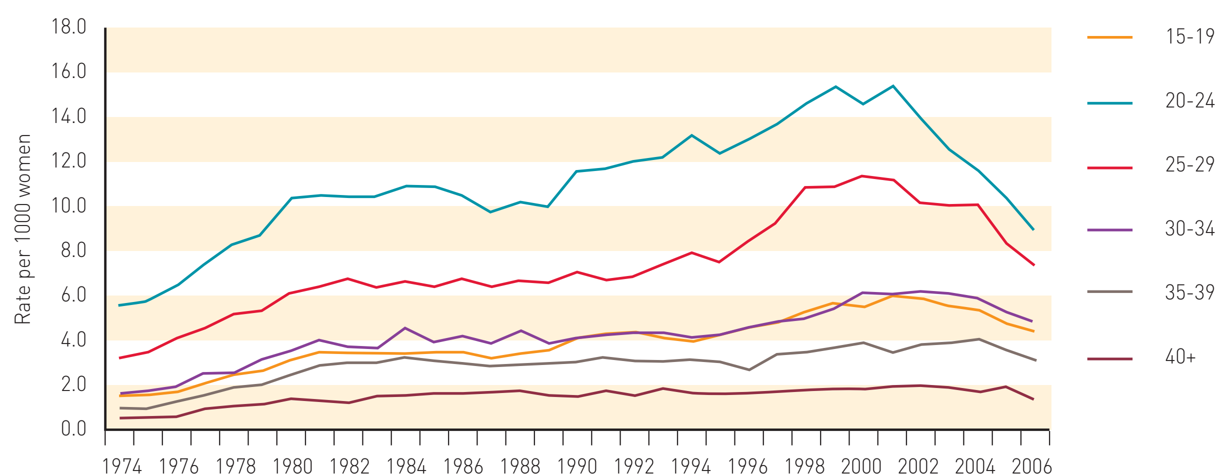
It is important to note that younger women (aged 18–25) are more likely to choose abortion than older women (see Figure 4). For example, in the ICCP survey 22% of 18-25 year olds chose abortion, compared to 10% in all other age categories. The acceptability of abortion in various circumstances has increased in the Irish population over time[8].

Most women from Ireland who decide to terminate their pregnancies travel to England for an abortion. UK Government statistics indicate that 5042 women giving addresses in the Republic of Ireland had abortions in English clinics in 2006[9]. These figures have been steadily decreasing over the last six years. In 2001 the figure was 6673.

Initial results from a CPA study suggest that a number of women are travelling to other jurisdictions, principally the Netherlands, for termination. Clinics in other jurisdictions

7 The Adoption Board (2005). Annual Report. Government Stationery Office, Dublin.
8 Rundle et al. (2004). Irish Contraception and Crisis Pregnancy [ICCP] Study. A Survey of the General Population. Crisis Pregnancy Agency Report No. 7. Dublin.
9 Department of Health (2006). Statistical Bulletin: Abortion Statistics England & Wales, 2006. Government Statistical Services, UK.

Figure 4: Abortion rate (per 1,000 women) for women by age groups 1974 – 2006



Sources: based on data from UK National Statistics Office and Department of Health, and CSO Population and Census data.

Table 1: Comparison of abortion rates in selected states

Country	Year for which latest data is available	Rate per thousand women
Australia	2003	19.7
Belgium	2003	8
Canada	2003	15.2
Denmark	2005	12.2
England and Wales	2006	18.3
Germany	2005	7.4
Finland	2004	9
France	2003	16.7
Ireland	**2006**	**5.2**
Italy	2003	11
Holland	2005	8.6
New Zealand	2005	19.7
Northern Ireland (NI)*	2006	3.5
Norway	2005	12.9
Scotland	2006	12.4
Spain	2004	8.9
Sweden	2005	20.2
USA	2003	20.8

**figures are for women from NI having a termination in England & Wales only*
Note: most rates calculated for women aged 15-44, some States may vary on age range
Sources: Jaarrapportage 2005 van de Wet afbreking zwangerschap, Inspectie voor de Gexondheidszorg, Oktober 2006 (This report is from the Dutch Department of Health); Alan Guttmaker Institute, USA; Department of Health UK and NHS Scotland

report that this is a relatively recent trend and have noted Irish women travelling to their clinics since January 2006. The Agency will undertake further research on this trend in the new Strategy.

However, despite the number of women travelling to other jurisdictions, the substantial decrease in the number of women giving Irish addresses in UK clinics since 2001 would indicate that the number of women travelling from Ireland for abortion procedures has been in a very gradual downward trend. This is further supported by the fall in births and abortions involving teenagers.

Ireland has a low rate of abortion compared to other countries (see Table 1).

Prevalence of concealed pregnancies

Research commissioned by the Agency estimates that 1 in every 625 births in a Dublin maternity hospital is concealed and that 1 in every 403 births in a rural hospital is concealed[10].

When a woman conceals or denies a pregnancy until a late stage it places a heavy emotional toll on her and creates difficulties for medical staff during her antenatal care and the delivery of the baby. In some cases a woman may abandon her baby following a concealed pregnancy. In the period between 1996 and 2005 some 24 newborn babies (six live and eighteen deceased) were found abandoned.

Fear of upsetting or disappointing parents or fear of parents' reaction were the most common reasons women gave for concealing their pregnancies. The stigma of crisis pregnancy and lone parenting must be further addressed, particularly through forthcoming public communications programmes.

A profile of women experiencing crisis pregnancy

Most people who have a crisis pregnancy are in their early twenties.

A smaller proportion of crisis pregnancies occur to women in their teenage years and to women in their thirties, forties and fifties.

The ICCP study found that participants' most recent crisis pregnancy was experienced at a mean age of 23.4 years for women and 24.6 years for men[11]. The Irish Study of Sexual Health and Relationships (ISSHR) found that the median age of crisis pregnancy was 19 for women under 25 years old. Among women aged 25 to 34 at the time of the study, the mean age at which they had experienced a crisis pregnancy was 22 years[12].

Furthermore, the ISSHR survey suggests that, over time, women are experiencing more crisis pregnancies and at a younger age. Abortion data from the UK continues to show that the majority of abortions to women giving Irish addresses involve women aged between 20 and 24[13].

The majority of women experiencing crisis pregnancy are in a relationship of some kind. Survey data from the ICCP report reveals that at the time of conception, 41% of women had a steady relationship with their partner, 24% had a casual relationship and 24% were married or engaged.

Studies show that being from a poorer background and/or having lower levels of educational attainment are related to experience of crisis pregnancy. The ICCP survey found a relationship between low socio-economic status (SES) and greater risk of crisis pregnancy. The ISSHR survey found that low SES was linked to earlier first sex, which in turn is related to a greater risk of crisis pregnancy. What is clear from these studies is that low SES is highly related to poorer educational attainment. Poor educational attainment is related to poorer levels of sexual health knowledge, sexual risk behaviours and unintended outcomes. Low SES is also related to having sex at an earlier age, and this is a risk factor for crisis pregnancy and other negative sexual health outcomes.

There is also evidence to suggest that younger women today may be more likely to define a pregnancy as a crisis than young women in the past. A much larger proportion of younger women now enter third-level education than older generations and look to establish themselves in a career. This changing context may affect the way in which a young woman responds to the news of becoming pregnant. This is more likely to affect women with higher levels of educational attainment and women who are in paid employment. These trends will be addressed by the Agency through this Strategy.

10 Conlon, C. (2006). Concealed Pregnancy: A case-study approach from an Irish setting. Crisis Pregnancy Agency Report No.15. Dublin.
11 Rundle et al. (2004). Irish Contraception and Crisis Pregnancy [ICCP] Study. A Survey of the General Population. Crisis Pregnancy Agency Report No. 7. Dublin.
12 Layte et al. (2006). The Irish Study of Sexual Health and Relationships. Crisis Pregnancy Agency and Department of Health and Children Report. Dublin.
13 O'Keeffe et al. (2005). Crisis Pregnancy Agency Statistical Report 2005. CPA Statistical Report, Dublin.

Factors contributing to crisis pregnancy

Pregnancy is most commonly interpreted as a crisis when the pregnancy is unplanned.

In the ICCP survey, 41% of women and 39% of men who had experienced a crisis pregnancy said that the pregnancy was a crisis because it was unplanned (regardless of the age of the person or the outcome of the pregnancy).

Additional reasons given to explain why a pregnancy was seen as a crisis differed according to the outcome of the pregnancy and the age of the woman; for example, women who chose to parent reported being too young (21%) or not married (17%) as reasons.

Younger participants (aged 18-25) were more likely to report that the crisis stemmed from being too young (71%) or from the fear of a negative reaction from their family (32%).

Those whose pregnancy resulted in abortion explained that the crisis was due to relationship difficulties (23%), not wanting the baby (23%), being too young (22%) or school/college commitments (16%). Women with a crisis pregnancy who chose or considered adoption spoke of similar concerns. For women over 36 years, the crisis came from their family being complete (21%) or medical difficulties (19%).

Qualitative research consistently shows that factors concerning career, education and employment strongly influence women's decision-making in crisis pregnancy situations[14 15]. Women assess the impact having children is likely to have on their education and career opportunities.

A common concern, among young women in particular, is that balancing a family and a career will be impossible. When considering the prospect of having a child, the dominant employment-related concerns are not having time to devote to both family life and work, and childcare costs.

Sex and use of contraception

CPA research found that the majority of couples reported that they did not use contraception when the crisis pregnancy occurred.

Research commissioned by the Agency has improved understanding of why couples have unprotected sex when they do not want to become pregnant. What has emerged from this new knowledge is the importance of recognising how various factors, such as relationship issues, availability of contraception, knowledge of sexual health and contraception, and personal beliefs, interact and play a part in crisis pregnancy prevention. In addition, key at-risk groups can now be profiled and targeted.

The ICCP survey found:

- 62% of women and 56% of men said that contraception had not been used when the crisis pregnancy occurred, usually because sex was unplanned or they were not prepared. Alcohol or drug use was a reason for not using contraception for 17% of women and 26% of men.
- Among those who did use contraception, most used the condom or the pill. 14% of women and 16% of men reported using 'withdrawal' as a contraceptive method. The reason the chosen method failed was unknown by 31% of women and 20% of men; condom or pill failure was reported by 43% of women and 33% of men.
- Only 10% of women and 5% of men who had had a crisis pregnancy said that they or their partner had used emergency contraception to prevent pregnancy after having unprotected sex. The main reason for not using emergency contraception was a belief that they wouldn't get pregnant (31%). This is similar to other findings that suggest women can underestimate their own fertility and the likelihood of pregnancy and so don't take secondary steps to prevent pregnancy if their chosen method of contraception fails.
- 10% of those under 45 years of age who did not want to become pregnant at last intercourse did not use contraception.

The ISSHR survey found that around 30% of men and women who had just met their partner or who had no steady relationship with them did not use a condom at last sex.

The majority of those who did not use a condom on their last occasion of sex said that this was because they trusted that their partner did not have a sexually transmitted infection (STI). Some 14% of those who had just met their partner and 27% of those who knew their partner but who were not in a relationship with them trusted their partner's STI status.

14 Murphy-Lawless, J., Oaks, L. & Brady, C. (2004). Understanding how sexually active women think about fertility, sex and motherhood. Crisis Pregnancy Agency Report No. 6. Dublin.
15 Mahon, E., Conlon, C. & Dillon, L. (1998). Women and Crisis Pregnancy. A report commissioned by the Department of Health and Children.

People at risk of crisis pregnancy

Young people aged 18-24, people who have first sex before age 17, women aged 35-44 and individuals with low socio-economic status and/or low educational attainment are particularly at risk of crisis pregnancy.

Both quantitative and qualitative research has identified groups at risk of crisis pregnancy and key risk factors. These provide important insights into why inconsistent use of contraception is still a feature of sexual behaviour in Ireland.

Key risk groups include:

- **Young people aged 18-24**

  Four key features are emerging from the research evidence regarding this at-risk group. These are: issues to do with alcohol and drug use affecting sexual behaviour and use of contraception; difficulties experienced in accessing contraception; lack of planning for sex and contraception; and poor knowledge levels on key aspects of sexual health, resulting from poor exposure to relationships and sexuality education at home and at school.

- **People who have had first sex before age 17**

  Quantitative research suggests strongly that early first sex (before age 17) is linked to an increased risk of unintended pregnancy and acquiring STIs[16]. Younger age at first sex is linked to a lower likelihood of using contraception at first sex. Women who have vaginal sex before age 17 are almost 70% more likely to experience a crisis pregnancy and are three times more likely to experience abortion. Qualitative research shows that young people are often confused about the right age to have sex and that they may become sexually active to fit in with friends or to please their partner[17 18].

- **Women aged 35-44**

  Key risk factors have been identified for this group of women. These include: ambivalence to pregnancy (even among women who state that they do not want to become pregnant), poor use of contraception compared to younger groups, poor fertility knowledge levels and negative attitudes toward the contraceptive pill. There is also an unsupported perception among this cohort of women that they are experiencing early menopause – as a result many of these women do not use any form of contraception.

- **Individuals with low socio-economic status and/or low educational attainment**

  Across all social spectra factors leading to risk-taking behaviour were identified; however, socially or economically disadvantaged groups or those who had limited exposure to the formal education system were particularly vulnerable to certain risk factors with regard to sexual behaviour and contraceptive use. Low SES and low educational attainment are linked with early first sex (before age 17), which in turn is linked to many negative sexual health outcomes.

Supports and services required by a woman who has a crisis pregnancy

Research[19 20 21] suggests that some women resolve a crisis pregnancy themselves. However, most women rely on the support of others: partners, family members, professionals or friends. For most women and men the support of a partner or family member was of primary importance. Women do see a clear role for the skills of a counsellor, even though the majority (three-quarters) of those in crisis pregnancy situations do not use counselling services.

Research suggests that some women are unable to get counselling, often because they don't know where to go for help or because they can't find a counselling service that offers the type of help they need. Other women said that they did not want to go for counselling because they did not feel it would help them or because they were worried that they would be asked to consider choices they had already rejected.

For some women a counsellor was the only person they felt they could talk to. Counsellors were particularly important when a woman's views about resolving the crisis conflicted with those of her family or partner, or where the woman wanted to express negative feelings about the pregnancy that she felt she could not share with anyone else. For many women, being able to talk openly and in confidence was more important than going through the available choices. Women often made their decision outside the counselling process; counselling

16 Layte et al. (2006). The Irish Study of Sexual Health and Relationships. Crisis Pregnancy Agency and Department of Health and Children Report. Dublin.
17 Mayock, P. & Byrne, T. (2004). A Study of Sexual Health Issues, Attitudes and Behaviours: The Views of Early School Leavers. Crisis Pregnancy Agency Report No. 8. Dublin.
18 Hyde, A. & Howlett, E. (2004) Understanding Teenage Sexuality in Ireland. Crisis Pregnancy Agency Report No. 9. Dublin.
19 Conlon, C. (2005). Mixed Methods Research of Crisis Pregnancy Counseling and Support Services. Crisis Pregnancy Agency Report No. 12. Dublin.
20 Loughran, H. & Richardson, V. (2005). Mixed Method Adoption Research. Crisis Pregnancy Agency Report No. 15. Dublin.
21 Nic Gabhainn, S. & Batt, V. (2004). Crisis Pregnancy Counselling in Ireland; A summary of research on crisis pregnancy counseling to inform the development of the strategy to address the issue of Crisis Pregnancy. Crisis Pregnancy Agency Report No. 4. Dublin.

helped these women to come to terms with the initial shock of an unplanned and unwanted pregnancy, or it offered practical help or support.

When women were questioned about what they wanted from a counselling service, the most important need was for 'a supportive listener'. Other needs common to women, regardless of the outcome of the pregnancy, were 'to talk through all your options' and 'help with making a decision'. Other women spoke about the importance of a non-judgmental response to the pregnancy and continuity of support during and after the crisis pregnancy.

Women who decided to continue the pregnancy also wanted information on pregnancy care (44%), information on parenting supports (40%) and help with telling others (24%) in the counselling context. Help with telling others is an important part of the counsellor's role, as it can connect women with the support of friends, family and partners that is so important to them.

The research recommends that in order to offer the best possible counselling services to women with a crisis pregnancy, improvements should focus on the following areas:

- Raising awareness of and access to services.
- Clearly communicating the type of support offered by each counselling service.
- Effective and appropriate referral of women on to other support services.

At an organisational level, setting standards, regularising training, and developing protocols were identified as areas for development.

Post-abortion supports

A range of services are required to support women who have had an abortion. All women are recommended to obtain a post-abortion medical check-up within 2 weeks of having an abortion. A minority of women attend for post-abortion medical check-ups in crisis pregnancy counselling services after returning to Ireland. The Irish College of General Practitioners report that 95% of GPs provide medical care after abortion. It is unclear as to how many women attend GP surgeries for this purpose.

This strategy outlines projects to increase the proportion of women who attend for post-abortion medical check-ups.

Many women who have an abortion report no negative psychological outcomes afterwards. Data from service providers in Ireland providing post-abortion counselling suggests that demand for such services is not very high. Some women, however, can suffer negative psychological outcomes. While much of the literature examining the psychological needs of women post-abortion is contentious and problematic methodologically, it is still very important to understand the factors that may lead to negative outcomes. The research literature suggests that women most at risk of negative outcomes are those who do not have psychological support from family and/or partner; those with pre-existing psychological problems; those whose own religious beliefs or those of their social environment are disapproving of abortion, and those who are ambivalent about the abortion. In addition, those who wanted the pregnancy and later lost the baby, for example due to such factors as foetal abnormalities, are also at risk of negative psychological outcomes. This strategy addresses the implications for standards of care in post-abortion medical and counselling work and the need to increase awareness among women of the services available to them.

Changes that will impact on the Strategy

The changing external environment has shaped the development of this Strategy and sets a number of challenges that will impact on and affect its implementation over the next five years.

Changing sexual attitudes and behaviours among younger people

Research commissioned by the Agency demonstrates significant changes in the sexual attitudes and behaviours of young people over time[22]. These changes are especially pronounced for women. For example, among older generations there are marked attitudinal and behavioural differences between men and women of the same age, with women holding more traditional views compared to men. Today, young men and women are more liberal than older generations and young men's and women's attitudes and behaviours have converged to a great degree. A larger proportion of young people have first sex below the age of 17, and this is associated with a series of negative sexual health outcomes e.g. crisis pregnancy, STI and abortion. While use of contraception is relatively high among young people and teenage births have been relatively stable over the last number of decades, these trends are by no means enough to protect against unwanted pregnancies or STIs.

Alongside these trends, there has been a dramatic shift in the representation of sex in popular culture. For many young people learning to negotiate and understand sexual boundaries in a culture that increasingly casualises and commodifies sex can pose problems. Young people are at a crucial stage in forming their sexual identities, and media messages can have a negative impact on cognitive and sexual development[23].

Research consistently demonstrates that young people's knowledge of sexual health and relationships has not kept pace with attitudinal and behavioural changes. Young people report that they are not happy with the quality and quantity of sex education being delivered at home, at school and more widely. While young women are increasingly exposed to some form of sex education, young men are not exposed to this to the same degree[24].

Implications for the Agency

The Agency has taken account of these factors and has based much of the future strategy and plans on them. The Agency's approach is to ensure that:

- Young teenagers have sufficient high-quality information and education to enable them to delay first sex until such a time as they are physically and emotionally prepared for this.
- Parents are better enabled to deliver comprehensive and effective sex education to their children.
- There is greater implementation of school-based relationships and sexuality education which is comprehensive, relevant and includes a clear focus on self-esteem, decision-making and related life-skills.
- Improvements are made in providing sex education for boys across various settings.
- Sexual health specialists can meet the challenge of promoting consistent and effective use of contraception.
- Access to contraception is improved, particularly for vulnerable groups. Partnership with the Department of Health and Children, the Health Service Executive and service providers (particularly GPs and Family Planning Clinics) will be essential in order to address this challenge.

22 Layte et al. (2006). The Irish Study of Sexual Health and Relationships. Crisis Pregnancy Agency and Department of Health and Children Report. Dublin.
23 American Psychological Association. (2007). Report of the APA Task Force on the Sexualization of Girls. APA.
24 Mayock, P., Kitching, K. & Morgan, M. (2007). Relationships and Sexuality Education (RSE) in the Context of Social Personal and Health Education - An Assessment of the Challenges to the Full Implementation of the Programme in Post-primary Schools. Crisis Pregnancy Agency and the Department of Education and Science, Dublin.

Health inequalities

Research evidence shows clearly that people from low socio economic status (SES) backgrounds in Ireland are vulnerable to lower levels of sexual health knowledge and poorer sexual health outcomes[25]. Internationally, tackling inequalities in health is an overarching aim of public health policies.

Implications for the Agency

The Agency needs to ensure that activities and programmes to promote and develop sex education and contraceptive services explicitly take into consideration lower SES groups and those who experience educational disadvantage. Cost also needs to be addressed as a factor affecting the use of contraception for both young men and young women, particularly those with lower incomes. Projects and interventions to develop sex education and good contraceptive practice must be cognisant of how cost and low socio-economic status will impact on the effectiveness of these interventions. Interventions must be guided by international best practice.

Ethnic diversity and asylum seekers

The period since the mid 1990s has seen an unprecedented increase in immigration into Ireland, with over 540,000 people (a minority of whom are asylum seekers) migrating into the country in the decade between 1995 and 2005[26]. It is estimated that at least 10% of the current population was born outside the country, with many people coming from countries with different languages and cultures[27].

This means that although the migrant population of Ireland is constantly changing, it is now increasingly becoming an established population, with an emerging younger generation attending schools across the country and participating in Irish society.

As this is a recent trend there is very limited research on how changes in the makeup of the population impact on the profile of crisis pregnancy. There is very little research in existence about attitudes amongst the immigrant population towards crisis pregnancy or about the outcomes of crisis pregnancy for women in this population in terms of the numbers opting to parent, place their child for adoption or terminate a pregnancy.

Economic migrants constitute the bulk of inward migration to Ireland. Asylum-seekers constitute no more than 10% of all foreign immigrants to Ireland since 1995. It is estimated that approximately 6,000 people are currently in the asylum process. Authorities have noted that the gender and origin of those seeking asylum have changed in the recent past, with an increased number of unaccompanied adult males now entering the process. On arrival, persons seeking asylum are offered a range of supports, including health screening and an introduction to the Irish health system.

Implications for the Agency

The Agency must ensure that it understands fully the effect and implications of a multi-cultural society on crisis pregnancy, its causes and profile. It will therefore be increasingly important for the Agency to review existing research, nationally and internationally, and to commission specific research where particular issues arise. In relation to those seeking asylum the Agency can play a role in assisting statutory bodies and voluntary organisations to provide sexual health information through the enhancement of existing health-related programmes and resources.

Developments in Information and Communication Technologies (ICT)

Digital technologies such as the internet, email, mobile messaging, instant messaging, video games, blogs and personal websites are becoming increasingly dominant in the lives of people in Ireland[28]; traditional broadcasting channels such as T.V., press and radio are in decline[29]. Young people, in particular, have developed and adapted to a world of constant change, using technology to create identities and connect "in disembodied forms"[30].

This access undoubtedly provides opportunities for development and innovation. Children and young people are ready learners, with technology offering endless resources[31]. But the speed of developments in communication and the constant interaction it facilitates bring with them certain risks, particularly for young people who may access age-inappropriate or inaccurate content.

25 Layte et al. (2006). The Irish Study of Sexual Health and Relationships. Crisis Pregnancy Agency and Department of Health and Children report. CPA, Dublin.
26 White et al. (2006). Children's and young people's experiences of immigration and integration in Irish society. http://www.ucc.ie/academic/geography/pages/migrant_children.htm
27 Central Statistics Office (2006). Census 2006: Persons resident in Ireland and present in the population by nationality 1996 – 2006. CSO, Cork.
28 Office for Communications (2006). Media Literacy Audit: Media Literacy amongst Children. United Kingdom.
29 Nielsen 2005. Joint National Listenership Research: Figures for 2005.
30 Hoffman, L. (1999). Gender, Sex and Sexuality. http://www.csa.com/discoveryguides/archives
31 Willet, R. (2005). New Models of Learning for New Media: Observations of Young People Learning Digital Design. http://www.childrenyouthandmediacentre.co.uk/publications.asp

Lack of regulation, lack of barriers and boundaries regarding sources and types of information available and the influences they will have on knowledge and behaviour are risks that need to be addressed.

Implications for the Agency

It is vital that the Agency keeps abreast with ICT developments in order to use the most effective and innovative means to communicate with its target audiences. New communication models and ICT advancements will also be at the forefront of the Agency's communications function.

In order to cut through the mounting volume of information sources and influences, it will be increasingly important for the Agency to continue to develop as an authoritative, trusted source of information in relation to sexual health and crisis pregnancy.

The Agency will utilise its on-line presence in particular to seek to counteract misinformation in relation to contraception and crisis pregnancy issues.

Health service reform

The radical restructuring of the health services has created a new landscape for the Agency to operate within. The Department of Health and Children now focuses on providing the overall organisational, legislative, policy, financial and accountability framework for the health sector. The Office of the Minister for Children has been established to integrate policy in relation to services for children and to build on the successes already achieved under the National Children's Strategy. The development of the model of unitary delivery through the Health Service Executive has brought about an increased focus on efficiency, consistency, quality and effectiveness in the health service. Development of a strong health-information evidence base for decision-making will be led by the Health Information and Quality Authority (HIQA).

Implications for the Agency

The restructuring offers significant advantages to all those operating in the health sector regarding national planning, holistic and integrated delivery structures, needs-based assessment and accountability. The Agency must now actively begin to integrate its planning and activities to avoid duplication, to increase efficiencies and to ensure fit with national objectives. The restructuring provides an opportunity to influence policy in a cohesive way and work collaboratively on shared projects.

National policies

The National Development Plan: *Transforming Ireland – A Better Quality of Life for All* sets out a roadmap for achieving economic and social goals over a seven-year period. The Plan outlines how investments will be made in key areas, three of which have a very direct relationship to and potential impact on the Agency's work: Human Capital, Social Infrastructure and Social Inclusion. The Ten-Year Social Partnership Agreement *Towards 2016* utilises a lifecycle framework, which orientates public services around the needs of people at different stages in their lives – children, young adults, people of working age, older people, etc. The key lifecycle stages identified as being of relevance to the Agency are children, young adults, and people of working age. The National Children's Strategy, which focuses on harmonising policy issues that affect children in a broad range of areas, is particularly relevant to the Agency's work.

Implications for the Agency

The Agency will need to focus resources to influence policy development and policy implementation in areas related to its mandate. In this regard it will be important for the Agency to capitalise on commitments and become involved in the implementation of national strategies that have a bearing on the mandates of the Agency. It will also be crucial to feed into the development of future national strategies related to the work of the Agency.

Legal environment

Probable legislative developments that could have implications for the Agency include legislation concerning the rights of the child and legislation relating to the age of consent.

Implications for the Agency

The Agency will need to keep abreast of legal developments and anticipate, in so far as possible, how emerging issues can be planned for.

Strategy

Objectives and strategic priorities

The Strategic direction for the Crisis Pregnancy Agency over the period 2007 – 2011 is focused on three central objectives that derive from its mandates:

Objectives

i. Reduce the number of crisis pregnancies.

ii. Reduce the number of women choosing abortion as an outcome of crisis pregnancy.

iii. Safeguard women's physical and mental health following termination of pregnancy.

Strategic priorities

Seven strategic priorities have been identified to help the Agency deliver its objectives

i. Knowledge about Relationships and Sexuality for Adolescents: Achieve measurable improvements in knowledge about relationships and sexuality among adolescents through home-, school-, and community-based education.

ii. Contraception: Improve access to and information on contraception and contraceptive services – particularly for groups at risk of crisis pregnancy.

iii. Communications: Conduct effective and innovative communications campaigns to promote positive behavioural and cultural changes regarding sexual attitudes, choices and behaviour.

iv. Crisis Pregnancy Services: Improve access to and delivery of crisis pregnancy counselling services and post-abortion medical and counselling services.

v. Continuation of Pregnancy: Improve the range and nature of supports central to making continuation of pregnancy more attractive. Ensure that women, their partners and families are fully informed about these supports.

vi. Research: Strengthen understanding of the contributory factors and solutions to crisis pregnancy; use research findings to promote evidence-based practice and policy development.

vii. Policy Influence: Influence policy makers and key players regarding prevention of crisis pregnancy, reproductive decision-making and crisis pregnancy outcomes.

On the following pages the rationale underpinning each strategic priority is set out. This is followed by a list of Projects for Change grouped under each strategic priority, and some associated Key Indicators.

Seven strategic priorities

I. KNOWLEDGE ABOUT RELATIONSHIPS AND SEXUALITY FOR ADOLESCENTS

ACHIEVE MEASURABLE IMPROVEMENTS IN KNOWLEDGE ABOUT RELATIONSHIPS AND SEXUALITY AMONG ADOLESCENTS THROUGH HOME-, SCHOOL-, AND COMMUNITY-BASED EDUCATION.

Rationale:

Sex education plays a critical role in preventing crisis pregnancy.

There is a well established link between educational aspirations, educational attainment, experience of sex education, sexual health knowledge and age of first sex. Both in Ireland and internationally, higher levels of educational attainment are associated with a higher age of first sexual intercourse. Higher levels of educational attainment are also associated with greater levels of sex education. Conversely, lower levels of educational attainment are associated with engaging in sexual intercourse at an earlier age. This, in turn, is associated with an increased risk of contracting an STI and of experiencing crisis pregnancy and abortion.

Research with young people in Ireland consistently demonstrates that they have significant knowledge deficits with regards to sexual health. Young people report that they want more and better sex education, which is not based solely on the biological aspects of sex, delivered across a range of settings. Attitudinal change and work on skills-building are important components of effective sex education programmes.

While implementation of the Relationships and Sexuality Education (RSE) programme in post-primary schools is improving, it is still inconsistent, with 30% of schools stating that they do not teach RSE in third year. Some schools report that they teach RSE but do not deliver all modules within the programme. A minority of schools in 2005 identified the Department of Education and Science (DES) as playing a role in evaluating whether the programme is being implemented or not. The DES has responded to this issue by incorporating SPHE/RSE evaluation criteria into Whole School Evaluation (WSE). Furthermore, the DES has increased the number of inspectors specifically skilled in conducting SPHE/RSE subject inspections, and their work is set to commence in the 2007/8 school year.

Young people report that school and home are viewed as trusted sources of information on sex and relationships, yet they tend to rely more on friends and the media for this information. Although research has demonstrated that open communication and sex education from parents in the home can delay first sex and increase safer sexual practices, most adolescents, especially boys, do not discuss sex with their parents. While the majority of parents are wholly supportive of sex education and acknowledge the unique and important role they play in imparting this information, many also feel ill-equipped and ill at ease discussing these issues with their children.

Barriers to delivering relationships and sexuality education can be even more pronounced for those who have left school early. 12.3% of 18 – 24 year olds were categorised as early school leavers by the Central Statistics Office in 2006. This equates to approximately 78,000 young people in this age range. Research commissioned by the Agency confirms that early school leavers are particularly vulnerable to negative sexual health outcomes such as unprotected early sexual activity. The Agency has funded a number of programmes through Youthreach and the Vocational Education Committee (VEC) to assist professionals in delivering effective and meaningful sex education to early school leavers.

There are also barriers to delivering the programme to young people with special needs – particularly those with a mild-to-moderate intellectual disability. Literacy difficulties and the need to utilise different teaching methods and approaches must be taken into account.

Differing cultural norms and religious beliefs may impact on how relationship and sex education is taught to students from migrant communities.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Build on the existing partnership with the Department of Education and Science and the HSE to achieve a more extensive delivery of Relationships and Sexuality Education (in the context of Social, Personal & Health Education (SPHE)) in post-primary schools. The CPA will work with partners to enable 100% of post-primary schools to deliver an RSE/SPHE programme over the next five years. The following projects will work towards this commitment:
    - Establish partnerships to identify specialist agencies that can support and assist in the delivery of RSE (in the context of SPHE) in the classroom. The role of specialist agencies will also be explored in relation to assisting those working with:
        - Early school leavers.
        - Young people with mild-to-moderate general learning disabilities.
        - Students from migrant communities.
    - Formally engage with young people, through schools and youth fora, to ensure their voice is heard when:
        - Reviews of the programme are being undertaken.
        - Resources are being developed.
        - Initiatives and new projects are being developed.
2. Assist parents to provide relationships and sex education to their children in the home.
    - Continue to disseminate the 'You can talk to me' DVD and booklet for parents on communicating with their children, and the Research Summary for parents on teenage sexuality.
    - Develop new resources (written, on-line and audiovisual) that focus on equipping parents with relevant and up-to-date information and the required communication skills.
    - Link with a national media partner to ensure all resources are disseminated to the widest possible audience.
    - Link with existing parent training courses and networks to further ensure widespread reach.
    - Evaluate the effectiveness of projects and make revisions accordingly.
3. A need has been identified for formal accreditation and recognition of SPHE teachers, and ways of doing this need to be considered with the Department of Education and Science. The Agency will work with the Department of Education and Science to explore the possibility of the development of a postgraduate diploma for teaching SPHE/RSE in primary and second-level schools. The requirements of school principals will also be investigated.

Key Indicators

- SPHE/RSE delivery is improved and increased in line with agreed DES policy.
- Measures established to assess:
    - The level of representation of young people's views in programme, resource and project development.
    - Take-up and usefulness of resources developed to assist parents to provide relationships and sexuality education.

II. CONTRACEPTION

IMPROVE ACCESS TO AND INFORMATION ON CONTRACEPTION AND CONTRACEPTIVE SERVICES – PARTICULARLY FOR GROUPS AT RISK OF CRISIS PREGNANCY.

Rationale:

A significant proportion of the population who are not trying to conceive have unprotected sex, putting themselves at risk of crisis pregnancy or STIs.

Projected increases in the number of 18-25 year olds in the population, together with the current level of risky sexual activity, demonstrate the need for better knowledge and use of contraception. Because crisis pregnancy affects all age and social groups, a comprehensive approach to improve contraceptive behaviour and knowledge is required. However, those most at risk of crisis pregnancy require tailored

approaches. These at-risk groups include younger people aged 18-24, people who are economically and educationally disadvantaged, and women aged 35-55.

The Department of Health and Children is responsible for policy on contraceptive services. The operational aspects are the responsibility of the Health Service Executive. The health service reform programme, implementation of the Primary Care Strategy and the possible development of a sexual health strategy provide good opportunities to put in place necessary management structures and to develop contraception services. General Practitioners, the nursing profession, staff in family planning/women's health clinics and pharmacists form a more localised infrastructure.

Easier and more equitable access to contraception services - when combined with education programmes - will increase consistent use of contraceptives. Expansion of contraception services will have the added benefit of normalising contraception-seeking behaviour and reducing the stigma some people attach to obtaining contraception. The Agency is ideally placed to advise and support the Department of Health and Children and the Health Service Executive in the development of policy and actions to address sexual risk-taking, improve access to services, increase take-up of services, and promote consistent and correct contraceptive use. The Agency's extensive research base, practical experience of developing tested sexual health promotion campaigns, and its experience of funding new models of delivery and monitoring effectiveness should be of value in this regard.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Finalise, in conjunction with the Department of Health and Children, three specific sub-reports of the Irish Study of Sexual Health and Relationships (ISSHR). These reports will provide additional up-to-date findings on contemporary sexual and contraceptive behaviour in Ireland.

2. Utilise the Agency's research expertise and knowledge to develop an evidence-based proposal to inform and support the inclusion of contraceptive service development in national sexual health plans and submit this to the Department of Health and Children and the Health Service Executive. Support and assist the Department of Health and Children and the Health Service Executive on planning and roll-out of any service developments related to the Agency's mandates, such as contraceptive service provision and contraceptive education, advice and information.

3. Fund pilot models of service delivery to improve access to services, increase take-up of services, and promote consistent and correct contraceptive use among at-risk groups. Evaluate these pilots with a view to mainstreaming.

4. Develop policy proposals on how the cost of contraception can be minimised in order to facilitate consistent contraceptive use among specific risk groups (such as young men and young women) and submit these to the Department of Health and Children and the Department of Finance. Actively promote the recommendations within the proposal among key personnel within each Department by conducting briefing and follow-up sessions with each. Seek a formal response from both Departments regarding proposed actions to reduce the cost of contraception for at-risk groups.

Key Indicators

- Improved uptake and use of contraceptive services demonstrated for 'at-risk' groups.
- Cost of contraception reduced as a barrier to use among 'at-risk' groups.

III. COMMUNICATIONS

CONDUCT EFFECTIVE AND INNOVATIVE COMMUNICATIONS CAMPAIGNS TO PROMOTE POSITIVE BEHAVIOURAL AND CULTURAL CHANGES REGARDING SEXUAL ATTITUDES, CHOICES AND BEHAVIOUR.

Rationale:

Evidence shows that authoritative and trustworthy communications and marketing programmes can be effective ways to reach key groups, to influence attitudes and behaviours and to challenge perceived social and cultural norms regarding sexual attitudes, choices and behaviours.

Connecting with groups most at risk of crisis pregnancy can be challenging, as our communications environment is becoming increasingly fragmented and 'noisy'. People at risk of crisis pregnancy often have poor knowledge levels on key sexual health matters and often do not know where they can access trustworthy information.

Developments in information and communications technology (ICT) provide a good opportunity for the Agency to connect in an immediate and intimate way

with young people. Keeping abreast of and using popular new technologies will become central to successful communications campaigns.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Use evidence from its research base to define target audiences according to specific need. The Agency will target young men, young women, and women aged 35-55 (focusing on those with lower educational attainment and lower SES) and will develop a three-year integrated marketing campaign on consistent and effective contraceptive use, including emergency contraception. The Agency will use the most effective messages and channels, with emphasis on the use of innovative ICT, and ensure ongoing tracking and modification of the campaign.
2. Analyse, identify and develop a two-year integrated marketing campaign aimed at delaying early sexual activity in adolescents. The campaign will involve partnerships with the State, commercial and voluntary sectors. It will be subject to ongoing tracking and evaluation.
3. Promote availability of and access to crisis pregnancy services and address the stigma of crisis pregnancy by continuing the Positive Options campaign for a further three-year period. Ensure ongoing evaluation of the campaign's effectiveness by benchmarking it against its current awareness level of 71% amongst its target audience.
4. Develop an integrated marketing campaign to promote the availability of free post-abortion medical and counselling services among women and ensure ongoing evaluation of the campaign's effectiveness.
5. Work with statutory bodies such as the Reception and Integration Agency, key non-governmental organisations, health professionals and other front-line workers to develop a new sexual health information component into existing health information programmes aimed at asylum seekers. This work will aim to address information needs at both the individual and service-provider level. It will also seek to build linkages between crisis pregnancy service providers and existing counselling services and supports available to asylum seekers.
6. Execute a national and regional media and public relations programme to communicate the strategic objectives of the Agency and position the Crisis Pregnancy Agency as the authoritative, influential and trustworthy voice on sexual health and crisis pregnancy.

Key Indicators

- Measures established to assess:
  - The level of representation of young people's views in communications programmes.
  - Awareness levels about sexual health issues among asylum seekers.
  - Awareness of free post-abortion medical and counselling services.
- Increased uptake of post-abortion medical and counselling services among women.

IV. CRISIS PREGNANCY SERVICES

IMPROVE ACCESS TO AND DELIVERY OF CRISIS PREGNANCY COUNSELLING SERVICES AND POST-ABORTION MEDICAL AND COUNSELLING SERVICES.

Rationale:

Crisis pregnancy counselling is a key support for women faced with a crisis pregnancy.

The aim of crisis pregnancy counselling is to ensure that the pregnant woman has a safe space to discuss and assess her circumstances and choices in order to allow her to make a decision. Counselling should be non-directive, and clients must take responsibility for their own actions, behaviour and decisions.

For women with little or no support from partners, family or friends, counselling is a vital source of help. However, currently three-quarters of those experiencing crisis pregnancy do not attend counselling. Women do not access services for a number of reasons, one of which is lack of clarity about the nature and extent of the counselling and information services available.

This issue can be addressed in part through the Agency's national communications campaigns. However, a major component of the Agency's response will be to follow through on its commitment to develop crisis pregnancy counselling services and to improve standards in crisis pregnancy counselling.

Research undertaken for the Agency has demonstrated a need to develop guidelines and protocols for service providers, including counselling protocols, referral protocols, procedures for specific client groups, internal protocols and service management guidelines. The Agency is committed to ensuring that a counselling agency's ethic of care to a woman in a crisis pregnancy situation is reflected in the development and use of such guidelines.

One particular issue where the development and implementation of protocols is essential is how each organisation's ethos interacts with its ethic of care to a woman in crisis. Potential clients are aware that ethos may vary or differ from one agency to another. This is to be welcomed, as it gives a woman choice of service provider, but it is important that an organisation's ethos is clearly stated, as women are less likely to attend and seek counselling if they are unsure about the service being given. A woman seeking crisis pregnancy counselling needs to be able to choose with confidence the agency she needs and is most comfortable with.

Regardless of the ethos of an organisation, crisis pregnancy counselling must be underpinned by an ethic of care. This is a standard to which all clients are entitled, regardless of which agency they choose to attend. This ethic of care acknowledges the needs of the woman as paramount and it is integral to the provision and conduct of all crisis pregnancy counselling services. Further, this ethic of care acknowledges the requirement for appropriate referral in circumstances where information requested by a client, or services that are required by a client, cannot be provided by any particular agency.

As well as ensuring quality of service, it is important to ensure that there is adequate choice. Research has demonstrated that some women value the availability of a local service, while others prefer the anonymity of services in larger towns away from rural communities. By bringing together regional information on levels of service provision, population levels and the service needs of women facing crisis pregnancy, the Agency can develop a profile of services required nationally.

When women have had an abortion, it is important for them to have access to high-quality post-abortion medical and counselling services. However, women do not always obtain these services, because they are not aware of them or because of the perceived stigma that remains around abortion in Ireland.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Undertake research to quantify the need for crisis pregnancy and post-abortion services nationally, based on population data, deprivation indices and other indicators, and compare those needs to the prevailing level of services delivered.
2. Identify statutory, voluntary and charitable organisations or individuals with the expertise and capacity to provide these services and provide annual grant funding to enable their provision.
3. Research and develop a toolkit for the commissioning and establishment of crisis pregnancy counselling services. Pilot the toolkit and revise it in line with outcomes from the process. Provide the finalised toolkit to all new services to assist in the establishment of quality-assured services. Provide the toolkit to established counselling services to assist them in protocol development.
4. Research the development of a self-assessment Quality Assurance Framework for the provision of crisis pregnancy counselling and post-abortion counselling services, in consultation with key partners.
5. Develop and roll out a pilot accreditation programme in crisis pregnancy counselling skills in partnership with the National University of Ireland, Maynooth. Make places on the pilot programme available for counsellors working in State-funded crisis pregnancy services. Conduct a thorough evaluation of the course.

Key Indicators

- Increased number of crisis pregnancy services established and operated to agreed quality standards.
- Crisis pregnancy counsellors operating in State-funded services participating in accredited training.

V. CONTINUATION OF PREGNANCY

IMPROVE THE RANGE AND NATURE OF SUPPORTS CENTRAL TO MAKING CONTINUATION OF PREGNANCY MORE ATTRACTIVE. ENSURE THAT WOMEN, THEIR PARTNERS AND FAMILIES ARE FULLY INFORMED ABOUT THESE SUPPORTS.

Rationale:

There are a large number of factors that affect whether or not a woman opts to continue with a pregnancy.

Challenges experienced by women to continuing a pregnancy and to parenting include relationship issues, childcare, finance, work, career, perceived stigma, poverty, feelings of being unable to cope, or being too young to have a child. The perceived role that the father can play in parenting the child also influences the woman's decision-making process.

A number of these factors can be addressed by providing particular supports that are responsive to those experiencing crisis pregnancy. National policies impacting on issues such as affordability of childcare, supports for lone parents and maternity and paternity benefit have a significant impact on crisis pregnancy decision-making. Partnering with Government departments and other bodies will allow the Agency to better affect policies related to these areas. It will also facilitate the development of creative, innovative projects aimed at addressing many of these factors, which could make parenting a more attractive choice to women.

The number of women placing their babies for adoption has decreased significantly in recent decades and continues to fall on an annual basis. Research suggests that certain barriers exist that prevent women from considering adoption, such as poor perception of adoption in society and limited presentation of adoption as an option by professionals working in the area of crisis pregnancy.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Develop a workplace project, to improve the experience of working women (and men) facing crisis pregnancy. The project will centre on the development of guidelines and protocols for managing statutory leave entitlements and on providing information to employees on benefits, rights and entitlements. The project will be piloted in a mix of workplace settings and through Employee Assistance Programmes. The pilot will be evaluated and the outcome promoted.
2. Fund a number of pilot initiatives that aim to increase the awareness and engagement of men, particularly younger men, in the support of their partners during crisis pregnancy and parenting. The projects will aim to provide a male-orientated aspect to service delivery and to complement counselling and support provided to their partner.
3. Fund pilot initiatives aimed at women - particularly young women - who need a high degree of support and assistance in progressing with their pregnancy and coping with parenting. The projects will extend into areas such as building and maintaining good relationships with the child's father, linking into education and training initiatives, parenting skills and personal development issues.
4. Utilise the findings of commissioned research to develop good-practice guidelines on addressing and presenting the choice of adoption. This research will also be used to inform the development of referral pathways for use by professionals who interact with those considering adoption. This work will be undertaken in consultation with the Office of the Minister for Children, relevant statutory bodies including the Adoption Board, service providers and medical/health professionals.
5. Undertake a review of demand for initiatives such as supported accommodation and short-term fostering which provide support to women during the timeframe in which they are considering adoption. Develop an approach for funding such initiatives and a plan for facilitating the mainstreaming of supported accommodation funding in particular.
6. Publicly endorse the full implementation of the Domestic Adoption Framework. Support the inclusion in the Framework of the natural mother's central role in the selection of the prospective adoptive parents.

Key Indicators

- Measures to assess the perception and presentation of adoption as an outcome in crisis pregnancy.
- Increased uptake of crisis pregnancy services by men.

VI. RESEARCH

STRENGTHEN UNDERSTANDING OF THE CONTRIBUTORY FACTORS AND SOLUTIONS TO CRISIS PREGNANCY. USE RESEARCH FINDINGS TO PROMOTE EVIDENCE-BASED PRACTICE AND POLICY DEVELOPMENT.

Rationale:

Research is key to tracking performance indicators and continuing an evidence-informed approach to the work of the Agency.

The Agency has an established record in using research to inform communications, service development, policy and standards.

High-quality research is required to understand the issues the Agency is dealing with and to design the most appropriate and effective interventions.

Research is essential to monitor the environment within which the Agency operates, nationally and internationally, and to track the work of the Agency itself. The Agency has a duty to ensure objectives are met and to achieve impact on its mandates.

Over the next five years, the Agency needs to sustain a solid evidence base and dissemination strategy to:

- Contribute to evidence-informed interventions and service improvement.
- Support long-term planning and evaluation.
- Build the case for policy change.
- Stimulate public debate.

The context within which crisis pregnancies are occurring is constantly changing. Survey data suggests strongly that women in their early twenties appear to be more likely to define a pregnancy as a crisis pregnancy than older women were when they were in their twenties. There is a strong possibility that economic, education, employment and lifestyle shifts may affect the way young women respond to unplanned pregnancy. During its first five years, the Agency has invested very heavily in understanding the causes of and responses to crisis pregnancy, in establishing base-line measures and in developing an evaluation framework for its work. It is imperative that the Agency keeps abreast of emerging trends and changes in the environment that impact on the prevalence of crisis pregnancy.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Maintain and improve the Agency's evidence base:
   - Conduct a literature review and synthesis of the Agency's published research and identify outstanding gaps in knowledge.
   - Commission or conduct new research to address gaps in knowledge and to maintain the Agency's current evidence base. Areas for further research include: sexual health issues facing Ireland's immigrant community; population data on the knowledge, attitudes and behaviours of teenagers in Ireland; women presenting under new circumstances for post-abortion medical assistance and the needs of women travelling to jurisdictions other then the UK for abortion.
   - Publish statistical reports that will monitor a range of base-line indicators in key areas related to crisis pregnancy.
2. Build research capacity on topics related to crisis pregnancy research by:
   - Commissioning research.
   - Setting up a research scholarship programme for individuals undertaking Masters or PhD programmes in areas related to the Agency's mandate.
   - Setting up a research awards scheme for qualified individuals to undertake scientific research in fields related to the Agency's mandate.
   - Making the Agency's quantitative databases accessible and available to the broader academic community by placing them in a data archive.
3. Publish good-practice guidelines, in partnership with professional bodies, to improve professional practice and ensure that it is informed by sound evidence. These should be completed for:
   - Employers, regarding the law in relation to pregnancy and maternity and its impact on those experiencing crisis pregnancy.
   - Members of the medical and counselling professions in relation to post-abortion counselling.

- Medical, social work and administrative staff working in maternity hospitals and counsellors on concealment of pregnancy.
- Teachers and those working with young people on using outside facilitators in teaching SPHE/RSE.
- Members of the medical and counselling professions on delivering quality crisis pregnancy counselling services for clients with an intellectual disability.
- Members of the crisis pregnancy counselling professions who come into contact with women and their partners where a foetal abnormality has been diagnosed.

4. Increase the spread and awareness of the Agency's research programme by extending the Agency's current series of research summaries to include new user groups. These will include employers, people in work, students, schools and educational representative bodies, and the nursing community.

   Develop an international database and increase the spread of the Agency's dissemination network to related groups and organisations in other countries. This will encourage and facilitate the sharing of information on initiatives, developments and programmes of work similar to our own.

5. Conduct a comparative exercise with other statutory bodies (nationally and internationally) to examine how the Agency's framework for evaluation compares with others with a view to improving it where necessary. Conduct periodic reviews (one in 2008/9 and the other in 2011) to ensure the evaluation framework underpinning the work of the Agency is informed by national and international good practice.

Key Indicator

- Measures established to assess:
  - the extent to which the Agency's reports contribute to increased understanding of crisis pregnancy and the environment within which the Agency works.
  - the extent to which guidelines produced by the Agency are endorsed and used by professional groupings.
  - the extent to which research findings reported by the Agency are correctly and effectively communicated in the media.

VII. POLICY INFLUENCE

INFLUENCE POLICY MAKERS AND KEY PLAYERS REGARDING PREVENTION OF CRISIS PREGNANCY, REPRODUCTIVE DECISION-MAKING AND CRISIS PREGNANCY OUTCOMES.

Rationale:

The national policy environment has a direct impact on the mandates of the Crisis Pregnancy Agency.

Sexual health policies and policies concerning education, parenting and reproductive decision-making ultimately have an impact on an individual's attitudes, behaviours and experiences.

National policies on contraceptive service provision, access, cost and availability have an impact on consumer choice, behaviour and, ultimately, crisis pregnancy.

Research also shows that the decision a woman makes when she is confronted with a crisis pregnancy is affected by a multiplicity of factors. One of these factors, particularly for women thinking of abortion, is the policy environment as it relates to women's aspirations for the future. Decisions to parent a child are affected by a variety of policies including welfare, housing, childcare, employment and education.

In the next five years, policy development and influence will be a growing part of the Agency's work. Expertise and knowledge developed over the previous four years will be harnessed into policy change so that measurable impacts can be achieved.

Projects for Change: To implement this strategic priority, over the next five years the Agency will:

1. Publish policy reviews on key topics related to crisis pregnancy. These will include, but may not be limited to:
   - The workplace and reproductive decision-making.
   - Relationships and sexuality education.
   - Teenage pregnancy and supports for teenage parents.

  - Crisis pregnancy and family formation in Ireland.
  - Sexual health and the immigrant community.

2. Participate in and organise policy fora on key issues, in partnership with others. Key partners include:
   - The workplace community, with respect to crisis pregnancy and workplace policy.
   - Sexual health professionals and practitioners, with respect to sexual health promotion and prevention of crisis pregnancy and STIs.
   - The migrant community, professionals and service providers working in the area, with respect to sexual health issues.
3. Monitor policy change nationally in order to assess the impact of the Agency's contribution.

Key Indicator

- Increased awareness of the impact of policy formation on crisis pregnancy and crisis pregnancy decision-making, as measured through those involved in the policy making process and the policies themselves.

Implementing the Strategy

Objective

Strengthen the Agency's organisational capacity to ensure it can deliver this Strategy.

Internal Strategic Priorities

1. Ensure the Agency has appropriate Board structures in place to ensure effective delivery of the Strategy.
2. Ensure that the staff structure and skill base enable the priorities in the Strategy to be addressed effectively.
3. Strengthen the Agency's core processes and systems and ensure they are sufficient to implement the plan.
4. Enable the Agency to monitor its implementation of the Strategy and to assess the impact of the Strategy on reducing the number of crisis pregnancies in Ireland.
5. Enter into partnerships with complementary organisations to ensure that the full ambition of this plan can be realised.
6. Provide value for money.

Internal Strategic Priority 1

Ensure the Agency has appropriate Board structures in place to ensure effective delivery of the Strategy.

Rationale

As a State body, the Agency is required to operate in accordance with good practice by adhering to those policies and procedures that affect the way the Agency is organised, governed and controlled. In particular, the Agency is required to operate in accordance with the Department of Health and Children's Framework for Corporate and Financial Governance and the Code of Practice for the Governance of State Bodies issued by the Department of Finance, which set out practices for good governance and clear lines of accountability. Application of good practice in governance by the Board and its Subcommittees will allow for effective control over the Agency's operations and robust monitoring of delivery.

Projects for Change

1. Review the Agency's current Corporate Governance Manual.
2. Ensure that the Board of the Agency participates in appropriate training, commencing with collective training on governance.
3. Ensure that Board and Subcommittee processes and procedures comply with good governance principles and practice.

Internal Strategic Priority 2

Ensure that the staff structure and skill base enable the priorities in the Strategy to be addressed effectively.

Rationale

Continuing to build and develop an organisation with an effective structure and affirmative culture will be a key contributor to the effective delivery of the Strategy. The Agency is proud of its reputation for being a dynamic organisation with committed and motivated staff; therefore it recognises the need to maintain a challenging, engaging and inclusive working environment. The success of the Agency is dependent on ensuring that staff members are engaged with the delivery of the Strategy. This can be achieved by ensuring that their individual performance plans are aligned to the Agency's strategic objectives, and that appropriate training and development are made available. The Agency must support the efficient and effective use of resources by establishing an organisational structure that has clearly defined roles and responsibilities.

Projects for Change

1. Re-develop Human Resource procedures and policies to ensure an appropriate working environment and work culture for staff, incorporating flexible working principles.

2. Enhance the Performance Management and Development Framework for staff and complete a training and development plan, with an annual personal plan for each member of staff, based in part on the skills and abilities they will need to develop in their role in implementing this Strategy.

Internal Strategic Priority 3

Strengthen the Agency's core processes and systems and ensure they are sufficient to implement the plan.

Rationale

During its first five years, the Agency developed a highly effective organisation based on:

- Experienced people with the right mix of expertise needed to address its early priorities.

- A robust staffing structure designed to ensure the optimum mix of roles and responsibilities.

- Processes and systems that allowed effective financial management.

- A number of important processes and procedures to underpin work in key areas of research, communications, funding and administration.

However, as this strategy commits the Agency to a number of important shifts in direction - more emphasis on targeted communications with specific groups, messages that are informed by research, forging partnerships and influencing policy - it is timely to review the 'fitness for purpose' of the organisation to ensure that the requisite skills, systems and culture are in place to deliver this ambitious plan.

The ICT system must facilitate efficient and effective use of information. In particular, it will be important to evaluate new and emerging technologies continually and ensure best use of ICT in all aspects of the Agency's work.

One of the Agency's core activities is effective communication on the role, objectives and functions of the Agency, the contributory factors to crisis pregnancy, and measures to address these. As technologies emerge, the Agency will need to utilise a wide variety of channels to achieve effective and consistent communications.

As policy influence becomes a larger proportion of the Agency's work it will be important to ensure that key members of staff have the necessary skills to achieve objectives. The Agency will also have to dedicate time to identifying key individuals, networks and fora that can facilitate the achievement of its policy objectives.

The Agency must also ensure that it has a strong focus on accountability and transparency and that systems and processes are regularly reviewed and improved to maintain high standards in these areas.

Projects for Change

1. Continually monitor ICT developments and integrate new approaches in the Agency's communications work.

2. Review the Agency's communication systems and processes through the Internal Audit function to ensure that the Agency is communicating effectively.

3. Continually review financial and accounting policies and procedures in line with the latest developments and departmental/Government policy.

4. Enhance management, Board and external reporting of all activities.

Internal Strategic Priority 4

Enable the Agency to monitor its implementation of the Strategy and to assess the impact of the Strategy on reducing the number of crisis pregnancies in Ireland.

Rationale

The Agency's purpose is clearly set out in the mandates in its Statutory Instruments; therefore it is very important to continually reassess the Agency's Strategy, objectives and operational and individual personal development plans to ensure that they are aligned towards the achievement of those mandates.

As the Agency is accountable for the achievement of its mandates, it must develop key performance indicators to ensure that success can be measured at mandate, strategic and operational levels throughout the course of

this Strategy, as well as formally evaluating this Strategy at its conclusion.

Setting up a robust monitoring and evaluation system that enables the Strategy to be evaluated objectively is fundamental to the work of the Agency. Key performance indicators and assessment parameters at the project, programme and strategic levels are crucial to effective evaluation. The Agency is committed to developing a matrix of key performance indicators for its second Strategy that fit with its approach to evaluation to date.

The development of key performance indicators and their integration into an overall strategic evaluation plan are dependent upon the work and cooperation of other professional bodies and organisations. The Agency will continue to work with partners to establish, collect and monitor data over the next five years.

Projects for Change

1. Continue our existing evaluation framework to ensure the Agency can assess the impact of its Strategy and strategic priorities on reducing crisis pregnancy.
2. Conduct a mid-term review of the Strategy to assess progress against strategic priorities and to gauge the direction of the Strategy against any major unforeseen developments that may become apparent.
3. Commission an independent evaluation of the Strategy in 2012.
4. Ensure that annual Service Plans are clearly linked to the objectives in the Strategy.

Internal Strategic Priority 5

Enter into partnerships with complementary organisations to ensure that the full ambition of this plan can be realised.

Rationale

The success of the Agency's work is highly dependent on the partnerships it develops, particularly with the Department of Health and Children, the Department of Education and Science and the Health Service Executive. Other pivotal alliances include the Office of the Minister for Children, the Department of Social and Family Affairs and the Adoption Board. In response to various themes highlighted in the Public Service Modernisation Programme, the Agency must also work to strengthen and enhance its relationships with other key constituents. These include individuals at risk of or experiencing crisis pregnancy, representative organisations, statutory and voluntary bodies, service providers - particularly those providing crisis pregnancy services - and the CPA Board and staff.

Projects for Change

1. Develop a Memorandum of Understanding to agree a partnership approach between the Crisis Pregnancy Agency and the Health Service Executive for the provision of information on sexual health, crisis pregnancy services and contraception services.
2. Develop a Memorandum of Understanding to agree a partnership approach between the Crisis Pregnancy Agency and the Department of Education and Science to comprehensively address the implementation of Relationships and Sexuality Education in second-level schools.
3. Form a number of strategic alliances so as to undertake joint initiatives with key Government Departments, State Agencies and representative organisations.
4. Organise networking events and develop learning networks with agencies and individuals involved in the broad areas of crisis pregnancy and sexual health.

Internal Strategic Priority 6

Provide value for money.

Rationale

The Agency is funded by Government, through the Department of Health and Children, and the majority of its expenditure (approximately 85%) is external to the organisation. Approximately 55% of the funding is distributed through the Agency's Funding Programme to voluntary or statutory bodies providing services related to crisis pregnancy. Approximately 30% is paid to commercial organisations such as advertising agencies, or to academic institutions for conducting research projects. The remainder of the Agency's funding is allocated to administrative costs. The Agency must ensure that it is fully accountable for these funds, both in terms of how the money is allocated to the various organisations and how organisations use the funds allocated to them.

Projects for Change

1. Keep abreast of public procurement guidelines and regulations and apply these rigorously to any contracts conducted on a commercial basis.
2. Monitor performance against commercial contracts through a combination of mechanisms including internal reviews, regular liaison with contractors and internal audit reviews.
3. Allocate and manage monies through the Funding Programme in accordance with the Agency Funding Criteria, Terms and Conditions.
4. Continue to review the proportion of administrative costs against service provision to ensure that they remain reasonable.

Budget

The Agency is funded through annual grants from Government, via the Department of Health and Children, as recommended by the Oireachtas All-Party Committee on Health and Children. This funding is provided in line with the provisions set out in the Statutory Instrument for its establishment, which states that "The Minister may pay to the Agency in each year, out of moneys provided by the Oireachtas, a grant or grants, of such amount or amounts as the Minister may decide".

The Agency received €8.762 million to support the delivery of the objectives set out in the Service Plan for 2007. The Agency will continue to work with the Department of Health and Children to maintain or increase this level of funding and support in order to deliver on the priorities identified within the Strategy, while remaining committed to ensuring value for money in the operation of the Agency's business.

Appendices

Appendices

Appendix I

Board of the Agency

The Agency is governed by an independent Board appointed by the Minister for Health and Children. The current Board was appointed in December 2006. Membership of the Board is drawn from Government Departments, key relevant health disciplines and representatives from the general community. Refer to Appendix II for a list of current Board Members.

The Executive of the Agency

The Executive of the Agency is comprised of a Director and a senior management team supported by administration, communications, research, policy and health promotion staff. The work programme is divided into four main areas:

- Funding programme.
- Communication, information and health promotion programme.
- Research and policy programme.
- Administration.

The Agency has developed the organisational structure to ensure that it is aligned with the Strategy and annual business plans.

Consultation and Partnership

The Statutory Instrument of the Agency provides for the establishment of a twenty-five person Consultative Committee drawing on the expertise of various statutory and non-statutory organisations. The function of the Consultative Committee is... "to advise the Agency in relation to (a) any matters pertaining to crisis pregnancy as are referred to it by the Agency and (b) any other matters coming within the remit of the Agency".

The Consultative Committee provides expert advice to the Board of the Agency and is a forum for organisations with an interest in the work of the Agency to present their views. An annual work plan is agreed with the committee. Refer to Appendix III for a list of the current membership.

The Agency is committed to working with a broad range of voluntary and statutory bodies to achieve the challenging objectives set out in the Strategy. To date, the service providers funded by the Agency as well as expert groups on contraception, parenting and adolescents have greatly assisted in advising the Agency on approaches. Similar arrangements will continue to be used in the future.

In the course of the first Strategy, the Agency developed models for working effectively in partnership with other relevant organisations in conducting research, in the delivery of funded projects, and in the development of campaigns and communications resources. The Annual Service Plans committed to by the Agency, which support the Strategy, provide an opportunity for the Agency to examine how partnership arrangements can best be achieved in the roll-out of programmes each year.

Appendix II

The Board of the Agency

Katharine Bulbulia, Chairperson

Maureen Bohan, Department of Education and Science

Helen Faughnan, Department of Social and Family Affairs

Peter Finnegan, Businessman

Cllr. Sally-Ann Flanagan

Dr. Anne Flood, Health Service Executive

Fergal Goodman, Department of Health and Children

Rosemary Grant, Coombe Women's Hospital

Geraldine Luddy, The Women's Health Council

Appendix III:

The Consultative Committee

Members of the Consultative Committee to the Crisis Pregnancy Agency as appointed by the Minister for Health and Children

Chairperson: Geraldine Luddy, Director, The Women's Health Council, and Board Member, Crisis Pregnancy Agency.

Members: Louise Graham, National Coordinator and representative of CURA

Karen Dent, member and representative of National Parents Council Post-Primary

The Reverend Bruce Pierce, representative of the Church of Ireland Bishops

Margot Doherty, Assistant CEO and representative of Treoir

Catherine Duffy, National Planning Specialist, Primary Care, HSE West and representative of Health Service Executive

Rhonda Donaghy, Chair, Congress Women's Committee and representative of Irish Congress of Trade Unions

Rosie Toner, Director of Counselling and representative of IFPA

Kay Garvey, Nurse and representative of Irish Nurses Organisation

Julie Kerins, Senior Social Worker, Cúnamh, and representative of Council of Irish Adoption Agencies

Sherie de Burgh, Director of Counselling and representative of One Family

Ursula Byrne, Education Officer and representative of An Bord Altranais

Alison Begas, Chief Executive and representative of Dublin Well Woman

Dr Naoimh Kenny, Assistant Director, Women's Health Programme, and representative of Irish College of General Practitioners

Rosaleen McDonagh, Project Officer, Pavee Point, and representative of the Travelling Community

Salome Mbugua, National Director, Akidwa, and representative of non-Irish nationals

Representative of people with disabilities – Vacant

Noelle Shannon, Taoiseach's nominee

Sunniva McDonagh, Senior Council and representative of the Irish Episcopal Conference

Frances Shearer, National Coordinator of RSE and representative of the education sector

Appendix IV

Strategy Subcommittee

This subcommittee was established in December 2006 to lead the development of the Agency's Strategy for 2007 to 2011.

Katharine Bulbulia (Chairperson of Subcommittee and Chairperson of Board)

Fergal Goodman (Board Member)

Helen Faughnan (Board Member)

Maureen Bohan (Board Member)

Peter Finnegan (Board Member)

The subcommittee was supported by the Executive of the Agency

Caroline Spillane (Director)

Dr. Stephanie O'Keeffe (Research and Policy Manager)

Fiona Larthwell (Administration Manager)

Enda Saul (Programmes and Communications Manager)

Administrative Support: Lynn Dowling

Appendix V

Staff of the Agency

Caroline Spillane, Director

Dr. Stephanie O'Keeffe, Research & Policy Manager

Fiona Larthwell, Administration Manager

Enda Saul, Programmes & Communications Manager

Aoife Kelly, Administration Officer

Orla McGowan, Education & Information Officer

Tracy Richardson, Programmes & Communications Officer

Sarah Ryan, Funding Officer

Mary Smith, Research Officer

Policy Officer (Vacant)

Lynn Dowling, Administration Assistant

Sarah Moran, Programmes & Communications Assistant

Maeve O'Brien, Research Assistant

Grace Hillis, Receptionist & Director's PA

Trish Wallace, Accounts / Office Clerk

Appendix VI

Code of Ethics for the Crisis Pregnancy Agency

The purpose of this Code of Ethics is to articulate the principles that guide the Crisis Pregnancy Agency's decision-making in light of its responsibilities towards its diverse constituencies. These principles will guide the decisions that are made regarding the development, funding and support of projects and the Crisis Pregnancy Agency's research (including the research it funds). The principles will form part of the frame of reference when proposals for funding are being assessed.

In its approach to its work, and in supporting the work of others, the Agency will:

1. Be respectful of and non-judgmental regarding the choices made by women who face crisis pregnancy.
2. Be respectful of a woman's autonomy and her right to privacy (within the constraints of the law).
3. Be guided by reliable research and good practice in all areas of our work.
4. Endeavour to work collaboratively with agencies working in the field.
5. Strive to promote policies that are respectful of the diverse experiences and viewpoints that exist on this issue.
6. Be supportive of agencies which
    - use professional approaches to counsel, educate and provide information to the public
    - fully inform clients of their organisation's ethos
    - promote informed decision-making in resolving issues regarding crisis pregnancy and related sexual health matters
    - use reliable research and responsible monitoring and evaluation methods to ensure accountability and good practice
    - work to promote equity of access and quality for clients
    - provide appropriate referrals when the information or service requested by the client is not available.

Appendix VII

Consultation Process

The consultation process for the Strategy took place over the period March to May 2007. Consultation was conducted through individual meetings, group discussion and telephone conversations. Issues arising from the consultation process were analysed by the Executive and grouped thematically. Emerging themes have been strongly reflected in the section entitled 'Changes impacting on the new Strategy', these have in turn influenced the development of the Agency's Seven Strategic Priorities.

Groups Invited to Consult

- Board of the Crisis Pregnancy Agency
- Consultative Committee of the Crisis Pregnancy Agency
- Executive and Staff of the Crisis Pregnancy Agency
- Youth reference panel (Office of the Minister for Children)
- Youth reference group (The Zone Youth Café, Tallaght Youth Service)
- Multi-sector reference panel comprising individuals from sporting, professional, media, enterprise, student, market research and advertising disciplines
- State-funded crisis pregnancy counselling service providers: Ballinasloe Crisis Pregnancy Support Service, Cura, Dublin Well Woman, Irish Family Planning Association, Kerry Crisis Pregnancy Counseling Service, Life Pregnancy Care Service, Mayo Crisis Pregnancy Support Service, Midlands Crisis Pregnancy Counselling Service, One Family, Pact, Sexual Health Centre – Cork, West Cork Crisis Pregnancy Counselling Service, Youth Health Service – Cork and Treoir (the national federation of services for unmarried parents and their children)

Individuals Invited to Consult

- Department of Health and Children: Primary Care and Social Inclusion
- Health Service Executive: Primary Care; Health Promotion; Mental Health; Social Inclusion
- Office of the Minister for Children
- Office for Social Inclusion
- Health Research Board
- Department of Education and Science – (Social, Personal and Health Education and Relationships and Sexuality Education support services)
- Adoption Board
- Department of Justice, Equality and Law Reform
- Reception and Integration Agency
- Economic and Social Research Institute
- National Economic and Social Forum
- National Parents Council - Primary
- Rape Crisis Network of Ireland
- Union of Secondary Students
- Irish Society for the Prevention of Cruelty to Children
- Irish College of General Practitioners
- Combat Poverty Agency
- National Youth Council of Ireland
- Union of Students in Ireland
- Irish Vocational Education Association
- Association of Community and Comprehensive Schools
- National Centre for Partnership and Performance