Discussion of the results

Overall the findings show both high levels of contraceptive use and high levels of contraceptive risk, highlighting the importance of maintaining use of contraception, promoting dual contraceptive use[17] and compensatory behaviour if risks occur. Current policy has aimed to increase the availability of oral EC by making it available over the counter. Some health care professionals (doctors, pharmacists and nurses) have raised concerns that promoting compensatory behaviour will reduce the use of primary contraceptives.[7,8] The low proportion of contraceptive risks that were compensated for in this study demonstrates the existing large scope for increasing EC use without this reflecting an increase in primary contraceptive risks.

The study shows a discrepancy between levels of primary contraceptive risks and compensatory behaviour. This highlights the importance of measuring the impact of interventions promoting EC use through levels of EC use in relation to levels of primary contraceptive risk. The impact of interventions promoting EC could also be measured in terms of unwanted pregnancy rates. This study, however, suggests that a low proportion of contraceptive risks result in pregnancy. This, combined with the level of efficacy of EC, means that a large, consistent increase in EC use and a very large sample size would be required for an impact on unwanted pregnancy to be demonstrated.

Female respondents in this study were more likely to have used EC than respondents in other recent surveys.[1] This is likely to reflect the use of a sample of young people aged over 16 years in education, as those from more socially deprived backgrounds may be less willing to use EC.[13]

Existing research has highlighted a range of reasons why young women may not use EC including: their perceptions regarding their susceptibility to pregnancy; links made between EC and a negative female sexuality; and concerns about side effects and concern about health care professionals' attitudes.[13,18,19] Within and between subject attitudinal differences between episodes of risky sex which were compensated for and those which were not are reported elsewhere.[14]

Conclusions

In this study the majority of sexually active people experienced contraceptive risks that, in many cases, were not followed by compensatory behaviour. The study findings suggest that interventions promoting contraceptive use should focus on the maintenance of behaviour and the need for compensatory behaviours (condom or EC use) when contraception goes wrong. Such an approach involves the acknowledgement that contraceptive risks do happen but can be managed.

Acknowledgements

The authors would like to thank their funders and all the young people who took part in the study. They would also like to thank each of the schools, further education, sixth form colleges, universities and teachers/lecturers for their help in enabling them to conduct the study.

Statements on funding and competing interests

Funding. Caroline Free and the research was funded by the Department of Health through a Primary Care NHS R&D training fellowship.
Competing interests. None identified.

References

1 Dawe F, Meltzer H. *Contraception and Sexual Health, 2002*. London, UK: Office for National Statistics, 2002. http://www.statistics.gov.uk.
2 Singh S, Darroch JE. Adolescent pregnancy and childbearing: levels and trends in developed countries. *Fam Plann Perspect* 2000; **32**: 14–23.
3 Office for National Statistics. *Termination of Pregnancy Data*. London, UK: Office for National Statistics, 2000. http://www.statistics.gov.uk.
4 Wellings K, Nanchahal K, Macdowall W, et al. Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; **358:** 1843–1850.
5 Price N. Use of contraception in women who present for termination of pregnancy in inner London. *Public Health* 1997; **111:** 377–382.
6 Rosenberg MJ, Waugh MS, Meehan TE. Use and misuse of oral contraceptives: risk indicators for poor pill taking and discontinuation. *Contraception* 1995; **51:** 283–288.
7 Edgardh K. Sexual behaviour in a low-income high school setting in Stockholm. *Int J STD AIDS* 2002; **13:** 160–167.
8 Lindburg L, Sonenstein F, Ku L, et al. Young men's experience with condom breakage. *Fam Plan Perspect* 1997; **29:** 128–131.
9 Glasier A, Baird D. The effects of self-administering emergency contraception. *N Engl J Med* 1998; **339:** 1–4.
10 Barrett G, Harper R. Health professionals' attitudes to the deregulation of emergency contraception (or the problem of female sexuality). *Sociol Health Illn* 2000; **22:** 197–216.
11 Delbanco SF, Stewart F, Koenig J, et al. Are we making progress with emergency contraception? Recent findings on American adults and health professionals. *J Am Med Wm Assoc* 1998; **53**(Suppl. 2): 242–246.
12 Graham A, Green L, Glasier AF. Teenagers' knowledge of emergency contraception: questionnaire survey in south east Scotland. *BMJ* 1996; **312:** 1567–1569.
13 Crosier A. Women's knowledge and awareness of emergency contraception. *Br J Fam Plann* 1996; **22:** 87–89.
14 Free C. Towards a contextual and dynamic model of young women's contraception use. PhD thesis, Guy's, King's and Thomas' Medical School, King's College London. University of London, London, UK, 2003.
15 Department of Health. *National Statistics*. London, UK: Her Majesty's Stationery Office, 2001.
16 Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. FFPRHC Guidance (April 2003). Emergency contraception. *J Fam Plann Reprod Health Care* 2003; **29**(2): 9–16.
17 Rademakers J, Coenders A, Dersjant-Roorda M, et al. A survey of attitudes to and use of the "double Dutch" method among university students in The Netherlands. *Br J Fam Plann* 1996; **22:** 22–24.
18 Free C, Lee R, Ogden J. Young women's accounts of the factors influencing their use and non-use of emergency contraception: in-depth interview study. *BMJ* 2002; **325:** 393–398.
19 Ziebland S, Maxwell K, Greenhall E. "It's a mega dose of hormones, isn't it?" Why women may be reluctant to use emergency contraception. *Br J Fam Plann* 1996; **22:** 84–86.