

Family planning and contraception practices of Maltese women

A dissertation submitted in partial fulfilment of the requirements for a
Masters in Gender, Society and Culture

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ABSTRACT

Family planning allows for women and girls to plan, time and space their children. All around the globe family planning policies and modern contraception methods have changed millions of women's and girls' lives. Most women spend around 40 years of their lives trying to control their fertility. Although family planning was confirmed as a human right at various international conventions and forms an integral part of the United Nations Sustainable Development Goals for 2030, Malta still has no family planning policy and no statistics or data on the current family planning and birth control customs of its people. This quantitative study set out to document the current contraception and family planning practices of Maltese persons assigned female at birth. The aim was to also check for associations between socio-economic factors and contraception practices, and to discuss potential links between contraception use and pregnancy outcomes among Maltese persons assigned female at birth.

The literature reviewed for this study focused on the way education, income, relationship status and religious beliefs impact the contraception choices of women. It also elaborated on how unplanned pregnancies, even when wanted, can have various long-term repercussions for mother, baby, the family, and the rest of society. It further highlighted how effective policies to be fair and equitable need to keep human rights and reproductive justice principles at their core because various complex societal and cultural issues interact and may affect women's contraception decisions.

This study provides previously unavailable insights into the reproductive choices, the number of births, miscarriages, and abortions of over 2000 Maltese women. The data for this study was collected through an anonymised survey which was posted on social media between February and March 2022. This questionnaire garnered over 2500 responses, mostly from women with a tertiary level of education. 76% of participants confirmed they are currently using some form of contraception. However, most respondents use the more unreliable methods like withdrawal and condoms, and this could explain the high number of unintended pregnancies reported. Unplanned pregnancies are the result of lack of contraception use, inconsistent use or due to contraception failure. Only just over a quarter of respondents use the more reliable modern methods of contraception such as the oral

contraceptive pill and intrauterine devices. Besides being more reliable, these methods allow women to be more in control of their fertility.

This study concluded that Malta needs a robust family planning policy and to conduct well-funded, professionally designed national research on family planning. More studies are needed to investigate further the numbers presented in this study.

Keywords: family planning; contraception use; unplanned pregnancy; reproductive justice; persons assigned female at birth.

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ABBREVIATIONS

CDC	Centre for Disease Control
COE	Council of Europe
FREC	Faculty of Research Ethics Committee
GREVIO	The Group of Experts on Action against Violence against Women and Domestic Violence
GP	General Practitioner
Gynae	Gynaecologist
HBSC	Health Behaviour in School-aged Children
ICPD	International Conference on Population Development
IUD	Intrauterine Device
IUS	Intrauterine Systems
LARC	Long-Acting Reversible Contraception
LGBTIQ	Lesbian, Gay, Bisexual, Transgender/Transexual, Intersex, Queer/Questioning
LMUP	London Measure of Unplanned Pregnancy
NHS	National Health Services
OCp	Oral Contraceptive Pill
OHCHR	Office of the High Commissioner of Human Rights
PGD	Pre-Implantation Genetic Diagnosis
SDG	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
UN	United Nations
UNFPA	United Nations Population Fund
US	United States
WHO	World Health Organisation

CHAPTER 1 INTRODUCTION

Family planning policies around the world have saved millions of girls' and women¹'s lives and reduced the number of unsafe abortions (Smith et al., 2009). Successful voluntary family planning programmes are those that span over various government services and policies and include the provision of information and access to contraception that allows citizens to plan when, with who and how many children to have whilst being sensitive to cultural norms, attitudes, and practices (Starbird et al., 2016). Family planning also makes economic sense for all involved. Every euro invested in family planning and related services returns a cost saving of more than double that amount. It further allows for girls and women to invest in their education and to delay childbirth thus allowing them to participate more effectively in the labour market (Kanem, 2018).

Family planning is high on the World Health Organisation's agenda and features prominently in the United Nations Sustainable Development Goals for 2030 (United Nations, 2019). In line with human rights conventions and health obligations, most developed countries have robust and well-functioning policies and services dedicated to family planning. Developing countries on the other hand are encouraged and supported to create appropriate family planning policies to improve the lives of girls, women and their children and the larger community (UN Women, 2020).

Many believe that voluntary family planning is the key to achieving healthier, more sustainable societies across the world and can be instrumental in helping to achieve the aims of the five main Sustainable Development Goals (SDG) themed; People, Prosperity, Planet, Peace, and Partnership (Starbird et al., 2016). Family planning positively affects communities by reducing poverty, reducing the rates of unplanned pregnancy, increasing educational opportunities for girls and women, reducing maternal mortality rates and unsafe abortions, reducing the spread of diseases, increasing gender equality, and increasing female empowerment (Starbird et al., 2016). This chapter introduces this study

¹ While the term woman is used throughout the dissertation, this study is inclusive of persons assigned female at birth, which may include trans men and gender non-binary persons.

by first introducing the location of the study and why this research is needed. It then describes the aims and significance of this study, my positioning as a researcher and the layout of this dissertation

The Maltese Context

Malta is a small independent island nation in the middle of the Mediterranean Sea, and part of the European Union. Malta's constitution states that the religion is Roman Catholicism with most of the population declaring themselves Roman Catholic (Scroope, 2017). The Church in Malta has had a tremendous influence on all aspects of society especially when it comes to sexual and reproductive health and related regulations (Deguara, 2019). All artificial contraception is still forbidden by the Catholic Church, and the only acceptable form of contraception allowed is the Natural Family Planning method (Moviment ta Kana, 2021). Natural family planning involves monitoring and keeping an accurate daily record of one's temperature, and cervical fluids, whilst also keeping a record of other fertility signs (NHS, 2021). Abortion laws in Malta are the strictest in Europe and abortion is not allowed under any circumstances (Gravino & Finkel, 2019). Embryos are protected by the Embryo Protection Act of 2012. The Act was only recently amended to allow for embryo freezing, with pro-life groups protesting the amendments and the Nationalist Party in opposition voting against the bill (Times of Malta, 2018). A more recent bill was however successfully passed through parliament, this time with the support of the opposition, and this new regulation will allow for Pre-Implantation Genetic Diagnosis (PGD), these tests are carried out on embryos prior to IVF processes (Sansone, 2022). Satariano (2020), mentions that the influence and popularity of the church has been in steady decline ever since the introduction of divorce legislation in 2011, and the civil union legislation in 2014. However, although the Church's popularity is waning, the overpowering past influence of the Catholic Church has been blamed as the main reason behind the lack of progressive family planning policies in Malta (Benavides, 2021).

The national health care service in Malta currently offers a comprehensive but at times overburdened service, with the national hospital Mater Dei catering for around 500,000 people from all over the island complemented by health care centres dotted around the

island and supported by an efficient and reasonably priced private primary health care system (Azzopardi Muscat et al., 2014). Health Centres offer Well Woman Clinics once a week offering gynaecology, antenatal, postnatal, and maternal health needs assessments (Health.gov.mt). When it comes to contraception and family planning, Malta, unlike most other developed and developing countries has no recent data on or about the family planning practices of its people. Malta has a dearth of information on the number of current contraception users and what types are most used, and no information is available on the number of unplanned pregnancies, miscarriages or abortions experienced by women in Malta.

Aims and Significance of the study

In this quantitative study the main aim is to identify the family planning practices of Maltese persons assigned female at birth. The research questions framing this cross-sectional quantitative study are:

1. What are the socio-economic correlates (income, education, religion) of contraception practices among Maltese persons assigned female at birth?
2. What are the links between contraception practices and pregnancy outcomes (including unplanned pregnancy, births, miscarriages, and abortion) among Maltese persons assigned female at birth?

This study aims to put forward some previously unavailable insights into the current family planning practices of Maltese women including insights into the number of unplanned pregnancies, miscarriages, and abortion. Amongst other data, data about the knowledge of various contraception methods, and the types of contraception methods currently used by sexually active women of reproductive age will be presented. Tests to check for significant associations between socio-economic factors (income, education, religion) and contraception use will be carried out.

This study is significant because it highlights the importance of family planning for the well-being of society, most especially for women and girls and discusses the importance of framing these family planning policies using human rights (Hardee et al., 2014) and reproductive justice (Ross & Solinger, 2017) principles and values. A human rights and reproductive justice framework can ensure fair and equal treatment for people from all

sectors of society and of different ethnicities, religions, and abilities. By presenting the literature from peer reviewed studies about the socio-economic factors that may affect family planning decisions, the repercussions of non-contraception use and lack of family planning, together with results from local women's current family planning practices, this research aims to aid policy makers when conducting much needed further research and developing policies and services.

Positioning of researcher

As a feminist, I am a firm believer in gender equality and a woman's right to bodily autonomy and self-determination. As a pro-choice activist, I see that an important element of limiting the number of illegal and unsafe abortions is by the implementation of robust family planning policies and the provision and uptake of contraception. Consistent uptake and use, I believe, is only possible through the well-informed choices of empowered women. I am very troubled by the experiences of women arising from unplanned pregnancies. I know from personal experience that unplanned pregnancies even when wanted, can have an adverse impact on women's lives but most especially impact vulnerable women and their children. Therefore, this research is close to my heart, and I sincerely hope it will give policy makers the impetus to carry out further much needed research into the repercussions of the lack of proper family planning on whole families and society but most especially on our children.

Dissertation layout

In Chapter 2, both the international and local context of this study and the effects of gender equality on reproductive health will be discussed. Chapter 3 presents the theoretical framework and a literature review on the socio-economic issues around family planning, contraception usage and their impact on society. Chapter 4 outlines the rationale and methodology implemented to carry out this study. In Chapter 5 the results of an online survey with women about their family planning experiences and contraception choices will be presented. A discussion on the findings will be presented in Chapter 6. Chapter 7 will conclude this study, present a summary of the main findings, and outline recommendations for policy, practice, and further research.

CHAPTER 2 THE CONTEXTUAL FRAMEWORK

Introduction

The purpose of this chapter is to set the scene of the study through placing it in a contextual framework by providing an overview of historical and current developments related to family planning. It starts by looking at major international human rights milestones and goes on to provide a detailed review of the Maltese context. Male power, privilege, oppression, and gender inequality create powerful barriers that affect the decision-making abilities, agency and behaviours of women and girls when it comes to their reproductive health and well-being, limiting their access to proper sexual education, information, and contraception care (Morrison, 2021). The way these aspects interrelate account for the singularity of national responses to family planning and thus, these issues will be discussed in relation to the context of Malta.

The International Context

Over the past 100 years thanks to feminism, the lives of women have changed dramatically. Women gained the right to vote, through gender equality laws and regulations women gained the right to work and to have an education and the right to control their fertility (Benson, 2017). Modern contraception methods played a crucial role in giving women the opportunity to take control of their fertility and the ability to space, time and limit the number of children they have (Benson, 2017). Prior to the oral contraceptive pill women's fertility was historically mostly in the hands of their male counterparts as methods such as coitus interruptus, and condoms were the most used forms of contraception (Satz, 2017). Since then, human rights-based family planning instruments have positively affected women's and girls' lives around the world (Starbird et al., 2016).

In 1968, at the International Conference on Human Rights, family planning – the right for girls and women to decide when, with whom, and how many children to have, if any at all, was acknowledged as a human right for the first time (UNFPA, 2021). Family planning was reconfirmed as a human right in three other international conferences, in Bucharest in 1974, in 1984 in Mexico and in Cairo in 1994 at the International Conference on Population

Development (ICPD) (Singh, 2010). At the ICPD, 179 countries pledged to adopt a programme of action that put reproductive health care, and voluntary family planning, together with safe maternal services and the prevention and treatment of sexually transmitted diseases at the forefront. In September 1995, a diverse group of people, consisting of 17,000 participants and 30,000 activists, the largest ever yet, met in Beijing for the Fourth World Conference on Women. Through this conference, the Beijing Declaration and Platform for Action was developed. The Beijing platform remains a powerful tool for action for the empowerment and equality of girls and women in 12 main areas, one of which is sexual and reproductive health and states that: “The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment” (United Nations World Conference on Women, 1995, para. 17). Reproductive rights as human rights were also reaffirmed 25 years later in 2019 in a conference in Nairobi to mark the 25th anniversary of the 1994 Cairo conference. The Nairobi conference is also known as ICPD+25 with the Deputy Secretary General of the United Nations committing the following:

To uphold the human rights of all people, including their right to sexual and reproductive health and to accelerate all efforts in support of gender equality and the empowerment of women and girls, with a particular emphasis on the most vulnerable and disadvantaged among us, to ensure that no one is left behind (ICPD+25, United Nations 2019).

In 2012 over 150 world leaders, together with leaders from civil society, and private benefactors, met in London at the Family Planning Summit. Together they committed to bringing family planning services to an additional 120 million people in developing countries by 2020 (UNFPA, 2020). In their paper, Hardee et al. (2014) criticised this summit and argued for the importance of maintaining a human rights-based approach in family planning and contraception provision. Organisations raised concerns that these ambitious goals “could signal a retreat from the human rights-centred approach underpinned at the 1994 International Conference on Population and development” (Hardee et al., pg.2). They argued that maintaining a human rights-based approach was central to provision because it enables laws and policies surrounding reproductive health to be scrutinised for inequalities and ensures that all policies follow obligations set out for policy

makers in international law, which have human rights principles at their core. A human rights-based approach also facilitates important human rights values of accountability, empowerment, and no discrimination, and allows full participation for all, taking into consideration the most vulnerable and marginalised whilst also ensuring that services are fair, of good quality, easily available and accessible. According to these authors, basing family planning policies within a human rights framework also ensures that policies are routinely monitored and that systems are in place to hold accountable those that are duty bound to provide such services (Hardee et al., 2014).

Family planning is also an important feature in the United Nations Sustainable Development Goals (SDG) for 2030 under both SDG 3 which targets health and wellbeing, and SDG 5 that targets gender equality. Sustainable Development Goal 5 (SDG 5) focuses on gender equality and aims to “Achieve gender equality and empower all women and girls” by 2030. Target 5.6 specifically mentions sexual and reproductive health: "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents for their review conferences."

The Maltese Context

Although Malta acknowledges and values the importance of the Sustainable Development Goals and that these can only be achieved through global co-operation (Zammit & Zammit, 2020), it still has no official family planning policy and an outdated sexual health policy (Psaila, 2021). The long promised national sexual health policy that was due for release in 2021 was once again postponed because its content was found to be based on outdated data, thus policy makers had to restart the whole process from scratch (Sansone, 2021). Condoms were only made available for sale at the University of Malta in 2015 (Borg, 2015), and emergency contraception only became available in 2016 after the Women’s Rights Foundation filed a judicial protest on behalf of 102 women (Gravino & Finkel, 2019).

Malta is a modern and progressive state, a leader in LGBTIQ rights (Samuelson, 2016), but paradoxically has a questionable track record when it comes to issues surrounding women's reproductive rights, and family planning (Branford, 2016). While in Malta in 2018 Nils Muiznieks, who at the time was the Council of Europe Human Rights Commissioner, penned a letter to then Prime Minister Joseph Muscat reminding him about his obligations towards women's reproductive rights insisting that:

The Committee on the Elimination of Discrimination Against Women and other international bodies have underscored that obligations to guarantee gender equality and non-discrimination require States to respect the right of women to make autonomous decisions about their sexual and reproductive health in general (Muiznieks, 2018, para 11).

The importance of gender equality and reproductive health care was reconfirmed in October 2021, by The Council of Europe Commissioner for Human Rights, Dunja Mijatovic. Commissioner Mijatovic reminded the Maltese authorities that they have the obligation to ensure that women in Malta have the right to equal enjoyment of their sexual and reproductive lives, and this should include the provision of affordable modern contraception services and the right to safe, legal abortion. The Commissioner also insisted that Malta needs to reverse outdated patriarchal structures and engrained societal stereotypes of the "roles and responsibilities of women and men" (Council of Europe, 2022, para. 7). She also said that to encourage the advancement of women's rights and gender equality, the authorities needed to immediately implement further reforms and agree to the Equality Act and the Human Rights and Equality Commission Act without further delay (Council of Europe, 2022).

Naudi et al. (2018) in their study conducted with victims of domestic violence explain how men dominate all aspects of public life in Malta, making it a patriarchal society. A patriarchal society is one where men lead and control most of the highest institutions, from Parliament to top leadership positions in all sectors of society. Their research discusses amongst other issues, how in Malta, many women are still far from equal to their male counterparts, and that this is evident in the high rates of cases of violence against women and domestic violence. They explain that many women in Malta are still not financially

independent but rely on their partners to provide for them, thus creating power imbalances in their relationships. Vella (2018) in her paper about the effects of the barriers of the patriarchy claims that in Malta these patriarchal structures together with the power of the Catholic Church work in tandem to control and limit women's reproductive rights and family planning choices. Women, she says, are still expected to do most of the childrearing and domestic chores, and when it comes to sexual and reproductive rights for women, these are almost non-existent.

Over the past few decades Malta has experienced a rapid decline in the number of births to Maltese women (Milne & Wright, 1997; Savona Ventura, 2012). Despite the lack of free contraception, a lack of family planning policies and the resistance of acknowledging the importance of artificial contraception by the Catholic Church, Malta currently has the lowest fertility rate in Europe (Eurostat, 2019). On the other hand, Malta paradoxically then has one of the highest teen birth rates within the EU, having the highest rate in southern Europe in 2019 at 11.9 teenage births per 1000 girls aged between 15 and 19 (Dibben, 2022). Since abortions are not registered, many suspect that the teen pregnancy rate could be much higher than the teen birth rate (Dibben, 2022). Furthermore, the international Health Behaviour in School-aged Children (HBSC) study of 2020 published by the World Health Organisation Regional Office for Europe found that sexually active Maltese teenagers registered the lowest usage of the pill and condoms. This study reports that 43% of 15-year-old males and 61% of females of the same age did not use a condom or the oral contraceptive pill during their most recent sexual intercourse experience (Inchley et al., 2020).

Malta's population has grown considerably over the last two decades with many migrants and asylum seekers of different ethnicities and nationalities from all over the world calling Malta their home. They currently form around 20% of the population, 9,000 of whom are asylum seekers mostly of African origin (Macrotrends, 2021). Due to the low response rate to the survey received from these groups, this study did not discuss the specific contraception needs of this section of Malta's population, however, these groups need to

be considered in future research as their needs are very likely to be more complex and possibly also more difficult to manage due to potential cultural and religious differences.

Contraception use in Malta

In a rare study about local family planning practices, Crockford (1992) discussed family planning practices of the time and talked about the clinics and the services provided. She explained how from the 1980s until around 1992 there were family planning clinics dotted around the island and these provided free contraception to vulnerable women in the form of the copper intrauterine device known as the copper coil (Crockford, 1992). More recent research from local gynaecologist and historian Savona Ventura (2010) explains how these family planning centres were subsequently closed in 1993 due to pressure from the pro-life movement, and the copper coil was no longer provided for free and removed from the local market. They were removed because the pro-life movement, heavily supported by the Catholic Church, deemed the copper coil as an abortifacient (Savona Ventura, 2012). Catholics believe that personhood starts at fertilisation and since the copper coil can potentially prevent a fertilised egg from implanting onto the uterus, it was and still is considered as abortifacient (Manson, 2012).

Most modern methods of artificial contraception are nowadays available in Malta against payment, all require a doctor's prescription except for Emergency Contraception and condoms which are available over the counter (Montanaro Gauci, 2020). From the little that is known it seems that women usually procure their prescription for contraception from their GP or their gynaecologist. Very few use the free Well Woman once weekly clinics where contraception can be prescribed, and women can also be seen by a state employed gynaecologist after a referral from the health centre GP or from their private GP (Health.Gov.mt, 2021). Women who use the state services may have to wait for at least three weeks for a gynae appointment at a health centre. Many women prefer not to wait and go to a gynaecologist or GP privately, paying for the service themselves. However, some women in Malta still experience a variety of barriers to accessing contraception or voluntary sterilisation (Savona Ventura, 2012). In October 2021, the Nationalist Party promised free contraception including the morning after pill for all women within 6 months

of their successful accession into power (Calleja, 2021). Following this, on Women's Day in March 2022 the Malta Labour Party also pledged to offer free contraception including intrauterine devices and free women's sanitary products that they said would be distributed at pharmacies (Magri, 2022).

Chapter Summary

This chapter provided an overview of major international milestones related to family planning and an account of the Maltese context in relation to gender inequality and sexual and reproductive health. The next chapter highlights research from other countries which may help to understand how similar issues can create potential barriers towards access and use of reliable methods of contraception for Maltese women. Literature outlining the possible effects of religion, education, income, and gender inequality on contraception use, together with research on unplanned pregnancy and its repercussions will also be presented.

CHAPTER 3 LITERATURE REVIEW

Introduction

In this chapter a review of the literature about the possible socio-economic factors affecting family planning and contraception decisions and the effects of unplanned pregnancies will be presented. First, the theoretical framework of this study is introduced based on the principles of Reproductive Justice. This is followed by discussion of academic studies highlighting experiences in countries where family planning policies and contraception use is given importance

Research for this review was mostly conducted online through Hydi, the University of Malta's online library, Google Scholar, and other relevant websites such as that of the World Health Organisation (WHO) and the United Nations Family Planning and Population (UNFPA). The main keywords used were *socio-economic, contraception, family planning, unplanned pregnancy, reproductive justice, social justice, human rights, women, poverty and unintended pregnancy, gender equality and family planning, family planning associations, history of contraception*. Most studies used were published within the last ten years.

Reproductive justice as a theoretical framework

The reproductive justice framework was established due to the historic reproductive oppression and abuse experienced by women of colour and has been described by social justice organisations as “an analytical framework and a social movement for self-determination” because it “combines” reproductive rights and social justice to create a reproductive justice framework, offering a way to look at women's reproductive lives in their full complexity and entirety (SisterSong.net, para 3). Since many black, poor, and marginalised women suffered injustices such as forced sterilisation, and higher maternal mortality rates it was important especially for black women to come together to respect the needs, decisions, rights, and choices of their women (Ross & Solinger, 2017). The term Reproductive Justice was coined in 1994 by SisterSong, a collective of black women activists. SisterSong define reproductive justice as “the human right to maintain personal

bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (SisterSong.net, para. 1). Many people assume that reproductive justice and reproductive rights are the same thing, however they are “philosophically different” (Osub & Gamble, 2017, para. 1). Reproductive rights place an emphasis on the right of access to safe legal abortion and contraception, whereas reproductive justice is broader and combines other aspects that affect a women’s access to reproductive health, such as the social, political, and economic difficulties that many women, especially vulnerable women face when trying to access safe abortion, contraception, or other family planning needs.

Reproductive justice moves away from the pro-choice/pro-life dichotomy that many black and marginalised women were very uncomfortable with (Daniel, 2021). Liddell (2018), in her review of the literature on the use of the reproductive justice theoretical framework by social workers concluded that oftentimes marginalised women were further disadvantaged by those using the reproductive rights argument of “choice”. Liddell (2018) mentioned that certain organisations when using a reproductive rights and health framework referred to vulnerable women’s choices as “poor choices”. Liddell (2018) explained that this put the blame on the individual woman instead of concentrating on the social and institutional hurdles or barriers she might have had to face. A reproductive justice framework on the other hand allows policy makers, social workers, and health professionals to ask questions taking a more holistic approach and allows them to counteract the oppressing intersecting power structures that interact with race, class, sexuality, gender, and religion (Liddell, 2018).

Reproductive justice also advocates for comprehensive sex education policies and freedom from any form of sexual violence and for safer communities free from discrimination and racism (Osub & Gamble, 2017). Using reproductive justice principles when designing and creating family planning policies enables policy makers to also cover the wider aspects of family planning (Daniel, 2021). Under the reproductive justice principle - the right to have children - policy makers may consider policies for couples that may need fertility treatments. They may also consider birth justice, and choices for women like home births

and the right to have a doula present, and the prevention of forced sterilisation (Daniel, 2021). The option and principle of the right not to have children covers issues of accessibility to, availability of quality contraception, together with the right to safe legal abortion, and after abortion care or the right to voluntary sterilisation (Ross & Solinger, 2017). The reproductive justice principle that parents should have the right to parent in safe and healthy environments may be associated with the rights to education, lack of racism, fair treatment by police, and adequate adoption laws (Daniel, 2021).

Eaton and Stephens (2020) in their paper on the importance of using a Reproductive Justice framework in research about women's reproductive health choices explain that this framework is significant because it recognises that women's and girls' reproductive health choices are influenced and "shaped by systemic oppressions (e.g. racism, sexism, classism, heterosexism which affect their ability to make meaningful choices about their reproductive lives" (Eaton & Stephens, 2020, p.209). They explain that researchers and health care workers must keep in mind that oftentimes women and girls make reproductive health decisions based not on their individual preferences or needs but because they are influenced by their family, communities, political, cultural, and social interactions that come together to affect their decisions. Eaton and Stephens (2020) explain that the reproductive justice framework highlights the complicated, multi-layered, gendered, social and political issues surrounding women's reproductive health choices, whilst also uncovering and taking into consideration systems of oppression, privilege, and power.

Tracy Morison (2021), a researcher with a special interest in reproductive health, tells us that reproductive justice as a framework is often under-utilised by certain researchers but is valuable for studies covering sexual and reproductive issues, because it offers a "cross-disciplinary feminist framework founded upon notions of human rights and intersectionality" (Morison, 2021, p. 2). Applying a reproductive justice theoretical framework enables researchers to take a fairer, more comprehensive, intersectional, and holistic approach whilst conducting studies on the topic of reproduction, family planning and contraception, because it also considers the social inequalities and differences in opportunity for certain communities. She tells us that it is especially useful as a framework

for explaining the phenomenon coined as the 'contraception paradox' by Gomes et al. (2018). The 'contraception paradox' discusses the issue surrounding contraception and oppression for vulnerable women. Although contraception has been hailed as the most important factor for women's empowerment, Morison (2021) explains that some feminist researchers are also concerned that for some women contraception can also become a form of oppression, especially with the rising popularity of long-acting reversible contraception (LARCs) in the form of IUDs and injectables. Morison (2021) explains that while contraception has resulted in economic, social, and political empowerment for many women, for others, especially marginalised, disabled, black, young, or vulnerable women, contraception can result in those in power exercising control over women's fertility and their reproductive choices. Morison (2021) in her paper reconfirms research by Bhan and Raj (2020) that posits that access to, and availability of contraception alone does not automatically translate to women's agency or empowerment over their reproductive health choices. This seems to also be the case for women with learning disabilities as history shows that women with learning disabilities may not have always been afforded the right to make their own contraceptive choices. The Depo-Provera injection is very commonly used amongst this group, and a larger number of young women with learning disabilities are also using IUDs. Many women with learning disabilities have very low usage rates of barrier methods when compared to women from other groups. The pill has also often been prescribed to women with learning disabilities who were not sexually active and who did not have menstrual health issues (McCarthy, 2009).

Reproductive justice as a theoretical framework was first adopted in literature to empower and fight for the rights of black, marginalised, and poor women whilst also keeping in mind an intersectional approach, however the literature shows that reproductive justice as a framework can and should be applied to policies in a variety of fields and areas of study or research that affect people's reproductive health, rights, and choices, regardless of socio-economic status, race, ability, religion, or nationality (Osub & Gamble, 2017).

Gender inequality and family planning

As discussed in Chapter 2, Malta is still very much a patriarchal society. The Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) in their baseline report of Malta in 2020 noted that laws were in place in Malta that aimed to ensure equality between men and women however the report also mentions that Malta is not even yet halfway to acquiring gender equality and noted

that gender inequality, patriarchal attitudes and gender roles are deeply rooted in Maltese society. The expectation that women should remain with their male partners at all costs and that their primary role is to care for the family is one of its consequences (p. 14).

These power imbalances between men and women have been shown to affect contraception and family planning decisions and research on reproductive and maternal health highlights the importance of putting women's empowerment and gender equality at the forefront to ensure better health for women and their families (Bhan & Raj, 2021). In a recent study funded by the Bill and Melinda Gates Foundation and published in *The Lancet*, Bhan and Raj (2021) outline the importance of choice and agency for women in global family planning programmes and discuss how some family planning programmes can increase instead of decrease gender inequality by perpetuating gender norms through placing strong pressure on women to become mothers. Such policies and practices may hinder instead of improving women's and girls' empowerment, gender equality and reproductive agency. Bhan and Raj (2021) found that often family planning programmes define their success by whether there is adequate availability and use of contraception, defining this as the sole successful indicator of whether women have agency and choice. However, these authors maintain that the availability or uptake of contraception does not necessarily translate into a realistic indicator of a woman's individual right of choice, because oftentimes women and girls are not exercising their own fertility preferences but are heavily influenced by social and community norms. Therefore, access does not necessarily lead to reproductive agency which they define as "the ability and action to achieve one's own health, wellbeing, and fertility goals" (Bhan & Raj, 2021, p. 99). Their research shows that putting sole emphasis on uptake of contraception use without

ensuring female empowerment and reproductive agency can have negative repercussions on girls and women's fertility and contraceptive choices, with vulnerable and marginalised women being mostly affected by these current practices (Bhan & Raj, 2021). They recommend that policy makers and service providers in the field of reproductive health and contraception provision address issues of "gender inequalities within households and communities as well as those within health systems" (Bhan & Raj, 2021, p.101). This, they say will help to ensure that women and girls are truly the decision makers when it comes to planning their fertility and reproductive needs. Furthermore in 2019, The Lancet published an in-depth series of five papers about gender equality, norms, and health. In part one of the series, Heise et al. (2019) explained how "sexism and patriarchy" intersect with other forms of discrimination and oppression such as racism, classism, to create serious negative impacts on health outcomes throughout one's life course. This first paper in the series throws a spotlight on the negative effects on people's health that are perpetuated by gender stereotypes and society's expected gender norms. They explained how gender unequal social structures, systems, policies, and institutions all interact to form discrimination and oppression that can have negative health effects, and negative repercussions on health care systems for all people, but most especially on women, girls, and minorities. Heise et al. (2019) argued that narrowing the gap of gender inequalities may result in yielding "multiple downstream benefits for health and development" (p. 2440). In this global study, Heise et al discussed how male privilege can affect all people from all walks of life but most heavily affects poor women and girls restricting their health and economic advancement in various settings and not only in developing countries (Heise et al., 2019). Heise et al. (2019) explained, in depth, how the multi-layered, complicated relationship of health and gender intertwine with other power structures to create gender health inequalities that start even before one is born, with the knowledge of a baby's biological sex. Heise et al., (2019) also refer to a study by Zaikman et al. (2016) which discusses how later as adults, males and females are exposed to sexual double standards and unequal gender norms for the same sexual behaviours. Males are encouraged to be sexually dominant, skilful, sexually experienced, and to have multiple partners. These attitudes they say are associated with a lack of condom use and sexual risk taking, and culturally contraception is not something that is discussed before participating in sexual

intercourse. Whilst on the other hand women in some societies are still expected to be chaste and pure and not meant to be sexually promiscuous. This in turn can lead to coerced sex, rape, sexually transmitted diseases, and unplanned pregnancies.

The main points put forward in this five-part Lancet series are that gender inequality and repressive gender norms, whilst separate, are both important factors that affect people's health, well-being, and reproductive choices. This series threw a spotlight on how lack of gender equality, lack of female empowerment and agency may lead to poorer health outcomes and reproductive choices. These gender equality issues with regards to contraception choice need to be taken into consideration most especially in patriarchal countries like Malta where bodily autonomy is non-existent, and women's rights are often ignored (Vella, 2021) because empowerment through gender equality, ensures that women and girls have agency to decide and make their own reproductive choices, achieve their own goals, irrespective of what is expected or allowed by the social norms of the countries they live in (Bhan & Raj, 2021).

The influence of religion and socio-economic status

Socioeconomic status is described by the American Psychological Association (APA) as comprising of "not just income but also educational attainment, financial security, and subjective perceptions of social status and social class" (American Psychological Association, 2017, para. 1). Socioeconomic status is touted as being able to forecast physical and psychological health outcomes as well as standard of living, and other opportunities and privileges affecting one's social standing in society (American Psychological Association, 2017). Religion, and low socio-economic status have often been associated with low contraception uptake and higher unplanned pregnancy rates and these factors also affect decisions of whether to keep or terminate an unintended pregnancy (Metcalf et al., 2016). Arousell et al. (2019) claim that "'low socioeconomic status' and 'religious barriers' have gained status as nearly universal explanatory models for why women in minority groups are less likely to use contraception than others" (para. 2).

The association between religion and contraception use is complicated and not straight forward (Moreau et al., 2013). Many factors influence this relationship; different religious denominations, level of involvement, a particular religion's beliefs on gender, and the influence of a particular religion on a society and its cultural norms (Moreau et al., 2013). Furthermore, different types of contraception have different efficacy rates and potential side effects and certain types may be culturally and religiously controversial and even unacceptable (Poncet et al., 2013). Srikanthan and Reid (2008) explain that every woman is an individual with her own health care needs and that many women may not follow the religion or cultural norms of the society they live in. They remind health care providers to be careful of not applying stereotypical religious norms when women seek contraception advice but on the other hand, they do need to recognise that these norms oftentimes influence a woman's decision making when it comes to contraception choice.

Metcalf et al. (2016) conducted a study with over 4000 women in Canada about the relationship between socioeconomic factors, method of contraception and unintended pregnancy. Through this study, which consisted of a self-administered questionnaire, they found that religious and cultural beliefs affected the type of contraception used. Barrier methods such as condoms were seen as being more natural and acceptable with religious participants. In 2013, Moreau et al. conducted a study called "Religiosity, religious affiliation, and patterns of sexual activity and contraceptive use in France". This study drew data from the 2005 Health Barometer survey, and data from a random sample of over 7000 women and over 5000 men between the ages of 15 and 44 was analysed. This study also found that Catholic religious women were less likely to use the more effective and reliable forms of contraception such as hormonal methods or IUDs. The authors remarked that this could be because the Catholic religion is very against any form of artificial contraception. They did not find the same significant associations with contraception effectiveness among Muslim women. These findings were also confirmed by Arousell et al (2019) in their qualitative study with 20 self-identified pious Muslim women in Sweden and Denmark. In this study, religion was not in any way found to be a barrier for Muslim women to use contraception, on the contrary, family planning was seen as an important aspect of being a respectable Muslim woman.

In France, studies have found low socio-economic status and vulnerability of minority groups to be the main reasons for lack of proper contraception use and that the use of more expensive, more reliable methods such as IUDs and IUS also known as LARCs are associated with high socio-economic status (Poncet et al., 2013). In Poncet et al.'s study, unemployment and low education levels were found to be associated with low contraception or no contraception use especially among migrant women, while for non-migrants, oral contraceptive use was highest in this group. Metcalfe et al.'s (2016) study also confirmed that socio demographic factors can affect contraception use, choice, and pregnancy termination. In their Canadian study, they found that no contraception use and non-use of hormonal contraception was associated with low educational achievement, however no statistically significant differences were found between income and type of contraception used within their sample. In contrast, a qualitative research study in Denmark and Sweden by Arousell et al. (2019) that sought to determine whether low socio-economic status and religiosity are barriers to contraception use among Muslim women found that low educational attainment, and low-income were not barriers to contraception use for this group. Arousell et al. (2019) found that for many of the women in their study, living in difficult financial situations, or being of lower socio-economic status, in contrast to current knowledge, was the prime motivator for using contraception, and priority was given to the number, spacing and timing of their children. A more recent study by Zvavitch et al (2020) in the United States established that educational attainment played an important part in contraception usage. They found that the higher the level of education attained, the more likely a woman was to consistently use contraception. Zvavitch et al. (2020) also contended that women with higher education have systems and support structures, access and privileges that may "buffer" the effects of consistent or inconsistent contraception usage in contrast to vulnerable and underprivileged women who have none of these buffers. Whereas all women irrespective of their socioeconomic background and status were sexually active, being black or vulnerable, with low education was once again reconfirmed as being more highly associated with unintended pregnancy.

The findings by Zvavitch et al. (2020) show that low socio-economic status and low educational attainment lead to inconsistent use of contraception and these factors

increase the risk of unplanned pregnancy. Contraception effectiveness, reliability and cost differ greatly between methods from the least effective being free (withdrawal and Natural Family Planning) to the most effective methods such as Long-Acting Reversible Contraceptives (LARC) being the most expensive (Mc Nicholas et al., 2014). A large study in the USA by Mc Nicholas et al., (2014) with over 9,000 women found that LARC users are 22 times less likely to have an unplanned pregnancy than other users. The CHOICE study found that when barriers to access such as cost, low knowledge, and fears about side effects were removed through proper counselling, provision of information and by allowing women to choose whatever contraception they want at no cost, women always choose LARCs in the forms of IUDs, IUS, and implants above all the other forms on offer (Mc Nicholas et al., 2014). Women were also more likely to continue using these methods long term as opposed to other methods which they were more likely to discontinue (Mc Nicholas et al., 2014). Consistency and adherence are important to prevent and limit the number of unplanned pregnancies (CDC, 2022). In the UK, providing teens with accessible long-acting reversible contraception (LARCs) resulted in halving the number of unplanned teenage pregnancies (Skinner & Marino, 2016). Thanks to the holistic approach adopted in the Teenage Pregnancy Strategy which consisted of a “combination of sex and relationship education, increased access to contraception and social inclusion strategies” teenage pregnancies in the UK were reduced to less than half (Skinner & Marino, 2016, p. 539). This ten-year strategy ran between 1999 and 2010 and consisted of a complex whole-government, well-funded programmes. The strategy successfully managed to cut teenage conception rates in the UK by 51% (Hadley et al., 2016) because it was “driven nationally and implemented locally with ringfenced funds, good training, joined-up departments and constant checking to see where and why it was working best” (Toynbee, 2013, para. 1).

Research from the UK also shows that women use different types of contraception throughout their life course, depending on their individual needs, their age, and relationship status and cultural norms (Firman et al., 2018). Relationship duration and age were the main influences on women’s type of contraception choices in the study by Firman et al. This research found that 26% of 16to 49-year-old women used the OCP as their primary method. Barrier methods and the OCP were the most popular methods among

younger women, and women in short term relationships. The use of these methods decreased with age, and the use of unreliable or no methods increased with age, they assume this is because it is more important for younger women in unstable relationships to avoid getting pregnant than for older women, or for women in more stable relationships. In France, for women in a new relationship, women who have multiple partners and women who are not in committed relationships, it is the norm and expected for condoms to be used. Women usually use the oral contraceptive pill when they are in more stable relationships and the use of IUS and IUDs is associated with women who have already had their desired number of children (Poncet, et al., 2013). Better understanding of various contraception methods used by women in different types of relationships, and their age may lead to better contraception provision and lead to more user discontinuation, which may also lead to lowering the number of unplanned pregnancies (Firman et al., 2018).

Unintended Pregnancies: Prevalence and consequences

Unplanned pregnancies are a result of both a “failure to use contraception and contraception failure” (Metcalf et al., 2016, p. 4). In the United States, almost half of all pregnancies are unintended (Aiken et al., 2015; Kost et al., 2015; Singh et al., 2010). In the UK, Public Health England (2018) estimated that 45% of pregnancies are unplanned. In Europe, reports show that unplanned pregnancies amount to around 43% of all pregnancies. This figure was announced at the launch of the Europe-Wide Contraception Atlas of 2019 where the message from MEPs was clear: much more must be done to reduce the number of unplanned pregnancies (Hutchinson, 2019). Unplanned birth rates globally were found to be approximately 38% but few developed countries have proper estimates of unplanned birth rates (Singh et al., 2010). Barton et al. (2017), Singh et al. (2010) and Kost et al. (2015) all argued that trying to understand unplanned birth rates and their consequences retrospectively is complicated because many women who might have at the time of conception classified their pregnancy as unintended would later, once having had the child, be unlikely to refer to their child as having been unplanned or unwanted. Retrospectively asking about pregnancy intentions either at birth or after birth about pregnancy intention is unreliable, due to “rationalisation bias” (Rackin & Morgan, 2018 p. 61). These authors explain that mothers are unlikely to later admit that the child was

unwanted at the time of conception. On the other hand, prospective analysis relies on asking respondents about future pregnancy intention long before they conceive. This time lapse may create bias and not reflect the reality of future wanted or unwantedness at time of conception (Rackin & Morgan, 2018). Klerman (2000) in her study about the feelings and attitudes towards pregnancy intendedness tells us that studies show that many women although experiencing an unplanned pregnancy due to contraception failure, are still very happy to find themselves pregnant and this can be another reason for skewed data when measuring for pregnancy intendedness. At the time of writing, Malta has no current statistics on the number of unintended pregnancies, or unplanned births, but the number of abortions carried out by Maltese women is estimated to be around 300 to 400 per year (Smith-Galer, 2021).

Limiting the number of unintended pregnancies should be high on every country's health agenda because unintended pregnancies have various negative repercussions and adverse health outcomes for both mother and baby, such as post-partum psychological distress (Barton et al., 2017), poverty (Zvavitch et al., 2020), physical and mental health issues for women and lower birth weight for babies (Kost et al., 2015). In the United States, Singh et al (2010) found that unplanned births are associated with lower birth weight, delay in receiving prenatal care, possible maternal physical and mental health issues, and poorer behavioural and educational results for children. However, Singh et al. (2010) reported that more research is needed in this area, especially research that studies the socio-economic factors, mental health, and relationship situation of mothers prior to conception. Kost et al (2015) in their research that consisted of an intensive study of unintended pregnancy intentions and birth outcomes using the US National Survey of Family Growth, developed innovative "more-nuanced measures of pregnancy intentions than used previously" (para. 4). First, they ensured to also measure the length of time by which the mistimed pregnancy was badly timed since previous research had found that if the baby was mistimed by over two years it was more likely to also be unwanted. They also measured the level of want or "desire" for the pregnancy. They then took note of the mother's characteristics such as age and socio-economic status whilst also considering the mother's background prior to conception. This allowed them to evaluate the different personal demographic and

socioeconomic status of these mothers. Their innovative research strategy confirmed that there are many “observed associations” between a woman’s pregnancy intendedness with her behaviour whilst pregnant and these behaviours can affect the future outcome for her offspring. They confirmed that women who gave birth to badly timed or unwanted babies had taken longer to acknowledge their pregnancy compared with mothers who had planned their pregnancy, resulting in delayed pre-natal care. Furthermore, babies born as a result of an unplanned pregnancy were less likely to be breast fed. Unplanned and unwanted babies, they confirmed, were also more likely to have lower birth weight (Kost et al., 2015). In a retrospective study, the only one of its kind using longitudinal contraception use information and data from the National Survey for Family Growth and National Longitudinal Survey of Youth 1997, Zvavitch et al. (2020) found that inconsistent users of contraception in the two years prior to conception were more likely to experience unplanned pregnancies and this is more likely to lead to poverty in the first year after birth especially among black women and women with low educational attainment. In fact, being white, married, living with both parents until the age of 18, having few children, achieving a high level of education, and having been employed for at least 6 months prior to having children were all reconfirmed in this study as important mitigating factors for not falling into poverty after giving birth.

Studies from the UK show that unplanned pregnancy is estimated to be around 41% of all pregnancies and is usually erroneously associated with lone motherhood and teenagers, however one in three pregnancies in partnered couples are also unplanned (Barton et al., 2017). In their study about the possible psychological distress associated with unplanned pregnancy in partnered women, Barton et al. (2017) tell us that symptoms such as anxiety, depression, and low moods can have negative repercussions on both the mother, her child, and the rest of the family. In their review of the data taken from the Millennium Cohort Study in the UK using data that tracked babies born to over 18,000 families between the years 2000 – 2002, Barton et al. (2017) analysed and studied the effects of unplanned pregnancies on partnered women. For their research pregnancies were classified into the following categories:

“Planned” (stated the pregnancy was planned); “unplanned, happy” (stated the pregnancy was a surprise and recalled being happy/very happy upon discovery of pregnancy); “unplanned, ambivalent” (stated the pregnancy was unplanned and they “were not bothered either way”) and “unplanned, unhappy” (stated the pregnancy was a surprise and recalled being unhappy/very unhappy upon discovery of pregnancy) (Barton et al., 2017, para. 9).

This extensive study reconfirmed that even in partnered women, unplanned pregnancies are more common among more vulnerable groups, more common for women where poor relationships are reported and where there is a lack of social support structures, and for black and ethnic minorities. The study also found that partnered women experiencing an unplanned pregnancy also suffered psychological distress when screened at nine months postpartum and this was most evident in the women who reported their pregnancy to have been unplanned/ambivalent but most especially in those who stated that they were unhappy about their unplanned pregnancy (unplanned, unhappy). The Barton et al. (2017) study concluded that since the results were nearly 15 years old at the time of publishing, significant societal changes might have possibly affected results with regards to attitudes towards single parenthood due to change in societal norms. At the same time, such changes would not have influenced or changed the psychological effects of unintended pregnancy on partnered women. Barton et al. (2017) concluded that it was not the relationship status that determined the mother’s mental health postpartum since even women in stable relationships who had experienced an unplanned pregnancy, especially those with limited support, suffered from psychological distress and thus recommended that partnered couples who had unplanned pregnancies, like lone mothers, would also benefit from more frequent postpartum follow-up mental health care.

Chapter Summary

This chapter highlighted the important values and principles of the Reproductive Justice framework and how these principles based on established human rights help in ensuring fair and equitable family planning policies. The literature reviewed shows how the patriarchy, gendered norms and lack of female agency and empowerment can limit a woman’s fertility choices. Literature showing how religion, socio-economic factors, relationship status may influence contraception choice and use and the possible negative

repercussions of contraception failure leading to unplanned pregnancies was also reviewed. From this brief review of the literature one can better understand how important family planning policies are for gender equality and how they should form an integral part of a developed country's welfare and care system to ensure societal health and well-being most especially for women and girls. The next chapter will describe the methodology used for this study.

CHAPTER 4 METHODOLOGY

Introduction

This chapter outlines the methods and tools used to gather the data required for this study, the rationale for choosing these tools, the sampling design, the ethical considerations, and the analytical tools used. Furthermore, the strengths and weaknesses of these methods are also described.

Research questions and hypothesis

This study aims to answer the following research questions:

1. What are the family planning and contraception practices of Maltese persons assigned female at birth?
2. What are the socio-economic correlates (income, education, religion) of contraception practices among Maltese persons assigned female at birth?
3. What are the links between contraception practices and pregnancy outcomes (including unplanned pregnancy, births, miscarriages, and abortion) among Maltese persons assigned female at birth?

Following the review of the literature, the following hypotheses in relation to the second research question were developed to be tested:

- There is no relationship between religiosity and contraception method.
- Higher religiosity is associated with use of less reliable contraception methods (e.g., natural family planning, withdrawal method)
- There is no relationship between level of education and contraception method.
- Higher level of education is associated with use of more effective contraceptive methods (e.g. LARCs)
- There is no association between income and contraception method.
- Higher levels of income are associated with use of more effective contraception methods.

The implications of the third research question will be answered through descriptive statistics.

Research method and design

A quantitative methodology was used in this study because quantitative methods are used in research to gather data about social phenomena in quantifiable terms since quantitative

studies enable researchers to measure the numbers and prevalence rates from their sample (Bhandari, 2020). Quantitative research and positivist frameworks are not usually popular research methods with feminist researchers who usually prefer to use more subjective, qualitative approaches (Hesse-Biber, 2012). However, Sprague and Zimmerman (1989) maintained that quantitative research adds “validity to feminist research projects” (Sprague & Zimmerman, 1989, p. 9). Many feminist researchers nowadays also understand that for certain topics especially personal or controversial ones, quantitative research offers a less invasive way of collecting data as opposed to the previously preferred qualitative methods (Lewis-Beck et al., 2003). It was important to use a quantitative methodology because to use this study for policy advocacy, robust data was needed that can be accurately measured and possibly also generalised to the rest of the female population, since policy makers rely heavily on quantitative data to make informed decisions (Munda et al., 2020). Descriptive quantitative research methods are used to answer what, where and when questions which were needed to gather information on how many women are currently using contraception and to quantify which types are the most popular methods used.

A cross-sectional study was used because as Kesmodel (2018) explained, a cross-sectional and descriptive study allows for the researcher to take a picture of current practices in place at a particular point in time. A cross sectional study can be used to generalise the results to the rest of the sample population even if conducted with a small representative sample. Using a cross-sectional study allows researchers to conduct a relatively quick study, whilst collecting data on different variables and multiple outcomes, together with relevant demographics. This cross-sectional study with women created the opportunity to quantify and identify the prevalence of contraception usage and failure rates leading to possibly determining an unintended pregnancy rate and contraception uptake rate. Cross-sectional studies are also recommended by Bryman (2016), for researchers who are interested in discovering relationships between variables.

Survey design and instrumentation

The research tool used, comprised of a questionnaire which consisted mostly of closed ended and multiple-choice questions, asking what, when, where and which questions (See Appendix 1). The survey was designed using Survey Monkey and consisted of 36 questions and was published on social media on the 17th February 2022 and remained open until the 9th of March 2022. The first section concentrated on demographical information, such as age, educational level, ethnicity, and number of children. The second section asked about knowledge of different contraception methods and about contraception use throughout the life course. The questions for this section were adapted from the New Zealand Family Planning Survey 2020. The third section consisted of questions relating to pregnancy which were adapted from the London Measure of Unplanned Pregnancy (LMUP) (Barrett, 2002) and asked about pregnancy intention, number of pregnancies and their outcomes.

Before launching this questionnaire, the survey was piloted extensively with various users between December and February 2022. After feedback from a diverse number of contributors who kindly agreed to reply to the pilot questions, the survey was updated and amended multiple times until there was no doubt that the questions were easy to understand and to respond to. The pilot survey which I shared with around 40 friends also enabled me to practice exporting and analysing data. This dummy data allowed me to become familiar with the analysing software SPSS.

Reliability and validity

To ensure internal validity and reliability numerous changes were carried out on the original questionnaire, this was done under the guidance of supervisors and only possible thanks to the patience of a group of around 40 volunteer test participants who agreed to help with the piloting of the survey. Piloting is an invaluable part of making sure that information gathered is collecting the data the researcher set out to collect and checks the validity of questions. Piloting also ensures that the technicalities are all ironed out beforehand (Cleave, 2021). The survey was designed in English but also translated into Maltese.

Drost (2011) in her paper entitled Reliability and Validity explains that reliability is measured by how possible it is for other researchers to replicate a study and how “repeatable” (Drost, 2011 p. 105) a study can be when conducted by another researcher and if it can gain the same results under different conditions, at different times, even possibly using different instruments. Reliability was checked using a test-retest system. Test-retest consists of conducting a study with a specific group of respondents and then conducting the same study once again at a later date (Morrison, 2019). The responses are then compared to check for consistency and the data analysed to check if respondents answered in the same way. This was done before launching of the survey. The final version was piloted and re-tested with different groups of people and the data collected was briefly analysed for consistency. The week after, the same sample was asked to retake the survey again to ensure that the data produced was similar and no issues occurred. Although this was a very small group of “test” respondents using this test-retest system also allowed to check for validity. Drost (2011) explains that to ensure validity researchers must be careful that they are collecting the data they intended to collect, and she gives the example of an IQ test – and explains that researchers must verify if the test being conducted measure intelligence. The initial data collected from the pilot proved to be valid and returned clear results. The data and answers received were clear, to the point, without issues or need for clarification from respondents and results were consistent and what was expected.

Sampling and data collection

After thorough consideration, it was decided that given the scope of the study and the limited resources, the most practical way to collect data would be by using a convenience sampling method. “A convenience sample is one that is drawn from a source that is conveniently accessible to us” (Chittaranjan, 2021 p. 86). Convenience sampling cannot be used to generalise results to the rest of the population, but only generalised to the subpopulation from where the sample is taken (Chittaranjan, 2020). Originally, the plan was to use stratified random sampling, however this proved to be too complicated and not possible to extract this sample data without incurring major expenses.

It was also decided that the recruitment of the sample for this survey would be through social media, since it was convenient and would be relatively effective to access participants through social media as there are many women only local groups. This decision was taken because in Malta “almost nine out of 10 persons aged between 16 and 74 years used the internet in 2021” (NSO, 2022 pg.1). From this population, 92.2% use the social media platform Facebook (Kemp, 2022). The website Napoleon Cat stated that in 2020, 46.7% of the total number of Malta’s Facebook users were women, together with other statistics showing that a high percentage of these 46.7% are women of reproductive age. Women of reproductive age were the main population required as participants for my survey. These statistics provided the main reason and help needed in deciding that an online survey was the more effective and most efficient tool for gathering the type of data required.

Evans and Mathur (2018) explained how due to technological advancements online surveys provide many advantages over traditional methods such as ease of use for both researchers and participants, forced completion of questions, quick analysis tools, availability on a variety of hardware such as mobile phones, tablets, laptops and are quick and cost effective. Due to the nature of the survey, it was important that participants felt comfortable and safe answering these questions. Questionnaires in the past used to be conducted either face to face, over the telephone, or by mail oftentimes with interviewers acting as intermediaries and possibly also injecting interview bias or even creating participant discomfort when asking personal questions (Evans & Mathur, 2018). The data collection platform Survey Monkey allowed for total anonymity of participants and no personal electronic information was collected or any other identifying data, and settings were set to not allow respondents to take the survey more than once. Nowadays respondents can answer questions in their own time and from wherever is most comfortable for them (Mahmutovic, 2021), something that would not have been possible with face to face gathering of data.

Data collection and analysis

Data was collected by sharing the link to the survey extensively on social media, mainly on Facebook and Instagram. Between 16th February and 9th March 2022 the survey was posted and shared mostly on social media groups such as Women for Women (Malta) a woman only Facebook group with over 45,000 women and Ommijiet Nghidu Kelma Flimkien, which has over 34,000 female members. This latter group is mostly Maltese speaking. The survey was also shared on other popular discussion groups such as The Salott which has a mixed gender population using both languages - all persons assigned female at birth and over the age of 18 were eligible to participate. These popular groups have varied female audiences with women from all walks of life and of all ages participating daily in discussions. The survey was posted in both Maltese and English. The survey was also posted on Instagram. In total, 3,167 responses were received, out of which a total of 2,851 were completed and valid. After removing foreign respondents, the final number was 2552 Maltese women, including persons assigned female at birth who may not identify as female.

Nay and Narayan (2019) argue “The success of a research project depends on the population sampled and how representative it is of the target population.” (p.31). In this convenience sample the number of respondents was of 2192 females of reproductive age, equally distributed from all areas of Malta, however the sample may not be truly representative of the population because most respondents had a tertiary level of education. The number of respondents required to have a confidence level of 99% with a 3% margin of error on a population of 113,200 women of reproductive age is 1819, for a sample with a 95% confidence level and 5% margin of error the amount would have been 383 respondents.

The data was analysed using both the tools available through Survey Monkey which allows researchers to download descriptive statistics, graphs, and tables but most figures, tables and tests were computed using SPSS software. Data was first cleaned and sorted – extracting any incomplete responses and eliminating foreign participants of which there were 208 – leaving a total of 2552 Maltese respondents of which 2192 are of reproductive age between 18 and 49. The large number of respondents received enabled this cross

sectional study to give a relatively reliable indication and snapshot of current family planning practices of Maltese persons assigned female at birth— data that was not available and had not been previously collected on such a large scale.

Graphs and tables were extracted from SPSS to describe and analyse the pertinent data related to the research questions. Crosstabs and non-parametric statistical chi-square and Kruskal Wallis tests were computed in SPSS to test whether socio-economic factors outlined in the introduction of this chapter and presented in the literature review were also significant in the sample. The chi-square test is one of the most popular and reliable tests for use with categorical and nominal data when analysing survey results, because the chi-square test is a non-parametric test that “does not require equality of variances among the study groups or homoscedasticity in the data” (McHugh, 2013 p. 143). The Kruskal Wallis test is used to test for differences between three or more variables but the ordinal, interval, or ratio data of the variable of interest must be available (Chan & Walmsley, 1997). To use this test the typical user reliability rating of the various contraception methods (e.g Condom = 87% reliable, Oral Contraceptive Pill = 93% reliable) was used to compare which groups use the more reliable effective methods of contraception.

Limitations of the study

Potential weaknesses of online surveys outlined in research by Evans and Mathur (2018) mentioned issues such as “poor response rate”, “privacy issues”, “unclear answering instructions”, “perception as junk mail”, “sampling”. With regards to this survey, none of these issues were encountered. This is evident from the high response rate, and the fact that the questions were clear and easy to answer, the survey was totally voluntary and on an opt in basis and anonymity was also guaranteed. A possible weakness could arise from the sample since most responses were obtained from a woman only Facebook group and other social media channels, therefore, the survey may not have reached certain women who are not currently active on social media.

The main weakness with this online survey was that it excluded persons under 18, due to current local legislation that dictate that youths below the age of 18 may not participate in

surveys or questionnaires unless with the express written consent of their parents or guardians. This requirement would have been impossible to manage online, therefore this meant that participation was restricted to over 18-year-olds. This omission means that a whole section of sexually active youths below the age of 18 were not eligible to participate in this survey.

Another possible limitation is the fact that this survey used the words Withdrawal (Coitus Interruptus) which may not have been understood by some participants. The same wording was also used in the Maltese version since the more colloquial and commonly used Maltese version for withdrawal was at the time deemed to be too vulgar sounding to be used in this survey, potentially offending the sensitivities of certain respondents. Another possible limitation of this study is the large number of women with a tertiary level of education, with an average of 60% of respondents having a tertiary level of education as compared to the 30% of the female population in 2020 (Gauci, 2021). However, the fact that this sample is more educated and affluent than the general population can possibly indicate that the situation is not as positive as the findings indicate, since women from lower socio-economic strata are more likely to use less reliable methods as is seen in studies from other countries.

Ethical considerations

Ethical considerations are an important part of any study and researchers must ensure that amongst other things, that respondents in any type of study are not subjected to any harm or can come to any harm (Bryman & Bell, 2007). Bryman and Bell, (2007) explain that researchers must ensure they receive free and uncoerced consent from respondents before proceeding with their study, and that the privacy and dignity of participants is observed, and that anonymity or protection of identity is ensured. They also explain that the aims and objectives of the research study must be clearly and truthfully clarified beforehand, and that transparency and honesty are important elements to ensure a study is ethically conducted (Bryman & Bell, 2007).

Due to the nature of this survey, it was especially important that all ethical guidelines were strictly adhered to, the survey was only distributed after it was reviewed and approved by

the Faculty of Research Ethics Committee (FREC) of the University of Malta. All respondents participated voluntarily and without any form of coercion and with full promise of anonymity and before commencing their participation confirmed that they had understood and consented to participating in this survey. Questions were formulated in both English and Maltese using gender-neutral language and a trigger warning was inserted before potentially sensitive questions regarding pregnancy. Participants were also directed towards where to find help should they have felt they needed professional support after potentially revisiting sensitive dormant emotions.

Chapter Summary

This chapter described the methodology utilised for a cross-sectional survey that sought to collect data and answer questions about the family planning practices of Maltese women of reproductive age. This quantitative study using a survey adapted from other well researched studies used by specialists in the field of family planning has garnered a substantial number of respondents. This was done by using a convenience sampling method, whilst safeguarding the anonymity of respondents. It has provided some interesting descriptive statistics and previously unavailable insights into the lives, knowledge and usage of contraception and family planning practices of Maltese women and people assigned female at birth. The following chapters will present the results and discuss the analysed data in further detail.

CHAPTER 5 RESULTS AND ANALYSIS

In this chapter, findings from an online anonymous survey conducted between February and March 2022 will be presented and analysed. The survey asked women about family planning and contraception knowledge and practices. The first part of this chapter presents tables and figures on demographic data. This is followed by the results from the second section which asked about contraception knowledge and practices, continuing onto the findings from the third section of the survey that asked respondents about birth, miscarriages, abortion, and pregnancy intentions. Crosstabs and statistical tests to explore relationships between variables and test the hypotheses outlined in the methodology chapter follow.

Demographic Data

Race and Ethnicity

The survey respondents were predominantly Maltese and Caucasian $n=2737$ with no respondents saying they were African but two declaring themselves black/British. Ten respondents identified themselves as Arab, eleven respondents said they were Hispanic, and thirteen respondents said they were Asian. Since these numbers were very small, they were excluded from the survey and only Maltese participants were included one of whom declared herself to be Arab. Therefore, after cleaning up invalid and incomplete responses and removing non-Maltese respondents, the final number of valid responses used to produce these results was of 2552 Maltese women and persons assigned female at birth.

In questions where current or primary contraception is mentioned the numbers reflect the responses from a pool of 2192 women of reproductive age, between 18 – 49 years of age.

Age, gender, and locality

Figure 1 Age range distribution

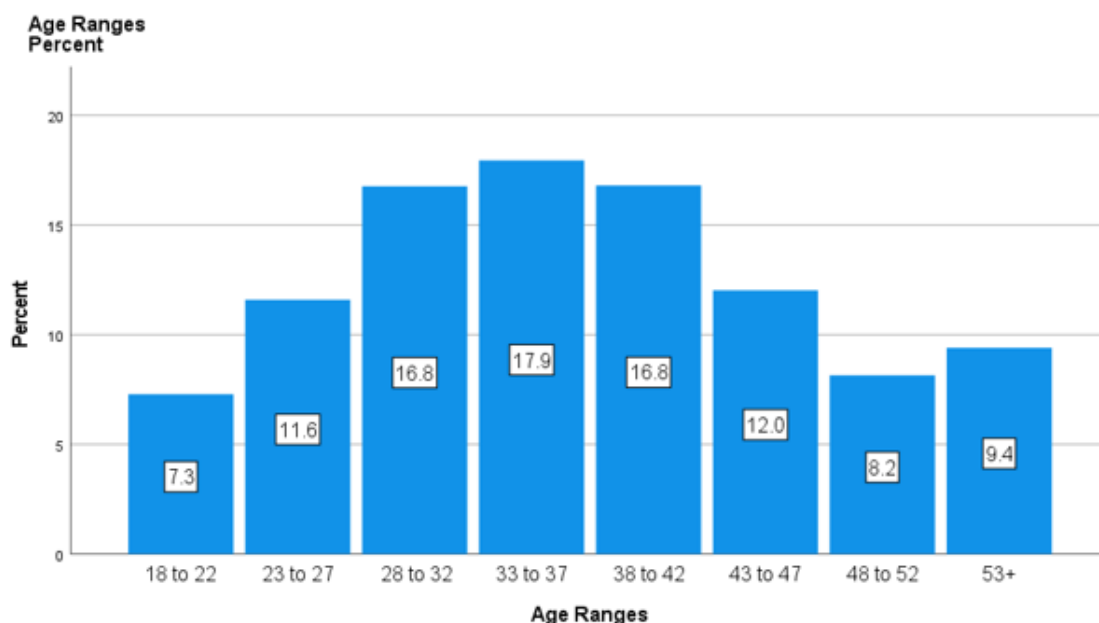


Table 1

*Comparison between general population
and sample population*

Age Range	General Population	
	%	Sample %
18 to 22	6.4	7.3
23 to 27	9.5	11.6
28 to 32	12	16.8
33 to 37	10.7	17.9
38 to 42	10	16.8
43 to 47	8.8	12.0
48 to 52	8	8.2
53+	14.4	9.4

The female population of Malta aged between 18 and 61, as of 31st December 2020 was 187,128 (NSO, 2021). Table 1 shows the comparison between the age distribution in the general population and the sample population – in general this sample generated a slightly higher percentage of respondents in all age groups of women of reproductive ages between 18 – 49. The geographical distribution of participants closely resembles that of the general population. 30% of respondents said they resided in the Northern region as

compared to the 22% of Malta's population who live in Northern area. 27% of respondents live in the Central region which compares closely to the 28% of the population that live in this area. 19% said they hailed from the South Eastern region with 21% of Malta's population living here. 19% said they lived in the Southern region whilst 21% of the population live there. 4% of respondents come from Gozo which is 6% of the population of the country (Local Government Division, 2021).

90.3 % of respondents said they are Maltese whilst 9.7% of people who responded to the survey were foreigners however these were removed from the results. The overwhelming majority of respondents (97%) are Caucasian. Most respondents (84%) have lived all their lives in Malta with only 16% having lived abroad for over 5 years. When asked what gender they identified with – 99% (n = 2536) answered they identified themselves as female whilst 0.4% (n=10) said they identified as male although they were assigned female at birth, and 0.2% (n=6) although assigned female at birth said they identified as “other”.

Disability

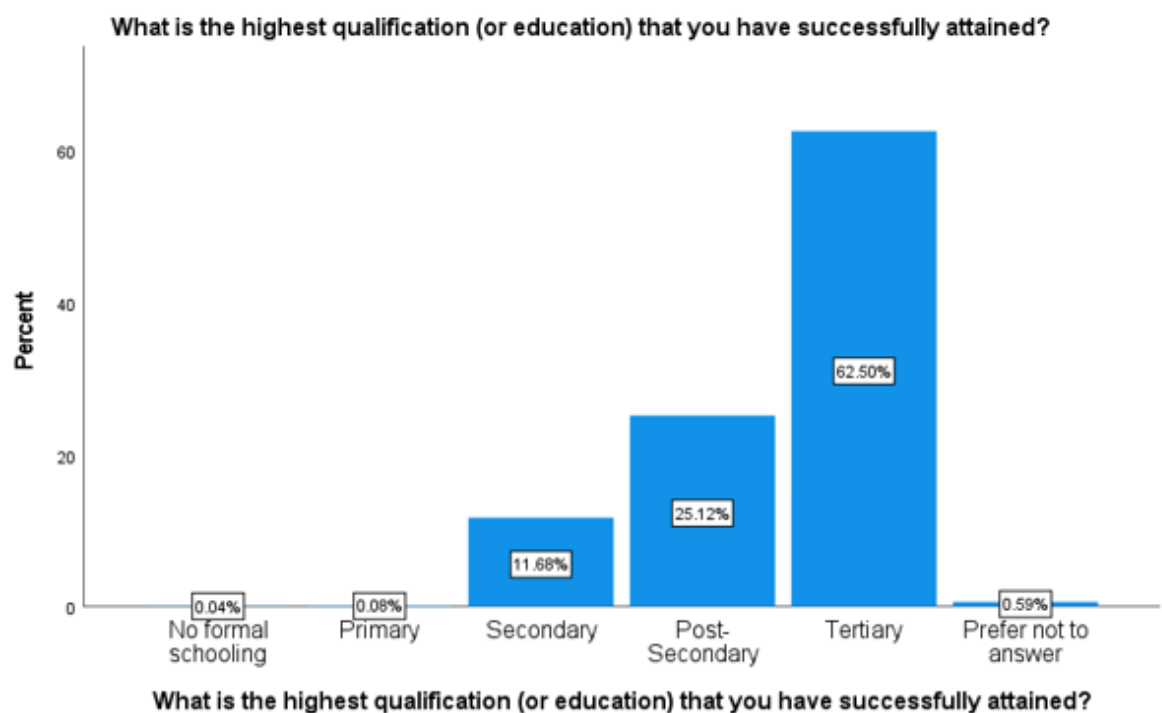
Respondents were not specifically asked in the survey whether they had been diagnosed or live with any physical or intellectual disabilities, therefore data on disability was not collected or analysed, however this does not mean that some respondents may not have possibly had a physical or intellectual disability. As seen in the literature review research clearly shows that women with intellectual or learning disabilities may be affected by circumstances beyond their control whereby their specific contraception and reproductive wants and needs are not clearly discussed directly and communicated with them (McCarthy, 2009).

Education

Most respondents had a tertiary level of education with almost no respondents indicating that they have No Formal Schooling, as seen in Figure 2. Local research by Tiziana Gauci published by the Central Bank of Malta in 2021 put the percentage of females with a tertiary level of education in Malta aged between 15 and 64 at 30%. The percentage of

respondents of this survey with a tertiary level of education is much higher with an average of 62.5%. According to Gauci (2021) the age group with the highest rate of tertiary educated citizens is the age group between 25 and 34, this is also reflected in my data with the highest rate of tertiary educated women in that age group. The age group with only a basic level of education (described by Gauci as up to lower secondary level) is the 55 and 64 age group, however this is not reflected in this sample as most of the respondents between 55 and 64 said they had achieved a secondary level of education. The respondents from my sample have a much higher level of education than the female population of Malta. Studies suggest that there is an association between educational level and contraception choice and adherence to family planning. -Chi-square tests will be carried out to test this hypothesis in the final section of this chapter.

Figure 2



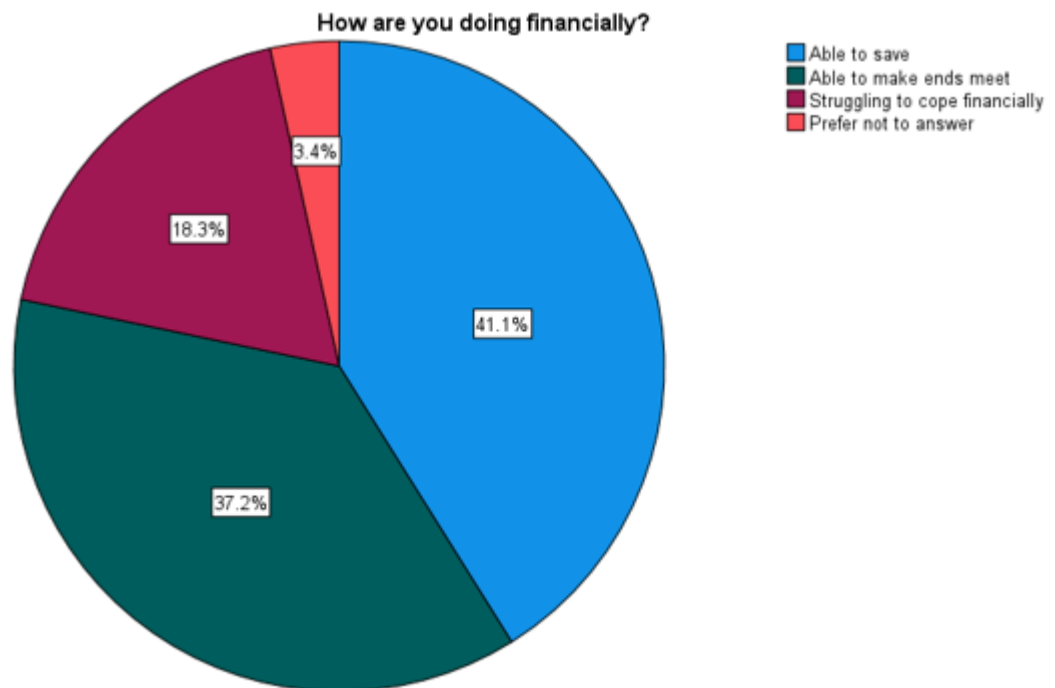
Employment and Income

Many respondents were in employment with 71% (n=1819) saying they were in full time employment (some mentioned full-time reduced hours) whilst 11% (n=286) said they worked part-time. 7% (n=170) of respondents were not employed due to family

responsibilities, 6% (n=151) said they were studying, while 2% (n=52) were retired. The rest were either unemployed or unable to work.

A relative majority of respondents, (41%), said they were doing well financially and were able to save; contrastingly 18% exclaimed that they were struggling to cope financially.

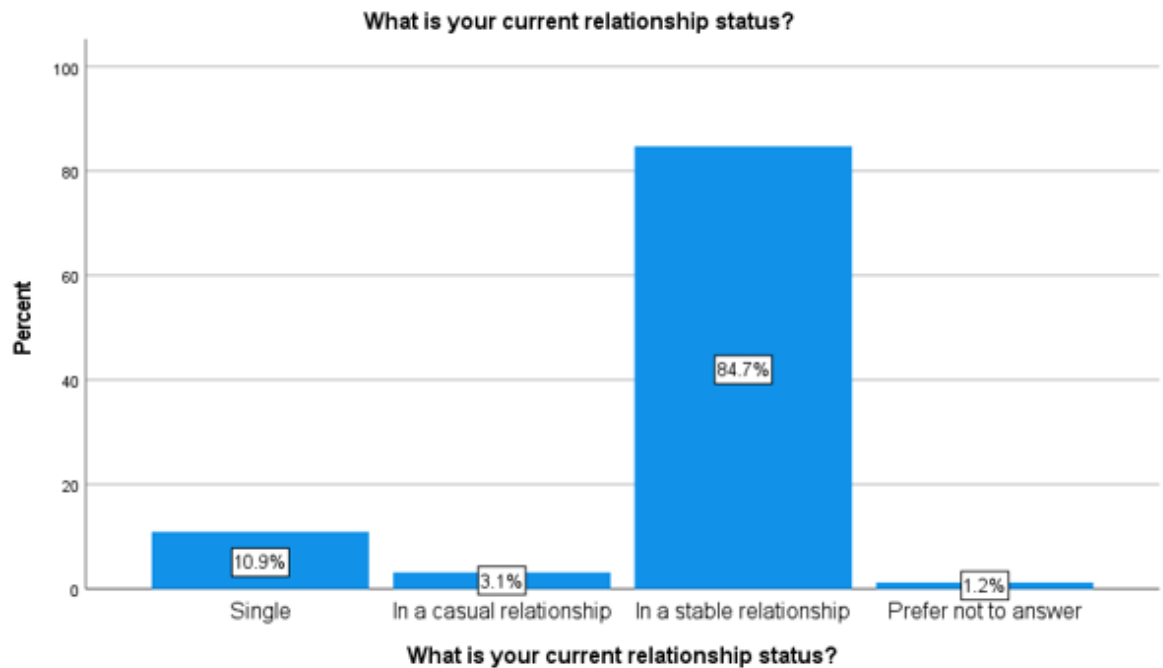
Figure 3



Relationships

Serious, steady, stable relationships are still culturally important (Deguara, 2020), and this is reflected in the fact that most respondents are married or in a serious stable relationship. When asked about their relationship status, 85% (n=2158) (Figure 4) said they were in a stable relationship, 11% (n=282) said they were single, while only 3% (n=82) said they were in a casual relationship. In terms of legal civil status, 54% (1402) said they are married or in a civil union with a person of the other sex, 34% are (n=863) single, 9% (n=224) are Divorced/Separated/Annulled, 1.0% (n = 24) are widowed, 1% (n=24) are married or in a civil union with a person of the same sex. 15 respondents preferred not to answer. 49% of respondents have one or more children living in their care under the age of 16. 23% have one or more children over 16 living in their care. A total of 55% (n=1395) of respondents have had at least one child.

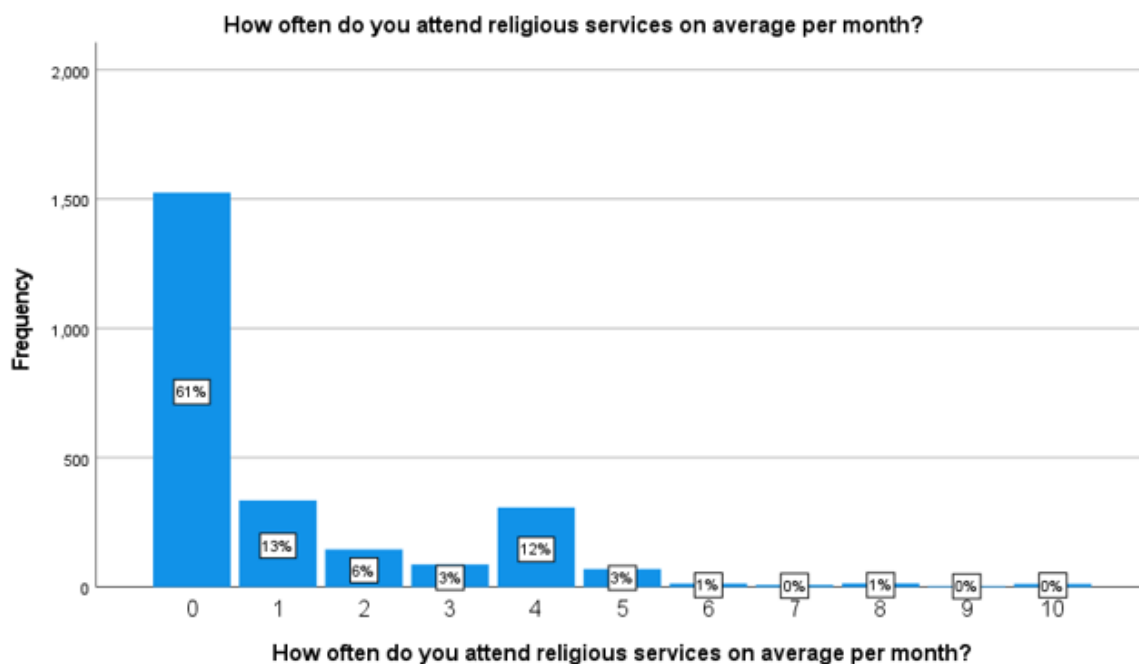
Figure 4



Religiosity

49% (n=1248) of respondents said that they did not consider themselves religious whilst 46% (n=1198) said they consider themselves religious and 4.2% (n=106) preferred not to answer. Although 49% of respondents said they consider themselves religious, 61% (n=1557) of respondents said they never attend religious services (Figure 5). Of note in Figure 5 is that 12% of respondents said they attend religious services four times a month, probably indicating that they attend mass on Sundays.

Figure 5



When asked: What religion, religious denomination or body do you identify yourself with most? (Even if you are non-practicing) as expected the overwhelming majority 80.6 % said they were Roman Catholic.

Asked to rate on a scale from 0 to 10 how important religion is for them – 18 % said it was not important at all and rated it 0 whilst 6% said it was very important and scored 10. Whilst 18 % gave a score of 5 meaning it is not unimportant but not very important either. Crosstabulations and Chi-Square tests have been carried out and will be presented in the final section of this chapter to compute the association between religiosity and contraception use.

Contraception Knowledge and Use

The second section of the survey dealt with contraception knowledge and use. When asked which contraception they had previously heard about – the overall knowledge of the various contraception types was positive, indicating that knowledge is relatively high. Table 2 shows that the least known method was the Depo Provera ²Injection with only 44%

² Depo Provera is the brand name of one of the injectables, another injectable is the self-administered Sayana Press injectable.

having previously heard about this method. Depo Provera comes in the form of a progestin-based injection given to users once every 8 or 13 weeks and can be especially useful for women who cannot use oestrogen (NHS, 2018). Almost half the women (49%) said they had heard about the Nuva Ring, a small soft plastic ring that one inserts into the vagina, which releases a consistent dose of oestrogen and progestogen into the blood stream and needs to be replaced once a month (NHS, 2021). 69% of respondents said they had heard about the contraceptive implant – which is a small plastic rod containing progestin that is placed under the skin and that provides contraception for up to three years.

Table 2

<i>Contraception Respondents have heard about</i>		
English	Maltese	%
^a Condom	Kondom	99.9%
Contraceptive Pill	Il-pillola kontraċettiva	99.8%
Emergency Contraception	Kontraċettiv t'emergenza	99.8%
Tubal Ligation	Għeluq tat-tubi	96.1%
IUS (Mirena/Jaydess)	IUS (Mirena/Jaydess)	94.8%
Vasectomy (the snip)	Važektomija	94.2%
Natural Family Planning	L-ippjanar tal-familja b'mod naturali	90.6%
Non-Hormonal IUD	IUD mhux ormonali	83.3%
Withdrawal (Coitus Interruptus) ^d	Withdrawal (Coitus Interruptus) ^b	81.0%
Female Condom	Kondom femminili	77.2%
Diaphragm	Id-dijaframma	72.7%
Implant	Impjant	68.7%
Nuva Ring	Nuva Ring	48.9%
Depo Provera	Depo Provera (injezzjoni)	43.7%

a. Dichotomy group tabulated at value 1 (heard about).

b. Withdrawal or Coitus Interruptus might be more commonly known as the "pull out" method, leading to some respondents not recognising the term.

Figure 6

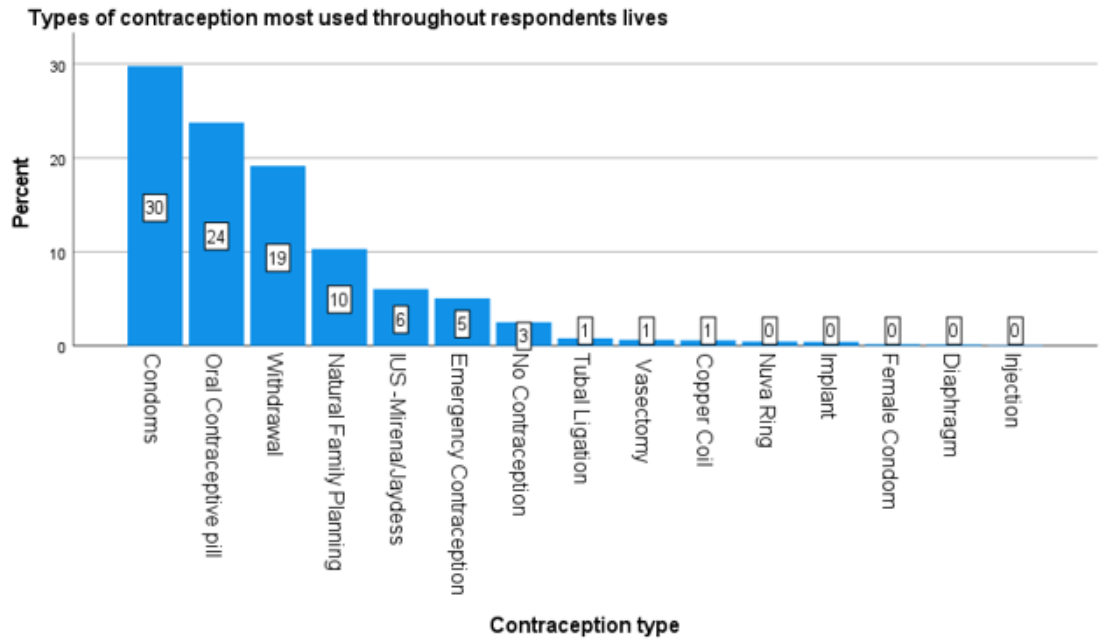


Figure 7

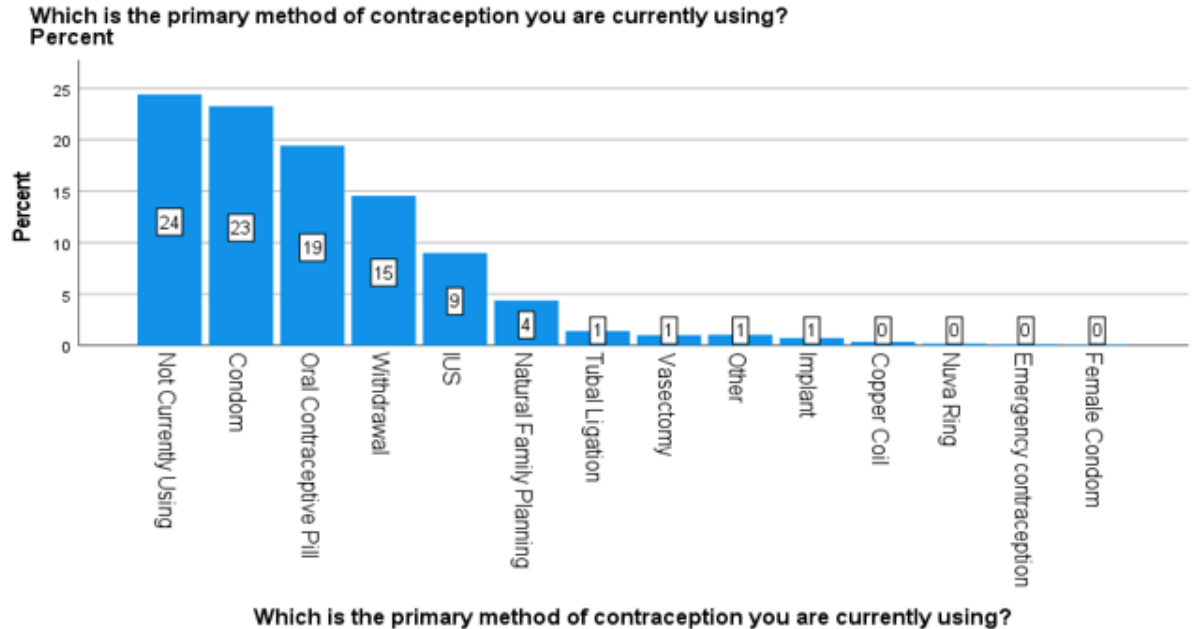


Figure 6 shows the most used forms of contraception by the respondents of all ages at different times of their reproductive lives whilst Figure 7 shows the current contraceptives used by respondents between the ages of 18-49 (n=2192). Of interest to note is that none

of the respondents are currently using diaphragms or the injectables, less women are currently using natural family planning 4% (n=88) compared to 10% (n=255) in Figure 6. Also, slightly more women are currently using Intra Uterine Systems (IUS) (n=197) as compared to the 6% (n=153) in Figure 6. The IUS, a long-acting reversible method of contraception is mostly used by respondents above the age of 38 usually because they would have already had children and it is also used as a type of hormone replacement for perimenopausal women (Braidwood, 2020). 24% (n=526) of respondents said they were not using contraception for various reasons but mostly due to trying to get pregnant (Figure 8). Therefore, it can be concluded that **76%** of respondents are using some form of contraception, namely condoms **23%** (n=510), the Oral Contraceptive Pill **19%** (n=426), and the Withdrawal method **15%** (n=319). This is not surprising with Malta having one of the lowest fertility rates in Europe (Eurostat, 2021).

Figure 8 shows the reasons why the **24%** (n= 526) said they do not use contraception, of note are the **22.4%** who said they are trying to get pregnant and the **19.9 %** of respondents who said they do not want to use contraception.

Figure 8

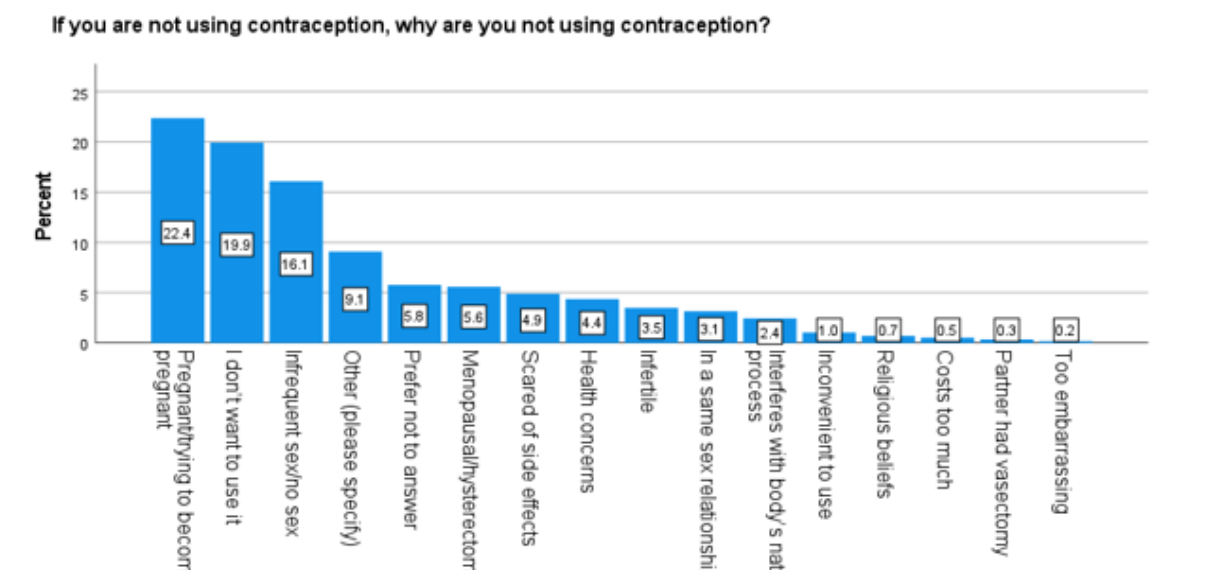
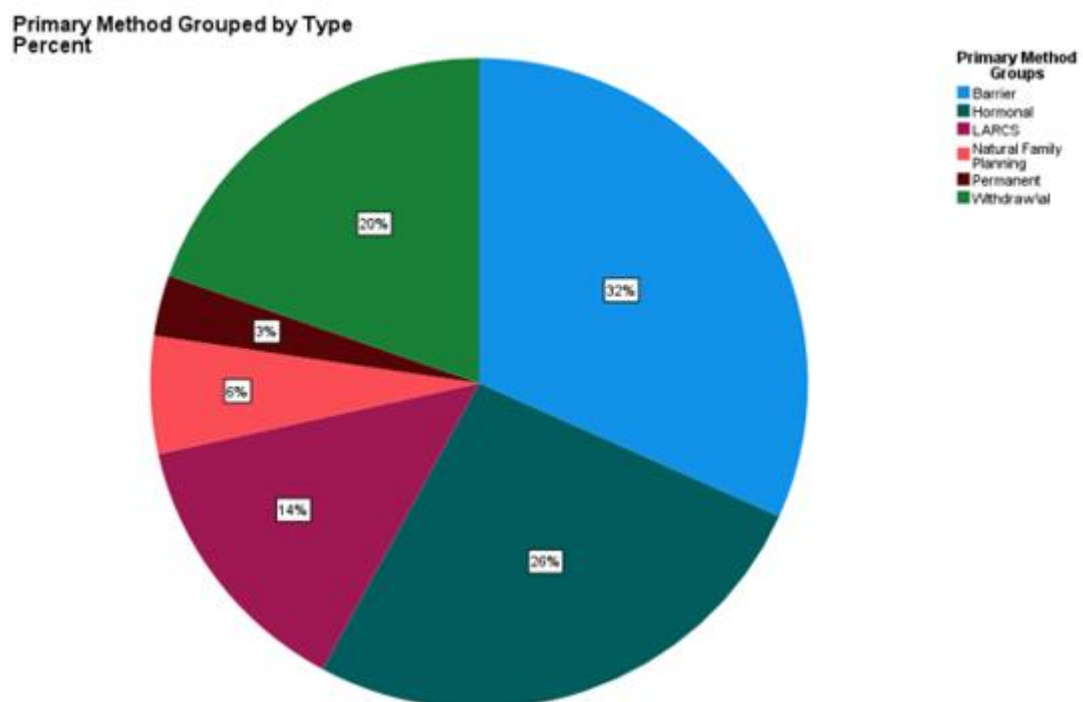


Figure 9 shows the most popular types of contraception currently being used by women of reproductive age (18 – 49) when recalculated after removing those who are not currently using contraception. The Barrier methods (Male and Female Condoms, Diaphragms) **32 %**, the Withdrawal method **20%** and Natural Family Planning **6%** together make **58%**. This means that **58%** of sexually active respondents of reproductive age are using the least reliable forms of contraception with the highest typical use failure rates. Long-Acting Reversible Contraceptive methods such as IUDs, IUS, implants, and injections are currently not popular with Maltese women with only 14% using these far more reliable methods that do not require user intervention.

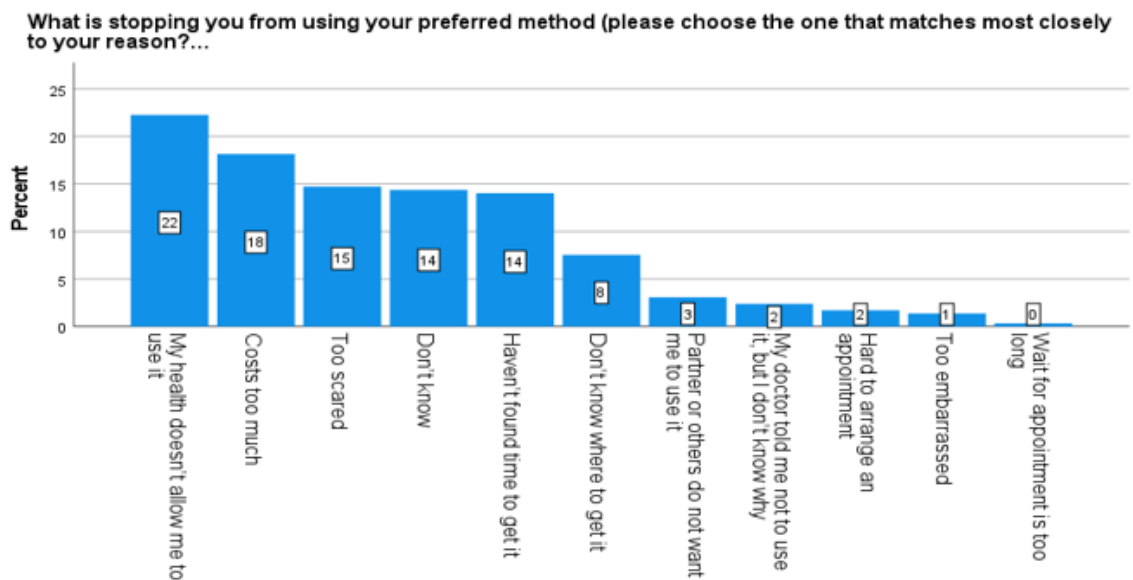
Figure 9



Contraception preference and access

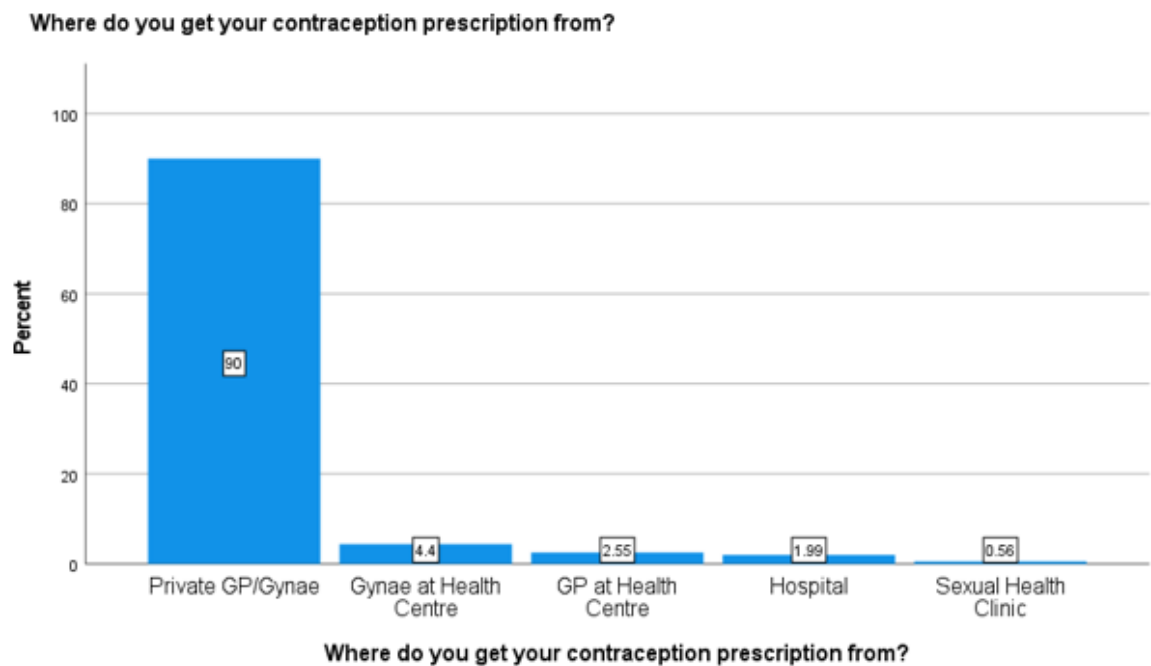
Research shows that user satisfaction is important for consistency and adherence to contraception use (McNicholas et al., 2014). Figure 10 shows that 71% (n=1182) of 1676 respondents who answered this question are happy and are using their preferred method of contraception. The other almost 25% of users who said they were not using their preferred method consisted of the following: 36% said that using condoms was not their preferred method, followed by those using the Oral Contraceptive Pill at 29%, and 22% of women using the withdrawal method saying that it was not their preferred method. 292 respondents gave their reasons for not using their preferred method. The reasons for not using their preferred method can be seen in Figure 10. The most common reason was that their health does not permit them to use their preferred method, the second was because it cost too much, and the third most popular reason was that they were too scared to use their preferred method.

Figure 10



All artificial contraception in Malta except for condoms and emergency contraception, require a prescription. Figure 11 shows that the overwhelming majority **90%** of women get their prescription from their private gynae or GP with only 10% of respondents getting their prescriptions from the public health services.

Figure 11



When asked “Have you ever experienced a health practitioner/pharmacist that was opposed to providing you with contraception? What was the contraception they refused to give you?” 10.4% of respondents said that they had experienced a health practitioner that had refused to provide contraception – this was an open-ended question and the majority answered that they were refused the Morning After Pill, a few were refused the Oral Contraceptive Pill and some mentioned tubal ligation.

Pregnancy, miscarriages, births, and abortions

Only respondents who had experienced a pregnancy were eligible to participate in this section of the survey.

1483 or 58% of respondents said they had experienced a pregnancy. Those who said they had never been pregnant were not able to continue, and the survey thanked respondents and for these the survey automatically ended.

Women were asked - How many pregnancies have you had that resulted in Birth, Miscarriage or Abortion?

Results can be seen in Figures 12, 13, 14:

Figure 12

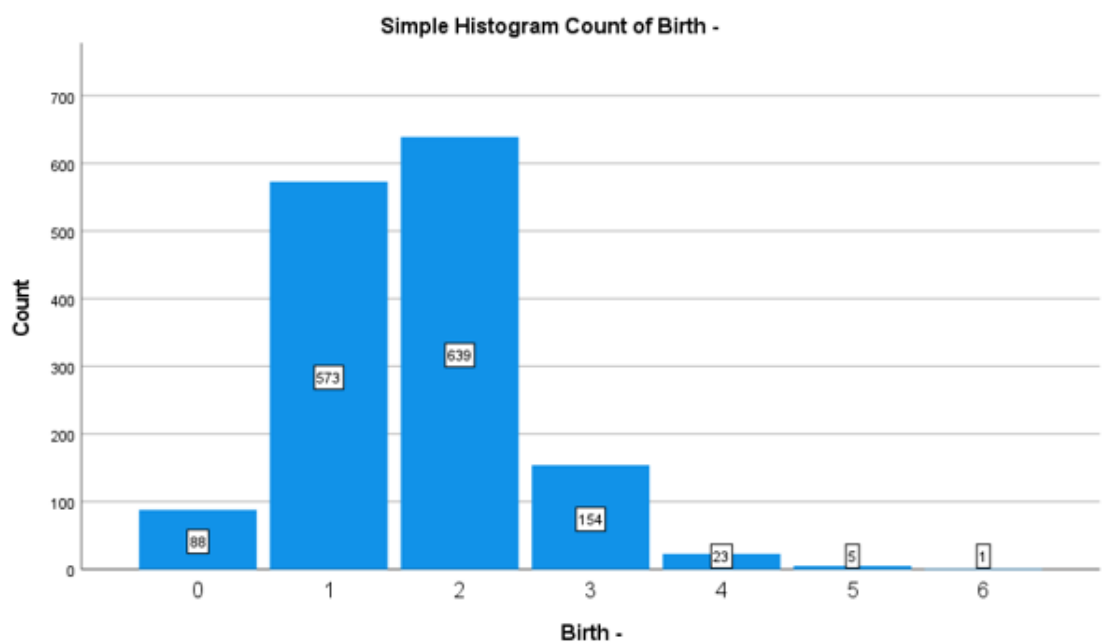


Figure 13

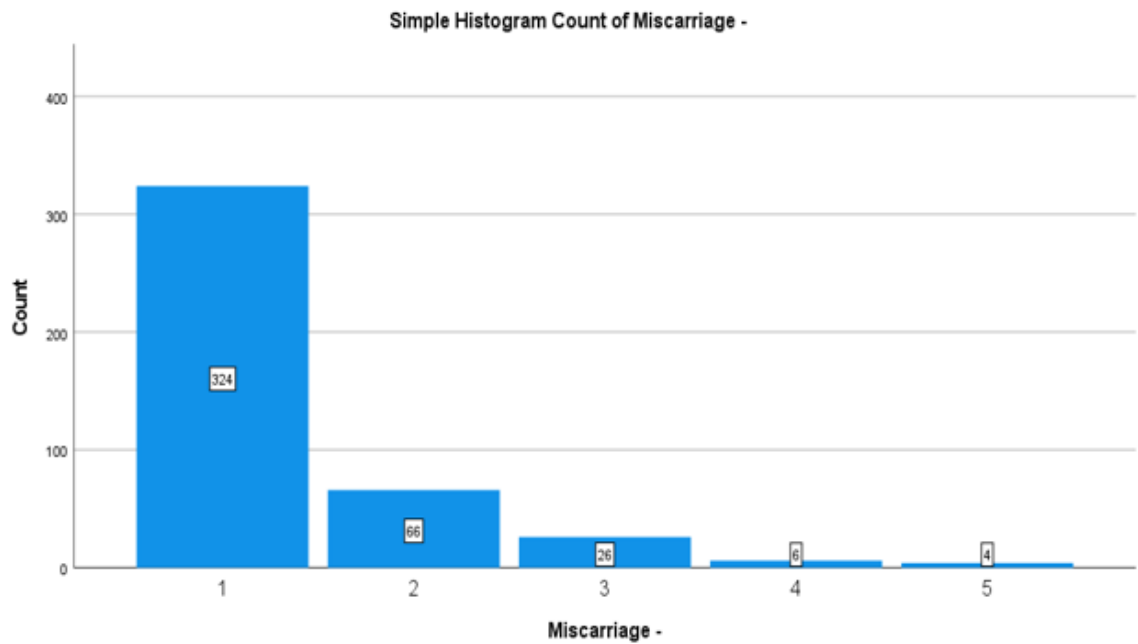


Figure 14

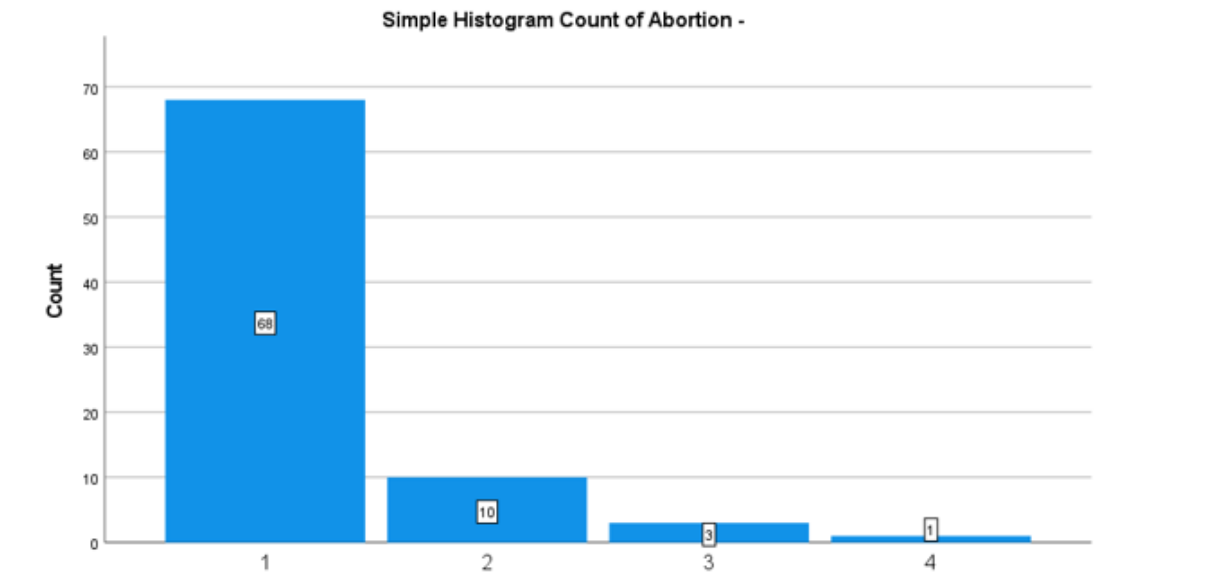


Figure 12 shows the number of live births. 88 women said they had experienced a pregnancy, but their pregnancy did not result in a birth. The total number of live births for 1483 women was 2436. Figure 13 shows that 28% (n=426) of respondents who experienced a pregnancy had at least one miscarriage. The total number of miscarriages for 1483 women was 598 (Figure 13). Not shown in the histogram is one woman who said she had

had seven miscarriages and one woman who said she had had thirteen miscarriages; they were accounted for but do not show in the table.

Figure 14 shows that a total number of 82 respondents or 5.5% of the 1483 respondents who had experienced a pregnancy have had at least one abortion with a total of 101 abortions.

These numbers translate to 245 miscarriages for every 1000 live births and 41 abortions per 1000 live births. The National Obstetrics Information System (NOIS) does not collect data for miscarriages below 500 grams (around 22 weeks gestation) but in personal communication, Dr. Distefano from the Department of Health Policy explained that they register women who are discharged from hospital with a diagnosis of spontaneous abortion. The National Hospitals Information System, in 2018 and 2019 registered 350 and 376 hospital discharges respectively calculated against the number of live births for those years these numbers would translate to 78 miscarriages for every 1000 live births in 2018 when there were 4,444 live births recorded (NSO,2021), and 86 miscarriages for every 1000 live births in 2019 when the total of live births was 4350 (NSO,2021). Dr. Distefano also mentioned that these numbers do not include women who may have had miscarriages and had not gone to hospital. The numbers reported by my respondents seem to suggest that in one year, with an average of 4000 live births in Malta per year, the number of miscarriages would be around 980 ($245 \times 4 = 980$), a much higher number than reported by Dr. Distefano. This could mean that a high percentage of women experiencing miscarriages do not go to hospital. There are no official statistics for the number of abortions carried out in Malta.

Contraception failure and unplanned pregnancy

Table 3 shows results of the contraception practices of women in the month before they got pregnant. Only **2.2%** said they were using contraception on every occasion. It is interesting to note that 3.3% said that they were using contraception, but their chosen method failed, which is likely to happen with the more unreliable methods such as condoms, withdrawal, and natural family planning. In Table 6 - 1296 said they were not

using contraception but only 791 said they were not using contraception because they intended to get pregnant (Table 4), implying that 505 women or **34%** of women got pregnant when they were not planning to get pregnant.

Table 3

In the month that I became pregnant..... (Please tick the statement which most applies to you):

	Frequency	%
I/we were not using contraception	1296	87.4
I/we were using contraception, but not on every occasion	106	7.1
I/we always used contraception, but knew that the method had failed (<u>i.e.</u> broke, moved, came off, came out, not worked e	49	3.3
I/we always used contraception	32	2.2
Total	1483	100.0



Table 4



*If you did not intend to get pregnant and still got pregnant
what contraception (if any) were you using at the time?*

	Frequency	Valid Percent
I intended to get pregnant	791	53.3
I/we were not using contraception	284	19.2
Withdrawal (Coitus Interruptus)	124	8.4
Prefer not to answer	107	7.2
Condom	84	5.7
Natural Family Planning	44	3.0
Oral Contraceptive Pill	38	2.6
IUS (Mirena, Jaydess)	6	.4
Non hormonal IUD (Copper Coil)	3	.2
Diaphragm	1	.1
Tubal Ligation	1	.1
Total	1483	100.0

Valid



Figure 15

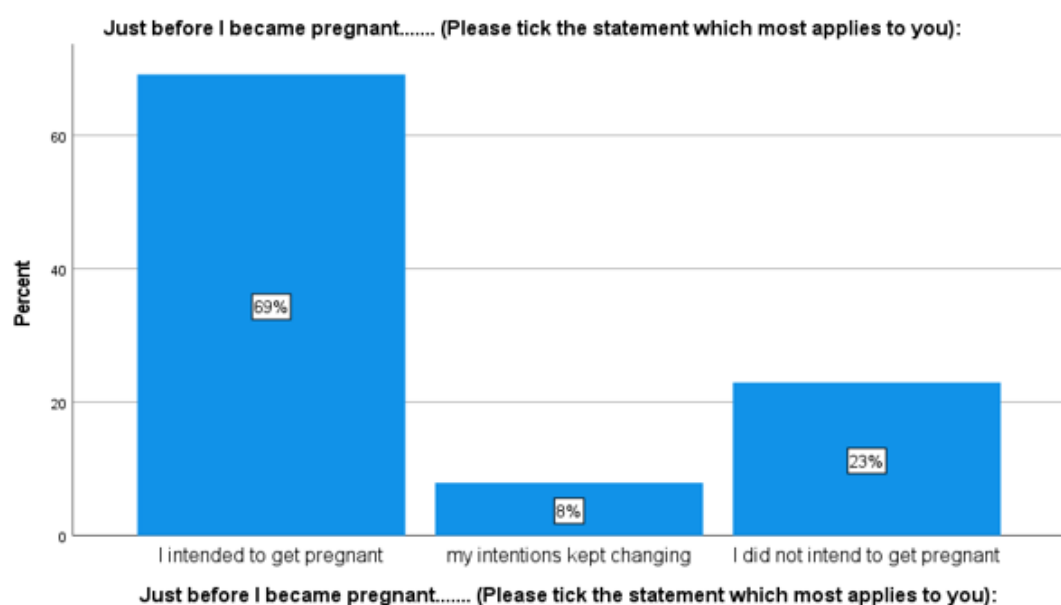


Table 4 shows that 53.3% of respondents said they intended to get pregnant, the remainder **46.7%** still got pregnant but did not intend to get pregnant. Table 4 also shows a discrepancy and difference in number of the previous calculation of **34%** of unintended pregnancies in Table 3, and different also to Figure 13, because when asked if before their last pregnancy they intended to get pregnant only **23 %** said they did not intend to get pregnant. Research shows that retrospectively women hesitate to say that their pregnancy was unintended at the time of conception, making it very difficult to confirm an unintended pregnancy rate (Rackin & Morgan, 2018). According to respondents of this survey this rate can be confirmed at least at **23%** (Figure 12.) but can be up to **47%, if one calculates contraception behaviour rather than pregnancy intention**. Table 4 also shows that 18% of women using the withdrawal method still got pregnant using this method, whilst 12% of condom users got pregnant using condoms and 5% of Oral Contraceptive Pill users still got pregnant whilst on the pill, (these numbers were calculated after removing the 791 women who said they intended to get pregnant). These rates are close to the typical use failure rates reported by the Centre for Disease Control that mentions that the failure rate of withdrawal is up to 22%, condoms is up to 13%, and of the Oral Contraceptive pill up to 7%.

Crosstabs and Tests of Hypothesis

Crosstabs

In France and in the UK, research conducted by Poncet et al (2013) and Firman et al (2018) showed that relationship status and duration have a significant effect on type of contraception chosen with users changing their contraception type according to their relationship status. A cross tab was run to check the contraception choices of women of reproductive age cross checked against marital status.

Table 5

*Which is the primary method of contraception you are currently using? * What is your legal marital status? Crosstabulation*

		What is your legal marital status?					Total
		Single	Married or in a civil union with a person of the opposite sex	Married or in a civil union with a person of the same sex	Divorced/S eparated/A nnulled	Widow ed	
Oral Contraceptive Pill	Count	276	120	0	27	2	426
	%	43.1%	15.1%	0.0%	27.3%	33.3%	27.5%
Natural Family Planning	Count	14	75	1	6	0	96
	%	2.2%	9.5%	12.5%	6.1%	0.0%	6.2%
IUS (Mirena/Jaydess)	Count	48	116	4	25	4	197
	%	7.5%	14.6%	50.0%	25.3%	66.7%	12.7%
Withdrawal	Count	82	219	1	17	0	319
	%	12.8%	27.6%	12.5%	17.2%	0.0%	20.6%
Condom	Count	221	263	2	24	0	510
	%	34.5%	33.2%	25.0%	24.2%	0.0%	32.9%
Total	Count	641	793	8	99	6	1548
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Interesting to note in Table 5 is that even in my sample the most popular methods used differ between single and married women. Single women mostly use Oral Contraceptive Pills (OCP) followed by condoms, withdrawal, and the IUS. Whereas married women use less reliable methods as they get older mostly condoms, and withdrawal followed by the OCP and then few use Mirena, as also seen in the UK (Firman et al., 2018).

Tests of hypotheses

Research shows that religion, education, and income can often be compounding and influential factors when it comes to adherence, consistency, and method of contraception use (Metcalf et al., 2016). Assuming that this could also be the same for the respondents of this survey, three hypotheses outlined below were tested to check for significant associations between socio economic factors (income, education, and religion) and if they influence contraception use and choice.

- H^0 There is no relationship between religiosity and contraception method.
- H^1 Higher religiosity is associated with use of less reliable contraception methods (e.g., natural family planning, withdrawal method)
- H^0 There is no relationship between level of education and contraception method
- H^1 Higher level of education is associated with use of more effective contraceptive methods (e.g., LARCs)
- H^0 There is no association between income and contraception method.
- H^1 Higher levels of income is associated with use of more effective contraception methods.

Statistical Tests

Religiosity and contraception choice

A Chi-square test for independence was carried out to check whether contraception choice is associated with religion. The results $\chi^2(8 \text{ n}=1548) = 58.423, p=0.001$ show a significant relationship and the null hypothesis that contraception method is not associated with religiosity is rejected. It is concluded that there is a significant relationship between contraception method used and religion. This hypothesis was further tested using a Bonferroni post hoc analysis (Table 6) which shows where the significant differences between the choices of contraception of women who consider themselves religious and those that do not consider themselves religious are most significantly noticeable. As can be seen from the table, there is a significant difference in the use of hormonal contraception, and the use of Natural Family Planning, whereas there is no difference in the use of Condoms, and no significant difference in the use of other methods such as IUDs and the Withdrawal methods.

Table 6

*Which is the primary method of contraception you are currently using? * Do you consider yourself religious: Crosstabulation*

			Do you consider yourself religious:			
			Yes	No	Prefer not to answer	Total
Which is the primary method of contraception you are currently using?	Oral Contraceptive Pill	Count	135 _a	272 _b	19 _{a, b}	426
		%	31.7%	63.8%	4.5%	100.0%
	Natural Family Planning	Count	67 _a	26 _b	3 _{a, b}	96
		%	69.8%	27.1%	3.1%	100.0%
	IUS (Mirena/Jaydess)	Count	96 _a	98 _a	3 _a	197
		%	48.7%	49.7%	1.5%	100.0%
	Withdrawal (Coitus Interruptus)	Count	147 _a	159 _a	13 _a	319
		%	46.1%	49.8%	4.1%	100.0%
Condom	Count	226 _a	259 _a	25 _a	510	
	%	44.3%	50.8%	4.9%	100.0%	
Total	Count	671	814	63	1548	
	%	43.3%	52.6%	4.1%	100.0%	

Each subscript letter denotes a subset of Do you consider yourself religious: categories whose column proportions do not differ significantly from each other at the .05 level.

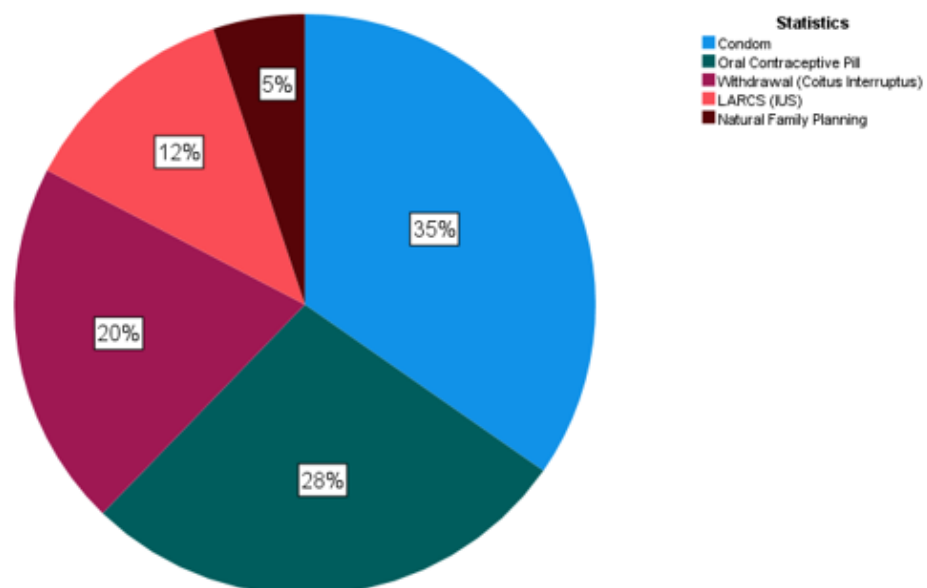
The Natural Family Planning method is the only method allowed by the Church as a means of contraception and the withdrawal method has also always been a very popular method of contraception in Malta (Milne & Wright, 1997). The alternative hypothesis (H1) assumes that there is an association between the use of these more traditional, less reliable methods and religiosity, as also noted in the literature. A Kruskal Wallis test was computed using the typical use reliability rating scores of the various contraception methods. The test revealed that there is a significant difference between the reliability rating of contraception chosen by women who consider themselves religious and those women who do not consider themselves religious $\chi^2(2, n=2169) = 27.278, p<.001$.

Education level and contraception choice

A cross tabulation carried out between contraception method and education level showed that even those respondents with a tertiary level of education still do not use the more effective forms of contraception, like LARCS. In fact, most women with a tertiary education use mostly condoms 34%, the oral contraceptive pill 27%, and coitus interruptus 20% as their primary methods of contraception (Figure 16).

Figure 16

Most popular methods of contraception used by tertiary educated women



Level of education may influence contraception use and choice (Poncet et al. 2013). A chi-square test of independence was computed to check if there was an association between contraception use and level of education among respondents. A chi-square test for independence was carried out to determine whether contraception use/choice is associated with educational level. The results are not significant $\chi^2 (16 \text{ n}=1548) = 23.746$, $p=.095$. The null hypothesis is not rejected, and it can be concluded that contraception choice is not associated to education level. A Bonferroni post hoc test was carried out to show any possible associations (Table 7).

Table 7

*Which is the primary method of contraception you are currently using? * What is the highest qualification (or education) that you have successfully attained? Crosstabulation*

		What is the highest qualification (or education) that you have successfully attained?					Total
		Primary	Secondary	Post Second	Tertiary	Prefer not to answer	
Oral Contraceptive Pill	Count	0 _a	38 _a	95 _a	290 _a	3 _a	426
	%	0.0%	8.9%	22.3%	68.1%	0.7%	100.0%
Natural Family Planning	Count	0 _a	11 _a	25 _a	60 _a	0 _a	96
	%	0.0%	11.5%	26.0%	62.5%	0.0%	100.0%
IUS	Count	0 _{a, b}	29 _b	35 _a	133 _a	0 _{a, b}	197
	%	0.0%	14.7%	17.8%	67.5%	0.0%	100.0%
Withdrawal	Count	1 _a	21 _a	79 _a	215 _a	3 _a	319
	%	0.3%	6.6%	24.8%	67.4%	0.9%	100.0%
Condom	Count	1 _a	35 _a	109 _a	364 _a	1 _a	510
	%	0.2%	6.9%	21.4%	71.4%	0.2%	100.0%
Total	Count	2	134	343	1062	7	1548
	%	0.1%	8.7%	22.2%	68.6%	0.5%	100.0%

Each subscript letter denotes a subset of What is the highest qualification (or education) that you have successfully attained? categories whose column proportions do not differ significantly from each other at the .05 level.

Women with a tertiary education are usually more affluent and socio-economically stable than women with only a basic level of education and one would have assumed that the more educated ones would be more likely to use the more reliable forms of contraception such as LARCs. To further test this hypothesis a Kruskal Wallis test was computed using the contraception reliability rating score to check whether there is a difference between the

reliability of contraception chosen by women with different levels of education, once again this test also showed no significant difference $\chi^2 (4, n=1548) = 8.423, p=.077$ therefore I fail to reject the null hypothesis and confirm that there is no difference between education level and contraception use.

Income and contraceptive choice

A chi square test of independence was computed to check whether contraception use is associated with financial wellbeing (struggling to cope, able to make ends meet, able to save). The results are not significant $\chi^2 (12 n=1548) = 18.879, p = .091$. Thus, there is no significant difference in contraception choice between women struggling to cope and those doing well financially.

Table 8

*Which is the primary method of contraception you are currently using? * How are you doing financially? Crosstabulation*

		How are you doing financially?				Total
		Struggling to cope financially	Able to make ends meet	Able to save	Prefer not to answer	
Oral Contraceptive Pill	Count	82	164	167	13	426
	%	19.2%	38.5%	39.2%	3.1%	100.0%
Natural Family Planning	Count	27	32	36	1	96
	%	28.1%	33.3%	37.5%	1.0%	100.0%
IUS (Mirena/Jaydess)	Count	41	70	85	1	197
	%	20.8%	35.5%	43.1%	0.5%	100.0%
Withdrawal (Coitus Interruptus)	Count	54	118	137	10	319
	%	16.9%	37.0%	42.9%	3.1%	100.0%
Condom	Count	88	180	217	25	510
	%	17.3%	35.3%	42.5%	4.9%	100.0%
Total	Count	292	564	642	50	1548
	%	18.9%	36.4%	41.5%	3.2%	100.0%

A further Chi-Square test was then also computed but this time using net monthly income, and this showed a significant relationship $\chi^2 (16 n=1548) = 37.900, p=.002$ and so the null hypothesis was rejected, the Bonferroni post hoc test for this can be seen in Table 9.

Table 9

*Which is the primary method of contraception you are currently using? * What is your current net monthly income from salary or social assistance? (Approx) Crosstabulation*

		What is your current net monthly income from salary or social assistance? In Euro					
		0 – 749	750 – 1499	1500 – 2999	3000 and <u>Over</u>	Prefer not to answer	Total
Oral	Count	80 _a	136 _a	167 _a	28 _a	15 _a	426
Contraceptive Pill	%	18.8%	31.9%	39.2%	6.6%	3.5%	100.0%
Natural Family	Count	9 _a	35 _a	37 _a	9 _a	6 _a	96
Planning	%	9.4%	36.5%	38.5%	9.4%	6.3%	100.0%
IUS	Count	28 _a	47 _a	86 _a	26 _a	10 _a	197
(Mirena/Jaydess)	%	14.2%	23.9%	43.7%	13.2%	5.1%	100.0%
Withdrawal	Count	36 _a	84 _{a, b}	150 _b	29 _{a, b}	20 _{a, b}	319
(Coitus Interruptus)	%	11.3%	26.3%	47.0%	9.1%	6.3%	100.0%
Condom	Count	103 _a	130 _a	207 _a	37 _a	33 _a	510
	%	20.2%	25.5%	40.6%	7.3%	6.5%	100.0%
Total	Count	256	432	647	129	84	1548
	%	16.5%	27.9%	41.8%	8.3%	5.4%	100.0%

Each subscript letter denotes a subset of What is your current net monthly income from salary or social assistance? (Approx) categories whose column proportions do not differ significantly from each other at the .05 level.

A further Kruskal Wallis test using the reliability rating to check for differences between the reliability rating of contraception chosen by women with different levels of income revealed that there is no significant difference between the reliability rating of contraception used by women with different net monthly income $\chi^2 (4, n=1548), 6.024, p=.197$. We can conclude that reliability of contraception is not associated with income in this particular test. Income and contraception use tests have garnered mixed results and further tests are needed.

Summary of findings

The results in this chapter show that most respondents are in a stable relationship, most are mothers, have a tertiary education and are in full time employment. Over 40% said they are able to save. Most do not consider themselves religious and never attend religious services. Knowledge of various methods of contraception is high and 76% of women are currently trying to control their fertility, 42% use the least reliable forms of contraception with only 34% of sexually active women using more reliable hormonal forms of contraception. Most women are using their preferred method but only 10% of respondents use the government services to obtain their prescription for contraception. Unplanned pregnancy rates range from 23 % to 47%, whilst 28% of respondents have had at least one miscarriage. Statistical tests to check whether socio-economic reasons affect contraception use and choice reveal mixed results. Associations were found between religion and contraception choice. Different tests show that education seems not to be associated with contraception use and choice but when tested against income, results are mixed. More research needs to be carried out to compare all test results, and results need to be interpreted with caution. The findings outlined above will be discussed in the next chapter.

CHAPTER 6 DISCUSSION

This study with Maltese women about their contraception and family planning practices was inspired by the New Zealand Family Planning Survey of 2020 (Family Planning New Zealand, 2020). In Malta just like in New Zealand, we have a “data desert” and very little to no recent information about the family planning practices of our women (Family Planning New Zealand, 2020). This study sought to present previously unavailable data on family planning practices amongst Maltese women. This chapter presents a discussion on these findings starting with a section on knowledge and general contraception practices, moving on to the relationship between socio-economic factors (religiosity, education, and income) and contraception use. It then goes on to discuss contraception prevalence and failure rates and the issue of unplanned pregnancies. Finally, the live births, abortion and miscarriage rates are discussed.

Knowledge and contraception practices

Knowledge of the various types of contraception is high among Maltese respondents signifying that lack of knowledge is not an issue and the want and need to control fertility is clear with over 75% of respondents currently using some form of birth control.

Withdrawal, condoms, and natural family planning methods have always been popular with Maltese women as seen in previous surveys by Milne and Wright (1997) and by Savona Ventura (2012), as can be seen in Figure 17 below, which compares past surveys to my survey. The current situation compared to previous years clearly shows that traditional methods, although on a positive downward trend, persist, with similar results for withdrawal in 2022 to those achieved in 2012, showing that not much has changed in the last decade, condoms are the only contraceptives that also provide protection from sexually transmitted diseases but seem to be less popular with current respondents than in Savona Ventura’s survey

In France, single women usually use condoms as do women in new relationships, they then move on to the OCP later when the relationship becomes more stable while LARCs are the preferred method for women who have already had the desired number of children (Poncet et al. 2013). Respondents of this survey also used different types of contraception

according to their relationship status. Although most single women were in stable relationships, single women used the OCP at a higher rate than condoms, followed by withdrawal and lastly Mirena (IUS), whereas married women used condoms as their primary method, followed by withdrawal, then followed by the OCP and then Mirena (IUS). Maybe married women use these least reliable methods because if they do get pregnant the repercussions of an unexpected pregnancy are perceived to be less traumatic and problematic within marriage as was found in a UK study (Firman et al., 2018).

On a positive note, hormonal contraception usage is slightly higher in 2022 when compared to 2010. The most significant difference in 2022 is in the use of intrauterine systems and devices such as the Mirena, with 11% of respondents in 2022 using various long-acting reversible contraception methods such as IUS, IUD, and implants. LARCs are the most reliable methods, but although the rate of use has improved, they are still not popular among Maltese women of all ages, of different educational attainment and from all walks of life.

Figure 17

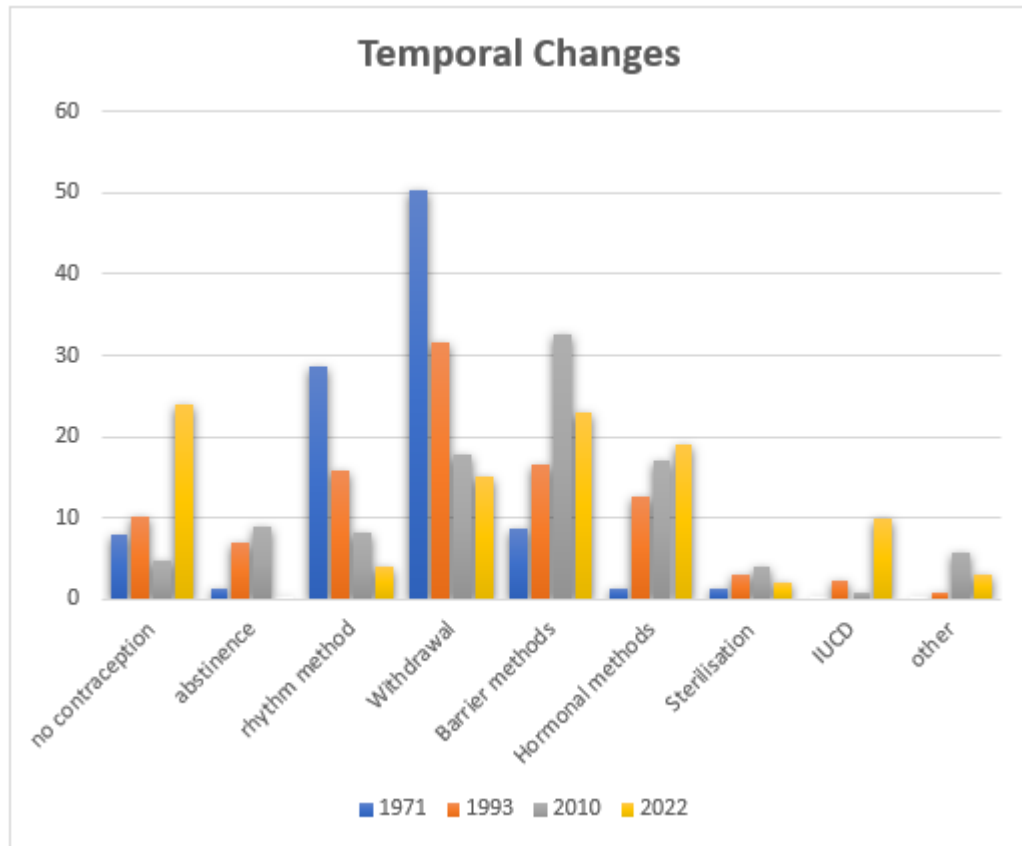


Figure 17 shows temporal changes from the other family planning surveys conducted in Malta in 1971, 1993, 2010 and my survey in 2022. No contraception users in 2022 include 6% of women trying to get pregnant and 4% either in same sex relationships or menopausal. No data for abstinence was collected in my survey of 2022.

As presented in the previous chapter, barrier methods (32%), the withdrawal method (20%) and Natural Family Planning/Rhythm method (6%) when combined show that 58% of participants in this survey are using the least effective forms of non-hormonal contraception as their primary method. This may indicate a possible resistance to using hormonal contraception in the form of pills, implants, injectables and hormonal intrauterine devices, which could be due to lack of proper information on risks and undue fears and myths about certain side-effects. The fact that these are also more costly could also be a barrier, as could also be societal, religious and cultural norms. The non-hormonal

copper coil although known about by over 83% of respondents, is barely used at all in Malta but widely used in other parts of the world, due to its high efficacy rate and the fact that once inserted, it can be forgotten and is effective for up to 10 years (Kaneshiro & Tod, 2010). Until recently it was not available in Malta due to its negative erroneous abortifacient reputation promoted by prolife groups. The copper coil has recently been reintroduced into the local market but is not generally prescribed by gynaecologists, who often recommend the hormonal IUS (Savona Ventura, 2012). The Mirena IUS whilst being one of the most effective forms of contraception is much more expensive than the copper coil and can set one back around 300 euros, besides it might not be the best choice for women who cannot use hormonal contraception.

Unfortunately, 25% of respondents confirmed that they are not using their preferred method. Of these, 36% are condom users, 29% are oral contraception users and 22% are users of the withdrawal method. Apart from health reasons, which in some cases may be unfounded due to lack of proper counselling or information (McNicholals et al., 2014) the main reasons that respondents mentioned for not using their preferred method were that their preferred method costs too much (18%), that they are too scared (15%) or that they don't know where to get it from (8%). These figures may signify that cost can be an issue towards using one's preferred method, that unwarranted fear due to lack of proper information may be limiting women from using the best method for their needs and information about where to access their preferred method is limiting their choices. Research shows that many factors influence women's birth control decisions. Concerns about side effects, health concerns, religion, family, society and cultural issues, accessibility, and economic aspects, together with relationship status and relationship contentedness and gender equality all play a part in a woman's choices and decisions (Bhan & Raj, 2021). These figures need to be investigated because lack of using ones preferred method of choice and knowledge may lead to inconsistent use and discontinuation which may lead to unplanned pregnancy (Mc Nicholas et al. 2014) Many women took the time to describe how they were not using their preferred method. Many of these qualitative responses were related to tubal ligation, with responses such as the following:

“I wish to get my tubes tied, but other young females who have tried before have been told to wait in case they or their male partners would like kids in the future”.

Other responses were related to negative effects associated with certain contraceptives: “the pill interferes with my body’s natural process and it gave me side effects and condoms irritate my skin and sex doesn’t feel good with them”,

Using one’s preferred method that reflects individual needs is important because various studies have shown that satisfaction with preferred chosen method is associated with more consistent user adherence (Mc Nicolas et al., 2014).

Socio-economic factors and contraception practices

Religion

Although most types of contraception are nowadays widely available against payment in Malta (Montanaro Gauci, 2020) all forms of artificial contraception are still banned by the Catholic Church except for the Natural Family Planning method, because sex is meant to be only for procreation (Moviment ta Kana, 2020). Regardless of the teachings of the Church most respondents of reproductive age (76%) are sexually active and using some form of contraception. Results show that most women said they do not consider themselves religious and 61% said they never attend any religious services, however this study still found a significant relationship between religiosity and contraception used. This was most evident in the use of hormonal contraception where a much higher percentage of non-religious women use the Oral Contraceptive Pill. The difference is also seen in the number of women that use the Natural Family Planning method, since this method was mostly used by women who consider themselves religious. Methods like withdrawal and condoms are also associated with women from religious backgrounds and women who consider themselves religious are less likely to use the more effective methods of contraception (Metcalf et al., 2016 and Moreau et al., 2013). A similar result was found among my respondents when a Kruskal Wallis test using reliability rating for the various contraception types showed a difference between the contraception choices of non-religious and religious women, with non-religious women using more reliable forms of contraception.

Local studies have often researched the effects of the Church on Maltese society most especially on women (Deguara 2019; Vella 2018). More research needs to be conducted with respect to the link between contraception use/choice and the influence of religion among Maltese women.

Education and Income

Research by Poncet et al., (2013) and Metcalfe et al., (2016) found that low educational attainment was associated with poor levels of contraception use and use of less reliable methods. Contrastingly, this survey found no significant difference between the contraception practices of women with different levels of education. There was also no difference in the reliability rating of contraception used by women with different levels of education. Women from higher socio-economic backgrounds and with higher educational achievements are known to use more reliable forms of contraception however this was not the case with respondents of this survey with only very few participants using the most reliable forms of contraception known as LARCs (IUD, IUS, implants). The use of LARCs was seen to be spread over women with different levels of education as was also the case with the other less reliable forms of contraception.

With regards to income, chi-square tests performed showed varying results when calculated on subjective feelings of financial stability and when computed against net monthly income. When calculated on subjectivity there was no association which might mean that even women who are well off use less reliable methods or that women who are not well off as seen in research by Arousell et al., (2016) might give contraception importance and are more motivated to use contraception due to their low socio-economic status and inability to afford a child or more children. The public health system offers very limited services when it comes to contraception and family planning with contraception only available against payment and with a doctor's prescription. The lack of free contraception may be contributing to the high use of cheaper or free methods of contraception such as condoms or withdrawal. 90% of respondents of this study, get their prescription by paying for it from their private GP or gynae. This shows that although the government does provide free gynae services and GPs at public health centres who can

also prescribe contraception, most women do not use these services. LARCs are very costly and difficult for many women to afford, most especially for students, single mothers, or vulnerable women (Mc Nicholas et al, 2014). The Maltese government does offer free insertion of hormonal Intra uterine Systems (IUS) in hospital for very vulnerable women; but the cost of the device is not covered by public health. Furthermore, women may have to wait for months to get an appointment with a public healthcare professional for insertion. Oftentimes, vulnerable women do not have the luxury of time either, especially those living in abusive situations and social workers working with vulnerable women residing in both Church and state residences need to reach out to the only privately funded NGO that covers contraception costs, the Women for Women Foundation to acquire contraception coverage for their vulnerable service users.

Research by McNicholas (2014) however shows that when women are equipped with knowledge about how various contraception works, the long- and short-term benefits, when women are fully informed about side effects, when shame and stigma are removed together with cost barriers, the vast majority always choose the most expensive and reliable methods that do not require user intervention such as IUDs, IUS, and Implants.

Contraception prevalence and failure rates

From Table 4 in the results and analysis section of this study, one can see the number of women who got pregnant whilst using contraception and which type of contraception they were using. One woman even reported getting pregnant after she had had her tubes tied. No contraception is 100% fool proof and typical use failure rates can confirm this. Typical use failure rates “express effectiveness among all women who use the method, including those who use it inconsistently and incorrectly. Perfect-use failure rates express effectiveness among only those women who use the method both consistently and correctly” (Guttmacher Institute, 2020, para. 2). Interestingly, these failure rates can be used to predict the numbers of potential unplanned pregnancies that may occur in the female population of reproductive age. This can be calculated if proper contraception prevalence and use of the different types of contraception used by women is collected. Even in this study typical use failure rates conform and are very similar to official typical

use failure rates. For example, condoms whilst effective as protection from STDs, when used as one's primary and only method of contraception are not the most reliable form to prevent pregnancy with a 13% typical use failure rate (CDC, 2021). This means that out of the 23.3% (n=510) of respondents who said they only use condoms as their primary method of contraception, at least 66 of them risk getting pregnant unexpectedly. Similarly, 19% (n=426) of respondents in this study said they used the Oral Contraceptive Pill (OCP) as their primary method. The typical use failure rate for OCPs is 7%. In this case it would mean that 30 respondents currently using the OCP may find themselves unintendedly pregnant. Looking at those 15% of respondents (n=319) that use the withdrawal method as their primary contraception, due to the typical use failure rate of up to 27%, this would mean that 83 women might get pregnant using this method in the next year. Just from typical use failure rates for these contraception methods, one can quite accurately predict that at least 179 respondents may fall pregnant unexpectedly while using these methods in the next year. In fact, the number of respondents who were using one of the above contraception methods and who said their contraception had failed and they got pregnant was 199, reflecting very realistically the typical use failure rates. The more reliable methods like LARCs in the form of the Mirena IUS have a typical use failure rate of just 0.15% (CDC, 2021), however, there were 6 respondents in this survey who said they got pregnant whilst using the Mirena (IUS) which makes the failure rate that of 0.9%, much higher than claimed by the CDC.

Unplanned Pregnancy

Unintended pregnancies whether wanted, unwanted or mistimed may bring about social, economic and health disadvantages, abortion is also a major consequence of unwanted unplanned pregnancies (Singh et al., 2010). A vast search on HYDI, Google Scholar and other databases did not result in any findings of local qualitative or quantitative research or local statistics on pregnancy intention or unplanned pregnancy in Malta. Accurately measuring unplanned pregnancy rates whether prospectively or retrospectively is extremely difficult because many unplanned pregnancies are not necessarily unwanted, and because many women even if the child was unwanted at the time of conception are unlikely to admit years later that their child was unplanned once the child is born (Rackin & Morgan, 2018).

This contrast regarding intendedness is also evident in the responses received in my research. When asked if they intended to get pregnant, 335 respondents (23%) clearly answered that they did not intend to get pregnant. However, when asked what contraception they were using at the time of pregnancy, if any, and if they did not intend to get pregnant, 47% (Table 4) of women responded that they did not intend to get pregnant and were either not using contraception or reported that their contraception had failed. Research shows that in Europe 43% of pregnancies are classified as unintended. Through this survey, the unintended pregnancy rate can be anywhere from a confirmed 23% to almost half of all pregnancies at 47%. These numbers are shocking especially due to the various physical and psychological repercussions for both mother and baby that may occur during pregnancy and after birth, not to mention all the socio-economic hardships that may also come with unplanned pregnancy for all the family and the economic burden for society at large. Such adversity is compounded by the fact that in Malta, abortion is criminalised and highly stigmatised.

It is important to note that when asked what contraception they were using if they did not intend to get pregnant, 20% of respondents stated that they were not using any contraception at all, even if they did not want to get pregnant. More research needs to be carried out to understand why so many women do not use contraception when they do not intend to get pregnant. Local researchers need to dig deeper to further understand the psychological or socio-cultural reasons for this risky behaviour amongst adults. Is it due to coercion, lack of empowerment, cultural influences, lack of proper knowledge, undue fear of side effects? Only through better understanding of the barriers to access and use can local researchers and policy makers eventually potentially manage to ensure less unplanned pregnancies, that can lead to better, healthier, and happier societies.

Live births, miscarriage, and abortion rates

The total number of live births amongst the 1483 respondents who have experienced a pregnancy was of 2436, an average of 1.6 children per respondent. The total number of miscarriages for the same group of respondents was 598, and the total number of abortions was 101. These numbers translate to 245 miscarriages for every 1000 live births and 41

abortions per 1000 live births. The total number of births, miscarriages, and abortions total to 3135 pregnancies amongst respondents. Out of all these pregnancies, 19.7% ended in a miscarriage or 28% of respondents said they had experienced at least one miscarriage. In the UK the NHS estimate that 1 in 8 pregnancies or 12.5% of women who know they are pregnant will experience a miscarriage (NHS,2018). If the reported numbers from this survey could be applied to the rest of the population it could mean that Malta has a much higher incidence of miscarriage amongst women who know they are pregnant than the UK, an incidence of 1 in 5 pregnancies. In Malta many mothers who have experienced a miscarriage complain in women-only social media groups that there are not enough proper after care services for women having had a miscarriage, with issues such as having to be in the same ward as happy mothers who have just delivered a healthy baby, to not enough perinatal mental health services with many women divulging being discharged from hospital with only a couple of leaflets and not enough proper support available during this traumatic time. Others also complain of being left for weeks on end feeling like a “walking coffin” waiting for their miscarriage to be naturally expelled without being given the option to have it removed as soon as there is no longer a heartbeat. The current miscarriage protocol is to first wait to see if the products of conception are naturally expelled, if not expelled naturally which can take around ten days specific medication is given to try to make this happen, finally if nothing happens, then women are offered a surgical procedure to remove the foetus (Fenech Conti, 2020). This endless waiting can prolong a woman’s miscarriage trauma for weeks. As mentioned in the results part of this study, Malta does not have a register that collects data about all miscarriages, but the only ones registered are those of women who have been discharged from hospital with a diagnosis of spontaneous abortion. Much more research needs to be conducted in Malta and more data needs to be collected to determine the realistic number of miscarriages amongst women of reproductive age. Miscarriages especially in early pregnancy are common but their psychological and potential short term and long-lasting effects are unfortunately often not taken seriously enough. Psychiatrists and psychologists now believe that pregnancy trauma can lead to depression and anxiety and that women who have previously had a miscarriage are more likely to suffer from post-natal depression even after the birth of a healthy child (Leis-Newman, 2012). This may have serious repercussion and long-term ill effects on all

the family and must be given much more importance. Women having suffered a miscarriage need to be given the respect, care, and proper health treatments they deserve after such a traumatic ordeal.

Malta is the only country in Europe where abortion is illegal under all circumstances and yet this survey shows that abortions are still happening and the rate from the respondents is 41 abortions per every 1000 live births with an average rate of just over 4000 live births every year, this would translate to at least 164 abortions per year by Maltese women. This is another important statistic, as no other data has previously been collected from women themselves. Websites like Women on Web that send abortion pills by mail to Malta have started to collect data, with 227 abortion pill packages shipped to Malta in 2020 during the Covid pandemic. Abortion once again is often a consequence of unplanned pregnancy and while not all unplanned pregnancies are unwanted and many women are happy to discover they are pregnant even when it is unexpected, some find the news devastating (Aiken et al., 2015). Contraception as we have seen in this study can often fail and those who discover they are unexpectedly pregnant and resort to terminate their pregnancy also deserve to be treated with kindness, respect, dignity, and compassion not as criminals.

Chapter Summary

This chapter has presented some new insights into the family planning practices of the women of Malta. It shed further light and discussed in more depth some of the findings that were presented in the previous chapter starting from a general overview of contraception practices and the associations between contraception, religion, education, and income. A breakdown of contraception prevalence and failure rates followed, ending with a discussion on unplanned pregnancies and the rates of births, miscarriages, and abortions. The next, final chapter brings together the most salient conclusions from this study and presents implications for research, policies, and services.

CHAPTER 7 CONCLUSION AND RECOMMENDATIONS

The aim of this study was to gather data about the family planning and contraception practices of women and persons assigned female at birth in Malta. This study highlighted the importance of family planning as a human right and the significance of keeping reproductive justice principles and values at the core of family planning policies. The literature reviewed showed that for women to control their fertility there are many social, cultural, and economic issues at play. Women's choices and their ability to freely choose the contraception and family planning decisions of their choice is rarely straight forward and very often influenced by external elements, often beyond their control. This is even more difficult and complicated for vulnerable women, women from low socio-economic backgrounds and women with different abilities especially in countries like Malta where patriarchal structures are strong. This final chapter brings together the main findings of this study, presents its limitations and puts forward recommendations for further research, policies, and services.

Summary of Main Findings and research implications

The large number of respondents that took part in this survey allowed for interesting previously unavailable data to be analysed. The data for this study was gathered through an anonymised online questionnaire and very clearly shows that most respondents (76%) who are sexually active and are not trying to get pregnant are currently using contraception and attempting to control their fertility. However, results in Figure 9 also show that most women (58%) are currently not using the more reliable modern types, with only 14% using the most effective long-acting methods. Results show high condom use, and high use of withdrawal method, both of which have a higher typical use failure rate, and further showing that many women's contraception is in the hands of their male partners. It is evident that it is not from lack of knowledge, because most women know of and have heard about most modern methods of contraception. Surprisingly, even though most women have a tertiary level of education, many still use these less reliable methods. This could also potentially mean that the situation of contraception use amongst other women not represented in this sample are more dire, and that even less women are using modern artificial methods and the more expensive but more reliable LARCs. It is important for

policy makers to understand why so few women are using hormonal contraception with just 26% of respondents currently using the more reliable hormonal methods only 14% using intrauterine systems, and only eight women using the non-hormonal intrauterine copper coil. Knowledge is not the issue because most women know about the various types of contraception available, however more research is needed to determine why this knowledge does not translate to more women using the more effective and reliable forms of contraception, which would also allow women to be more in control of their own fertility and may lead to lowering the number of unplanned pregnancies.

When it comes to unplanned pregnancies results show a high number of unintended pregnancies and at an estimated rate of between 23% and 47%. Research presented shows the possible negative effects of unplanned pregnancy. Using unreliable methods could be the cause of such a high rate. Of course, not all unplanned pregnancies are unwanted and create stress, but knowing the possible dire repercussion that many women, especially vulnerable women can face due to unplanned pregnancy this issue must be further researched.

A large number of miscarriages were reported by participants, showing that 28 % of women reporting a pregnancy had suffered a miscarriage. This large percentage of miscarriages reported by respondents must also be further investigated, especially since research shows that there are long lasting negative effects on women experiencing this extremely traumatic life event. Malta's health care services with regards to current miscarriage protocols should be improved and post miscarriage mental health support services reviewed and improved to limit the post traumatic effects of miscarriages.

Whilst chi-square tests show that religion seems to be associated with contraception use, education and income seem not to be associated. This may mean that even though almost half of women said they did not consider themselves religious their contraception choices seem to in some ways still be controlled by cultural forces beyond their consciousness. This could possibly also be attributed to the strong patriarchal atmosphere all around us, many times subconsciously infiltrating our choices without us even being aware. Conversely

education does not seem to have a significant effect on contraception choices, but this could be because this survey is not statistically representative of the educational level of the population. In this survey over 60% of respondents have a tertiary level of education whereas only 30% of women in the general population have a tertiary level of education. When it comes to contraception and income, tests showed mixed results, with Chi-square tests on subjective financial wellbeing showing no influence on contraception choice, however when checked against net monthly income there was a significant association. When income was checked against reliability rating, once again the reliability rating of contraception chosen by women with different earnings was not found to be different. These results need to be observed with caution as the income of the participants of this sample is not necessarily representative of the general population.

Limitations of this study

A significant limitation of this quantitative study was that it was not conducted by a team of dedicated professionals in the fields of contraception, public health, policy, and human rights nor was a team of statisticians employed to analyse the data collected - this research was carried out by a student for a Master's degree in Gender, Society and Culture. Limited time, a lack of previous experience in conducting quantitative research and analysis of the complex data, a limited knowledge of the vast issues affecting contraception choices, and lack of proper skills in writing scientific papers, together with financial constraints and limited resources placed limitations on the way data was collected, analysed, discussed, and presented.

Using a convenience sampling method means that the survey cannot claim to be representative of the whole population, despite the large sample size. The exclusion of excluded participants under 18 years and those of non-Maltese participants are further limitations. The fact that the survey was online meant that it was only accessible to women with internet access that had access to a computer or a smart phone. Respondents also needed to be confident with using social media applications. Using an online survey instead of the more accurate stratified random sampling system which is usually conducted either over the phone or through face-to-face interviews, meant that sections of the population

may have been excluded, namely the more vulnerable or illiterate, women with intellectual or physical disabilities and possibly also other ethnic minorities.

Recommendations for further research

This study has clearly shown that a national representative survey surrounding the family planning practices of Maltese people using a random stratified sampling method is urgently needed. A more in-depth, well-funded research study conducted by experts in the fields of public health, social policy, contraception, gender, social justice, reproductive justice, and statistics is way overdue. This has also been repeatedly recommended by experts in the field for many years with Prof. Savona Ventura also recommending this back in 2012. Another recommendation would be more in-depth studies potentially using qualitative methods with various groups that might be more vulnerable and harder to reach such as migrant women, women with disabilities and youths younger than 18. Further research could also focus on a thorough evaluation of services provided by the state, focusing on current practices and policies with regards to contraception availability and provision. This evaluative study would contribute to understanding the current situation and help with identifying any existing possible pitfalls. Further research is also needed to identify and evaluate the knowledge and attitudes of healthcare professionals when it comes to the complex issues at play surrounding people's family planning decisions. This would help to pinpoint other important inadequacies and lack of knowledge that is essential for also assessing future training needs. Research is also recommended to understand further the causes and repercussions of unplanned pregnancy on the local population both from a health perspective and from a socio-economic viewpoint. Research is also needed to understand more in depth the experiences of women who experience a miscarriage, the potential physical and psychological effects of miscarriage, and the effectiveness of services in this area. With regards to abortion, further studies are needed to understand the prevalence of abortion, the circumstances and experiences of women who access abortion care and the impact of the current abortion ban on their wellbeing, including studies exploring the effect of abortion stigma.

Recommendations for policy and services

The above recommendations should then be followed by a modern and robust National family planning policy, one that keeps human rights and reproductive justice principles and intersectionality at its core whilst respecting and following international scientific guidelines. A robust family planning policy should be the government's first important step towards keeping their electoral promises of providing various forms of contraception for free to all genders. Research presented in this study shows that provision is not enough. Understanding women's and men's preferred methods and needs is imperative to ensure consistent usage and to prevent unplanned pregnancy. Research shows that it is also economically advantageous for governments to invest in providing services that result in as many children as possible being born to well prepared and ready couples, armed with the best possible skills to parent their children in safe and healthy environments.

In the meantime, public health officials in clinics and hospitals need to be properly trained to talk about and recommend contraception to women of reproductive age, most especially to young women. Research shows that doctors and potentially also nurses and other health care professionals need to be specifically trained to understand human rights and reproductive justice principles and intersectionality issues to ensure that women's choices are truly their own and that contraception is a choice women make willingly without coercion from their doctors, family members or due to cultural pressure.

From the knowledge and insights gathered from this study, the ideal scenario would be to introduce modern, warm, and friendly non-medical family planning centres around the island. These centres could be complementary to other already available medical services. The idea would be that these centres would help to address all aspects of reproductive health, from advice and provision of contraception to discussion of fertility issues, sexuality, miscarriage, sexual health issues all the way up to menopause and HRT. Family planning centres would also help to create and collect much-needed currently unavailable data that policy makers need to create and improve services continuously and consistently. More importantly, if properly managed and well resourced, family planning centres can provide a nurturing and safe environment where people from all walks of life can feel safe and

supported away from possible societal shame and stigma. A place where they can freely and at no cost discuss and find counselling and therapy for their most intimate and sometimes most traumatic life altering events, that may come with experiences such as unplanned pregnancy, infertility, miscarriage, abortion, gender identity issues and sexual health problems.

General Conclusion

Women spend around 40 years of their lives trying to control their fertility; women's reproductive health deserves the proper care and investment to ensure the best possible outcomes for future families whether for those trying to conceive or those trying to prevent conception. The proper timing, planning, and spacing of children is an important and integral aspect of a woman's existence that affects not only her but all her family and society at large.

Choice is the key word; Malta's women deserve to have a choice of contraceptives to choose from and the ability to freely discuss their options together with the help of a health care provider. All women in Malta, regardless of their socioeconomic situation should have the ability, support, knowledge, accessibility, and opportunity available to them to enable them to choose, to use, their preferred contraception method and the one most effective towards their own individual needs. As seen, women's contraception choices are complicated and inconsistent and a lot of factors are at play, but with a human rights and reproductive justice framework, policies can be implemented that are fair and equitable and tailored to women's diverse needs. I sincerely hope this research study will be the catalyst to more professional and in depth, robust research in family planning practices on a national scale. Our families deserve this, Malta deserves and needs this.

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APPENDICES

Appendix A - Survey in English

Dear Participant,

My name is Francesca Fenech Conti and I am a student at the University of Malta, presently reading for a Masters Degree in Gender, Society and Culture. I am presently conducting a research study for my dissertation; this is being supervised by Dr. Andreana Dibben and co-supervised by Dr Marie Briguglio.

The aim of my study is to collect information about family planning practices with persons who were assigned as female at birth in Malta.

Data will be collected via the use of an anonymous online questionnaire. Participation is voluntary, however, by proceeding to answer the questionnaire, you are giving your consent to take part in this study.

Any data collected from this research will be used solely for the purposes of this study, and should you choose to participate in this questionnaire, you can stop at any time and there is no obligation to continue once you have started. However, once you submit the survey, your participation cannot be reversed since there will be no way to trace your answers back to you.

Please note that some of the questions may be of a sensitive nature. Should you feel you need to reach out for help you may contact:

Peri-Natal Mental Health Clinic at Mater Dei – Tel: 2545 4544

Richmond Foundation –Tel: 1770

Victim Support Malta - Tel 21228333

Kellimni.com - www.kellimni.com

Should you have questions about family planning or contraception please contact Family Planning Advisory Services (FPAS): Tel: 27780037

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me by phone 99911100 or e-mail on francesca.fenech-conti.16@um.edu.mt. You may also contact my supervisor on andreana.dibben@um.edu.mt

I have read and understood the above (will not allow to proceed to survey unless ticked)

Gender:

☐ Male (assigned female at birth)

☐ Female

☐ Other (assigned female at birth)

Age at last birthday (Please note you must be 18 or over to complete this survey):

Where do you live?

- ☐ Central – Attard, Balzan, Birkirkara, Gzira, Iklin, Msida, Pieta, Gwardamangia, St. Julian's, San Gwann, Santa Venera, Sliema, Ta'Xbiex.
- ☐ Northern – Dingli, Gharghur, Mdina, Mellieha, Mgarr, Mosta, Mtarfa, Naxxar, Pembroke, Rabat, St. Paul's Bay, Swieqi
- ☐ South Eastern – Birgu, Bormla, Fgura, Floriana, Kalkara, Marsa, Marsaxlokk, Marsascala, Paola, Senglea, Tarxien, Valletta, Xghajra, Zabbar, Zejtun
- ☐ Southern – Birzebugia, Ghaxaq, Gudja, Hamrun, Kirkop, Luqa, Mqabba, Qormi, Qrendi, Safi, Santa Lucija, Siggiewi, Zebbug, Zurrieq
- ☐ Gozo – All

What is your Nationality?

- ☐ Maltese
- ☐ Other

What is your ethnic group?

- ☐ White
- ☐ Asian
- ☐ Black
- ☐ Arab
- ☐ Mixed ethnic background Other (Specify)

What is the highest qualification (or education) that you have successfully attained

- ☐ No formal schooling
- ☐ Primary
- ☐ Secondary
- ☐ Post-Secondary
- ☐ Tertiary
- ☐ Post Tertiary

Marital Status

- ☐ Single (never married or annulled marriage and not remarried)
- ☐ Married or in a civil union, with a person of the opposite sex
- ☐ Married or in a civil union, with a person of the same sex
- ☐ Separated, formerly in an opposite-sex marriage or civil union
- ☐ Separated, formerly in a same-sex marriage or civil union
- ☐ Widowed (not remarried)
- ☐ Divorced (not remarried)

Have you ever resided outside of Malta for a continuous period of at least 5 years?

- ☐ Yes
- ☐ No

What religion, religious denomination or body do you belong to/identify yourself with?

- ☐ Roman Catholic
- ☐ Orthodox
- ☐ Church of England
- ☐ Protestant
- ☐ Islam
- ☐ Judaism
- ☐ Buddhism
- ☐ Hinduism
- ☐ No Religion
- ☐ Other

How many children do you have Under 16 years of age?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 and over

How many children do you have Over 16 years of age?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4 and over

What is your employment status?

- ☐ Employed
- ☐ Unemployed
- ☐ Student and/or person having an unpaid working experience
- ☐ Retired
- ☐ Cannot work due to illness or disability

- Taking care of the house and/or family
- Other (Specify)

What is your current monthly income? (Approx)

- 0 – 749 euro
- 750 – 1499 euro
- 1500 – 2999 euro
- 3000 euro and over

Which Methods of Contraception have you heard about?

- | | | |
|--|----------|----------------|
| ○ Oral Contraceptive Pill | Heard of | Never heard of |
| ○ Nuva Ring | Heard of | Never heard of |
| ○ Natural Family Planning | Heard of | Never heard of |
| ○ Diaphragm | Heard of | Never heard of |
| ○ Female Condom | Heard of | Never heard of |
| ○ IUD (Mirena/Jaydess) | Heard of | Never heard of |
| ○ Withdrawal | Heard of | Never heard of |
| ○ Tubal Ligation (Getting Tubes tied) | Heard of | Never heard of |
| ○ Implant | Heard of | Never heard of |
| ○ Non hormonal IUD (copper, gold coil) | Heard of | Never heard of |
| ○ Depo Provera (Injection, the jab) | Heard of | Never heard of |
| ○ Emergency contraception (Morning After Pill) | Heard of | Never heard of |
| ○ Condom | Heard of | Never heard of |
| ○ Vasectomy (the snip) | Heard of | Never heard of |
| ○ Other (Please specify) | Heard of | Never heard of |

Which method of contraception have you ever used?

- | | | |
|--|------|------------|
| ○ No Contraception | | |
| ○ Oral Contraceptive Pill | Used | Never Used |
| ○ Nuva Ring | Used | Never Used |
| ○ Natural Family Planning | Used | Never Used |
| ○ Diaphragm | Used | Never Used |
| ○ Female Condom | Used | Never Used |
| ○ IUD (Mirena/Jaydess) | Used | Never Used |
| ○ Withdrawal (Coitus Interruptus) | Used | Never Used |
| ○ Tubal Ligation (Getting Tubes tied) | Used | Never Used |
| ○ Implant | Used | Never Used |
| ○ Non hormonal IUD (copper coil) | Used | Never Used |
| ○ Depo Provera (Injection, the jab) | Used | Never Used |
| ○ Emergency contraception (Morning After Pill) | Used | Never Used |
| ○ Condom | Used | Never Used |
| ○ Vasectomy (the snip) | | |
| ○ Other (Please specify) | | |

Which method of contraception are you currently using?

- ☐ No Contraception
- ☐ Oral Contraceptive Pill
- ☐ Nuva Ring
- ☐ Natural Family Planning
- ☐ Diaphragm
- ☐ Female Condom
- ☐ IUD (Mirena/Jaydess)
- ☐ Withdrawal (Coitus Interruptus)
- ☐ Tubal Ligation (Getting Tubes tied)
- ☐ Implant
- ☐ Non hormonal IUD (copper, gold coil)
- ☐ Depo Provera (Injection, the jab)
- ☐ Emergency contraception (Morning After Pill)
- ☐ Condom
- ☐ Vasectomy (the snip)
- ☐ Other (Please specify)

Is your contraception your preferred method or would you prefer to be using something else?

- ☐ Yes, I am using my preferred method
- ☐ No, I am not using my preferred method
- ☐ I do not use artificial contraception at all
- ☐ I do not use any form of contraception

What is stopping you from using your preferred method?

- ☐ Costs too much
- ☐ Haven't found time to get it,
- ☐ My health doesn't allow me to use it,
- ☐ Hard to arrange an appointment,
- ☐ Too scared,
- ☐ Wait for appointment is too long,
- ☐ Don't know where to get it,
- ☐ Partner or others do not want me to use it,
- ☐ Too embarrassed,
- ☐ Against my religion
- ☐ My doctor told me not to use it, but I don't know why
- ☐ Don't know,
- ☐ Other _____

If you are not using contraception, why are you not using contraception?

- Religious beliefs
- Infrequent sex/no sex
- Interferes with body's natural process
- Scared of side effects
- I don't want to use it
- Health concerns
- Costs too much
- Want as many children as possible
- Menopausal/hysterectomy
- Inconvenient to use
- Partner had vasectomy
- In a same sex relationship
- Infertile
- Don't know where to get it from
- Partner doesn't want me to use it
- Don't know how to use it
- Too embarrassing

Who do you get your contraception prescription from?

- No prescription required I use condoms,
- No prescription required I use the withdrawal method
- No prescription required I use natural family planning,
- No prescription required when in need I use Emergency Contraception
- Family GP
- Health Centre GP
- GP at Pharmacy
- Private Gynae,
- Gynae at Health Centre,
- Hospital,
- Sexual Health Clinic,
- Other (please Specify)

Have you ever experienced a health practitioner who was opposed to providing you contraception?

- Yes
- No

What was s/he opposed to providing?

Trigger Warning: Next questions are about pregnancy, miscarriage, and abortion.

The next section is for those respondents who have experienced pregnancy.

How many pregnancies have you had?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ Over 3

For each of the pregnancies, what was the outcome?

First pregnancy:

- ☐ Natural miscarriage
- ☐ Birth
- ☐ Abortion

Second Pregnancy:

- ☐ Natural miscarriage
- ☐ Birth
- ☐ Abortion

Third pregnancy:

- ☐ Natural miscarriage
- ☐ Birth
- ☐ Abortion

Fourth Pregnancy:

- ☐ Natural miscarriage
- ☐ Birth
- ☐ Abortion

Subsequent pregnancies:

- ☐ Natural miscarriage
- ☐ Birth
- ☐ Abortion

When was your most recent pregnancy?

- ☐ 0 – 2 years ago
- ☐ 3 – 5 years ago
- ☐ 6 to 10 years ago
- ☐ Over 11 years ago

Please think of your current (or most recent) pregnancy when answering the questions below.

In the month that I became pregnant..... (Please tick the statement which most applies to you):

- ☐ I/we were not using contraception
- ☐ I/we were using contraception, but not on every occasion
- ☐ I/we always used contraception, but knew that the method had failed (i.e. broke, moved, came off, came out, not worked etc) at least once
- ☐ I/we always used contraception

Just before I became pregnant..... (Please tick the statement which most applies to you):

- ☐ I intended to get pregnant
- ☐ my intentions kept changing
- ☐ I did not intend to get pregnant

Thank you for participating.

Should you have experienced any anxiety or psychological discomfort while completing this questionnaire please note you may find help at the following organisations:

Peri-Natal Mental Health Clinic at Mater Dei – Tel: 2545 4544

Richmond Foundation –Tel: 1770

Victim Support Malta - Tel 21228333

Kellimni.com - www.kellimni.com

Should you have questions about family planning or contraception please contact Family Planning Advisory Services (FPAS): Tel: 27780037

Appendix B – Survey in Maltese

Għażiża Parteċipanta,

Jiena Francesca Fenech Conti, studenta l-Universita' ta' Malta. Bħalissa qed insegwi *Masters Degree in Gender, Society and Culture*. Preżentament qed nagħmel riċerka għat-teżi tiegħi, teżi li qed jiġi sorveljat minn Dr Andreana Dibben u ko-sorveljat minn Dr Marie Briguglio.

L-għan tar-riċerka tiegħi huwa li niġbor informazzjoni dwar il-prattika ta' 'ppjanar għall-familja f'persuni li ġew assenjati sess femminili fit-twelid, f'Malta.

L-informazzjoni għal din ir-riċerka ħa tiġi miġbura permezz ta' kwestjonarju anonimu onlajn. Il-parteċipazzjoni hija volontarja, waqt li bil-parteċipazzjoni tiegħek tkun qed tagħti l-kunsens tiegħek biex tiegħu sehem f'dan l-istudju.

L-informazzjoni miġbura ħa tkun qed tintuża biss għall-għan ta' dan l-istudju, u jekk taħżen li tiegħu sehem f'dan l-istudju tista' tiddeciedi li tieqaf fi kwalunkwe ħin, u jekk tibda mintix obbligata tkompli. Madankollu, hekk kif tissottometti l-istħarriġ, il-parteċipazzjoni tiegħek ma tkunx riversibbli minħabba li ma jkunx hemm mod li bih ir-risposti tiegħek jistgħu jiġu ntraċċati.

Jekk jogħġbok innota li xi wħud mid-domandi jistgħu ikunu ta' natura sensittiva. Jekk tħoss il-bżonn għall-għajnuna tista' tikkuntattja lil:

Peri-Natal Mental Health Clinic 2545 7410

Richmond Foundation 21 224580; 21 482336; 21 480045

Kellimni.com

Għal domandi dwar kontraċezzjoni jew ippjanar tal-familja tista' tikkuntattja lil Family Planning Advisory Services (FPAS) fuq 2778 0037; 2034 1686

Grazzi tal-ħin u l-kunsiderazzjoni tiegħek. Jekk tkun tixtieq tistaqsi xi ħaġa tiddejjaqx tikkuntattjani fuq 99911100 jew ibgħatli imejl fuq francesca.fenech-conti.16@um.edu.mt. Tista' tikkuntattja wkoll lis-superviżur tiegħi fuq andreana.dibben@um.edu.mt

Nikkonferma li qrajt u fhimt l-informazzjoni t'hawn fuq (ittikkja biex tiegħu sehem fl-istħarriġ)

Sess:

_ Raġel (assenjat sess femminili fit-twelid)

_ Mara

_ Aktar (assenjat sess femminili fit-twelid)

Eta' li għalaqt l-aħħar (Irid ikollok 18-il sena jew aktar biex tiegħu sehem f'dan l-istħarriġ):

Eta' _____

Fejn toqgħod?

- Zona Ċentrali – Attard, Balzan, Birkirkara, Gżira, Iklin, Msida, Pieta', Gwardamangia, San Ġiljan, San Ġwann, Santa Venera, Sliema, Ta' Xbiex.

- Zona Tramuntana – Dingli, Għargħur, Mdina, Mellieħa, Mgarr, Mosta, Mtarfa, Naxxar, Pembroke, Rabat, St. Paul's Bay, Swieqi
- Zona Lvant – Birgu, Bormla, Fgura, Floriana, Kalkara, Marsa, Marsaxlokk, Marsaskala, Paola, Senglea, Tarxien, Valletta, Xgħajra, Żabbar, Żejtun
- Zona Nofsinhar – Birżebbuġa, Għaxaq, Gudja, Ħamrun, Kirkop, Luqa, Mqabba, Qormi, Qrendi, Safi, Santa Luċija, Siġġiewi, Żebbuġ, Żurrieq
- Għawdex – Kollu

X'inh i n-nazzjonalita' tiegħek?

- Maltija
- Aktar

X'inh i l-grupp etniku tiegħek?

- Ażjatiku
- Għarbi
- Etnika mħallta Aktar (Speċifika)

X'inh i l-oġħla kwalifikazzjoni (jew edukazzjoni) li akkwistajt b'suċċess?

- Xejn skola formali
- Primarja
- Sekondarja
- Post-Sekondarja
- Terzjarja
- Post-Terzjarja

Stat Ċivili

- 'Single' (qatt ma żżewwiġt jew annullajt jew ergajt iżżewwiġt)
- Miżżewġa jew f'unjoni ċivili, ma persuna tas-sess oppost
- Miżżewġa jew f'unjoni ċivili, ma persuna ta' l-istess sess
- Separata (bi żwieġ jew unjoni ċivili ma persuna tas-sess oppost)
- Separata (bi żwieġ jew unjoni ċivili ma persuna ta' l-istess sess)
- Armla (m'ergajt ix x iżżewwiġt)
- Divorzjata (m'ergajt ix x iżżewwiġt)

Qatt għext barra minn Malta għal perjodu ta' aktar minn 5 snin?

- Iva
- Le

Ma liema reliġjon, denominazzjoni reliġjuża jew korp tappartjeni jew tidentifika?

- Ruman Kattoliku

- Ortodoss
- 'Church of England'
- Protestanta
- Iżlamika
- Judaista
- Buddista
- Induwista
- Ateista
- Aktar

Kemm għandek tfal taħt is-sittax-il sena?

- 1
- 2
- 3
- 4 jew aktar

Kemm għandek tfal t'aktar minn sittax-il sena?

- 1
- 2
- 3
- 4 jew aktar

X'inhu l-istat tal-impjegat tiegħek?

- Impjegata
- Mhux impjegata
- Studenta u/jew persuna li taħdem b'mod volontarju
- Irtirata
- Ma nistax naħdem minħabba mard jew diżabilita'
- Nieħu ħsieb id-dar u/jew il-familja
- Aktar (Speċifika)

Xi kemm taqla' paga fix-xahar?

- 0 – 749 ewro
- 750 – 1499 ewro
- 1500 – 2999 ewro
- 3000 ewro jew aktar

Liema metodi ta' kontraċezzjoni smajt bihom s'issa?

- Il-pillola kontraċettiva
- Nuva Ring
- L-ippjanar tal-familja b'mod naturali
- Id-dijaframma
- Kondom femminili
- IUD (Mirena/Jaydess)

- 'Withdrawal'
- Ligazzjoni tat-tubi fallopjani
- Impjant
- IUD mhux ormonali (ramm, spirali fid-deheb)
- Depo Provera (injezzjoni)
- Kontraċettiv t'emergenza (*Morning After Pill*)
- Kondom
- Vażektomija (*the snip*)
- Aktar (Speċifika)

Liema metodi kontraċettivi użajt s'issa f'hajtek?

○ Xejn		
○ Il-pillola kontraċettiva	Użajtha	Qatt m'Użajtha
○ Nuva Ring	Użajtha	Qatt m'Użajtha
○ L-ippjanar tal-familja b'mod naturali	Użajtha	Qatt m'Użajtha
○ Id-dijaframma	Użajtha	Qatt m'Użajtha
○ Kondom femminili	Użajtha	Qatt m'Użajtha
○ IUD (Mirena/Jaydess)	Użajtha	Qatt m'Użajtha
○ 'Withdrawal'	Użajtha	Qatt m'Użajtha
○ Ligazzjoni tat-tubi fallopjani	Użajtha	Qatt m'Użajtha
○ Impjant	Użajtha	Qatt m'Użajtha
○ IUD mhux ormonali (ramm, spirali fid-deheb)	Użajtha	Qatt m'Użajtha
○ Depo Provera (injezzjoni)	Użajtha	Qatt m'Użajtha
○ Kontraċettiv t'emergenza (<i>Morning After Pill</i>)	Użajtha	Qatt m'Użajtha
○ Kondom	Użajtha	Qatt m'Użajtha
○ Vażektomija (<i>the snip</i>)		
○ Aktar (Speċifika)		

Liema metodu ta' kontraċettiv qed tuża bhalissa?

- Xejn
- Il-pillola kontraċettiva
- Nuva Ring
- L-ippjanar tal-familja b'mod naturali
- Id-dijaframma
- Kondom femminili
- IUD (Mirena/Jaydess)
- 'Withdrawal'
- Ligazzjoni tat-tubi fallopjani
- Impjant
- IUD mhux ormonali (ramm, spirali fid-deheb)
- Depo Provera (injezzjoni)
- Kontraċettiv t'emergenza (*Morning After Pill*)
- Kondom
- Vażektomija (*the snip*)
- Aktar (Speċifika)

Thossok qed tuża l-metodu kontraċettiv li tippreferi, jew tippreferi tuża xi haġa differenti?

- Iva qed nuża l-metodu li nippreferi
- Le mhux qed nuża l-metodu li nippreferi
- Ma nuża l-ebda kontraċettiv artifiċjali
- Ma nuża l-ebda tip ta' kontraċettiv

X'qed iżommok milli tuża l-metodu ta' kontraċettiv li tippreferi?

- Jiswa wisq
- Ma sibtx ċans nixtrih
- Saħħti ma tippermettilix li nużah
- Diffiċli wisq biex tagħmel appuntament
- Nibża' wisq
- Iddum wisq tistenna għal appuntament
- M'għandix idea minn fejn jinx tara
- Il-partner jew xi ħadd ieħor ma jridnix nużah
- Nistħi wisq
- Kontra r-religjon tiegħi
- It-tabib qalli ma nużaħx imma ma nafx għala
- Ma nafx
- Aktar _____

Jekk mhux tuża kontraċettivi, għaliex għażilt li ma tużax?

- Minħabba t-twemmin religjuż
- Nuqqas ta' sess/xejn sess
- Minħabba li ma jinxix mal-proċess naturali tal-ġisem
- Nibża' mill-effetti mhux mixtieqa
- Ma rridx nuża
- Minħabba s-saħħa
- Jiswa' wisq
- Irrid li jkolli ħafna tfal
- Menopawsa/Isterektomija
- Inqisu bħala inkonvenjent
- Il-partner għamel važektomija
- F'relazzjoni ma persuna tal-istess sess
- Infertili
- Ma nafx minn fejn nista' nixtri
- Il-partner ma jridnix nuża
- Ma nafx kif tużahom
- Imbarazzanti wisq

Minn fejn iġġib il-preskrizzjoni?

- M'għandix bżonn preskrizzjoni għax nuża kondoms
- M'għandix bżonn preskrizzjoni għax nuża l-'withdrawal method'

- M'għandix bżonn preskrizzjoni għax nuża l-ippjanar tal-familja b'mod naturali
- M'għandix bżonn preskrizzjoni għal meta niġi bżonn il-kontraċettiv t'emergenza (morning after pill)
- It-tabib tal-familja
- Tabib miċ-Ċentru Tas-Saħħa Pubblika
- Tabib fi spiżerija
- Ġinekologista privat
- Ġinekologista fiċ-Ċentru tas-Saħħa Pubblika
- L-isptar
- 'Sexual Health Clinic'
- Aktar (Specifika)

Qatt iltqajt ma xi persuna fil-qasam tas-saħħa li rrifjutat li ttik kontraċettiv?

- Iva
- Le

Għaliex?

Attenzjoni: Id-domandi li jmiss jitrattaw it-tqala, 'miscarriage' u abort. Is-sezzjoni li jmiss hija għal dawk li esperjenzaw tqala.

Kemm il-tqala esperjenzajt?

- 1
- 2
- 3
- Aktar minn 3

Għal kull tqala li kellek, x'kien ir-rizultat?

L-ewwel tqala:

- 'Miscarriage' b'mod naturali
- Twelid
- Abort

It-tieni tqala:

- 'Miscarriage' b'mod naturali
- Twelid
- Abort

It-tielet tqala:

- 'Miscarriage' b'mod naturali
- Twelid
- Abort

Ir-raba' tqala:

- 'Miscarriage' b'mod naturali
- Twelid

- Abort

Tqaliet sussegwenti:

- 'Miscarriage' b'mod naturali
- Twelid
- Abort

Meta kienet l-aħħar tqala tiegħek?

- 0 – sentejn
- 3 – 5 snin
- 6 sa 10 snin ilu
- Aktar minn 11-il sena ilu

Jekk jogħġbok irreferi għall-aktar tqala riċenti tiegħek meta twieġeb dawn id-domandi li ġejjin.

Fix-xahar li fih inqbadt tqila..... (Jekk jogħġbok ittikkja dak li l-aktar jgħodd għalik):

- Jien/aħna ma konniex qed nużaw kontraċettivi
- Jien/aħna konna qed nużaw il-kontraċettivi imma mhux dejjem
- Jien/aħna dejjem użajna kontraċettivi imma ndunajna li l-metodu li użajna kien falla (tqatta', iċċaqlaq, inqala', ħareġ, ma ħadimx eċċ) mill-inqas darba waħda
- Jien/aħna dejjem użajna kontraċettivi

Qabel ma nqbadt tqila.....(Jekk jogħġbok ittikkja dak li l-aktar jgħodd għalik):

- Kont ippjanata li ninqabad tqila
- Ma kontx ċerta mill-intenzjonijiet tiegħi
- Ma ridtx ninqabad tqila

Grazzi talli pparteċipajt.

Jekk esperjenzajt anzjeta' jew skumdita' psikoloġika waqt li kont qed timla' dan il-kwestjonarju tista' ssib l-għajnuna minn dawn l-organizzazzjonijiet:

Peri-Natal Mental Health Clinic f' Mater Dei 2545 7410

Richmond Foundation fuq 1770 jew 21 224580; 21 482336; 21 480045

Victim Support Malta fuq 21 228333

Kellimni.com

Jekk għandek xi domandi li tixtieq issaqsi dwar l-ippjanar tal-familja jew kontraċezzjoni nitolbok tikkuntattja lill-Family Planning Advisory Services (FPAS) fuq 2778 0037; 2034 1686