

“Between TikTok and Textbooks: How Social Media and Sex Education shape Contraceptive Practices and Knowledge among Young Adults in Ireland.”

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Abstract

As social media use continues to increase, young adults are exposed to a great amount of information on a daily basis. This can make it challenging to distinguish between reliable and unreliable sources. In order to investigate the impact of social media on the sexual health knowledge, I seek to understand the role of the time spent online as a possible influence on the contraceptive practices and knowledge within the Irish context. For this study, I rely on existing survey data from cohort '98, wave 3 and 4 of Growing Up in Ireland. My paper analyzes the association between attending Relational and Sexuality Education (RSE) and two outcomes: experienced pregnancies and STI prevention knowledge. In addition, I analyze whether the associations vary depending on the time spent online. While previous research has examined the relation between social media use and health knowledge, very little attention is given to the relationship between social media use and sexual health knowledge. The findings of my paper demonstrate evidence of a positive association between attending RSE and contraceptive knowledge regarding STI prevention ($p = .049$). The results also indicate that those who attended RSE are more likely to have experienced pregnancy ($p .036$), which may be related to young adults being sexually active at an early age. However, my analysis does not show evidence of a weaker or stronger association for young adults who spend time online. My study highlights how RSE contributes to the transmission of knowledge regarding sexual health knowledge, but also the need for further research into how social media may potentially contribute to contraceptive practices and knowledge.

Keywords: gender, contraceptive practices and knowledge, Relational and Sexuality Education (RSE), sexual health knowledge, time spent online

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1 Introduction

Sex education in schools plays a crucial role in informing children and young adults about contraception. With the rise of social media, young people are also increasingly exposed to non-scientific information about contraception (Todaro et al., 2018). In school programs, the content of sex education is relatively formal and focuses mainly on preventing pregnancy and Sexually Transmitted Infections (STIs) (Lameiras-Fernández et al., 2021). On the other hand, inaccurate information is often shared through the social network on social media or by influencers who are against the use of hormonal contraception and support natural birth control (Todaro et al., 2018). This puts young people at reproductive age at risk of receiving unreliable information about contraception. There is growing awareness of the influence of social media on health education, but not yet enough on sex education (Jones et al., 2014), nor on the combined influence of the two. This highlights the academic relevance of further research into if and how social media use may interact with sex education to shape contraceptive practices and knowledge among young adults.

Young adults often express regret over the first time they had sexual intercourse, because they feel they should have waited longer (Nolan & Smyth, 2020). Layte and McGee (2007) found that having sex before the age of 17 was often associated with a higher likelihood of regret, both for males and females. In line with the latter, the younger age at first intercourse is often associated with a lower likelihood of the use of contraceptive practices (Wellings et al., 2001). This can lead to unwanted or early pregnancies, as well as an increased risk of STIs, which can result in long-term mental and physical health issues (Layte et al., 2006; Palmer et al., 2019). This demonstrates the societal relevance of my study, as it highlights the factors that influence contraceptive practices and knowledge among young adults. This is essential for the development of effective sexuality education and for supporting adolescents to make healthier and more informed sexual choices.

I examine these questions in the Irish context. Relationships and Sex Education (RSE) was introduced in Ireland in 1995 (Global Education Monitoring Report, 2023). Due to the strong influence of the Catholic Church, not all schools have included this course in their curriculum. Despite the government's attempts to modernize the course, there is much resistance from conservative parents and religious organizations (Global Education Monitoring Report, 2023). Given the strong influence of the Catholic Church on institutions and culture, Ireland is an interesting country for research into contraceptive use among young adults and its determinants.

In order to gain a comprehensive understanding of contraceptive use among young adults in Ireland, it is essential to first define what constitutes modern contraception and the role of gender regarding contraceptive decision-making. The modern contraceptive method is described by Hubacher and Trussel (2015) as “a product or medical procedure that interferes with reproduction from acts of sexual intercourse” (Hubacher & Trussell, 2015). Methods of contraception include, among others, contraceptive pills, intrauterine devices, injectables and condoms (WHO, 2023). Research on opposite-sex couples in the United States has shown that contraceptive responsibilities largely align with traditional gender roles, and that women are often more likely to initiate the discussions and make decisions regarding contraceptive use (Fennell, 2011).

Understanding the gendered dynamics of contraceptive decision-making provides a crucial foundation for examining broader social influences on young adults' reproductive choices. One of these influences is social media, which has become an important part of young people's lives and may shape their attitudes and behaviors related to contraception. Studies on gender and social media usage have shown that females are more likely than males to use social media for educational purposes (Alnjadat et al., 2019). In addition, research conducted by Gok

(2016) has examined the impact of social media on the academic lives of university students. He highlighted that many students, both males and females, developed addictive behaviors, leading to a negative impact on their habits and social interactions (Gok, 2016). These findings highlight the complex relationship between gender, social media engagement and the need for further research into how these dynamics influence young people's lives.

Since I am interested in RSE and social media as agents of socialization, I examine if there is an association between attending RSE in secondary schools and contraceptive practices and knowledge of young adults, and if this association is different depending on how much time they spend on social media. My research questions are: "Is there an association between attending sex education and contraceptive use and knowledge among young adults in Ireland?" and "Is this association stronger or weaker for young adults who spend more time online?" For this research, I rely on existing survey data from young adults, aged between 17 and 20 years, participating in the cohort study Growing Up in Ireland (GUI, Central Statistics Office, 2025). This is exploratory research since there is little to no knowledge on this topic. My research will provide more insight into the influence of social media use on health education.

2 Theoretical background

2.1 Socialization

Socialization is an important mechanism of social reproduction in which people acquire specific attitudes, values and behaviors in accordance with widespread social roles and societal expectations (Guhin et al., 2021). The term socialization continues to be used in various sociological fields, including, among others, studies on gender and education. According to Parsons (1951), socialization is essential to maintain social continuity and for preserving social order. Through socialization, individuals learn to imitate behaviors and develop a sense of identification (Guhin et al., 2021).

However, Parsons' concept of socialization has also faced criticism, particularly for its insufficient attention to individual agency. Childhood scholars, in particular, argue that this framework does not adequately account for the agency of children or individuals in the early stages of socialization (Guhin et al., 2021; Pugh, 2014, p.81). Building on this critique, sociologists continue to use the concept of socialization. In particular, sociologists of sex, gender, and sexuality use this framework. Socialization plays a crucial role in the reproduction of gender roles and remains an essential mechanism in the way gender is reproduced as a structure (Guhin et al., 2021).

2.1.1 Socialization through gender roles regarding contraceptive practices

Building on the theory that gender is reproduced as a structure, Lorber (2011) states that it begins with the sex category based on genitalia at birth. Parents then decide whether to buy clothes and treat their children according to what we, as humans, have associated with a particular sex. Children are then treated in a way that aligns with societal expectations of their sex (Lorber, 2011). For example, girls are often seen as sweet and caring, while boys are expected to be tough and show minimal emotion (Lorber, 2011). In addition, parenting is reproduced when the role of the mother differs from the father. Traditionally, mothers take care of the children while fathers work to provide an income for the family. This results in different experiences and expectations for both parents, which they reflect on their children. According to Lorber (2011) this contributes to "gender being continuously created and recreated" through everyday actions. This is in line with the concept of "doing gender", where people behave according to their gender, introduced by West and Zimmerman (1987).

The process of the reproduction of gender is deeply connected to socialization. Socialization plays a fundamental role in shaping individuals' understanding of gender and sexuality, particularly through sex education. Gansen (2017, p.255), for instance, examines the process of gendered sexual socialization in preschool classrooms, demonstrating how teachers' responses to children's behavior, such as "heterosexual romantic play, bodily displays, and unwanted touching" (Gansen, 2017, p. 255), reinforce normative gender dynamics. Through these interactions, children internalize and reproduce the idea that "boys have gendered power over girls' bodies" (Gansen, 2017, p. 255). This finding aligns with broader sociological discussions on how socialization processes, including those occurring in educational settings, contribute to the reinforcement of gender norms (Guhin et al., 2021).

A study by Julie Lynn Fennell (2011) highlights the gendered division in decision making regarding contraceptive use within heterosexual relationships. She emphasizes that hormonal contraception is the most common form of contraception for these couples. Since most contraceptive methods are available specifically for women, and as women are usually the ones who take hormones, they are more likely to become responsible for the overall contraception in the relationship (Fennell, 2011). Her research also shows the socialization of contraceptive practices differs between men and women. For example, women reported that their parents had informed them about hormonal contraception, while men had been informed about condom use. Men also stated that their parents did not inform them about any hormonal contraception and women were often not taught how to use condoms (Fennell, 2011). Fennell emphasized the unequal distribution of contraceptive use since there are more contraceptive options available for women than for men. In addition, most couples reported to use a condom only for several weeks at the beginning of the relationship, after which women are most likely to use hormonal contraception methods (Fennell, 2011). This highlights how contraceptive responsibility is socially structured and often divided by gender.

2.1.2 Socialization through Sex education regarding contraceptive practices

Sex education, as a key site of socialization, is shaped by societal debates over whether it should be considered a private or a public responsibility. Some argue that sex education should remain within the family, with the parents as the primary educators, while others view it as a public concern that schools should address comprehensively (Kiely, 2023). In Ireland, contemporary policy conceptualizes sex education as a shared responsibility between schools and parents, ensuring that both institutional and familial influences contribute to young adults' understanding of sexuality and relationships. This dual approach reflects the broader role of education in transmitting social norms and values related to gender and sexuality (NCCA, 2019; Kiely, 2023).

Research conducted by Cheedalla et al. (2020) examined the impact of sex education on contraceptive practices and demonstrated that young adults who received comprehensive sex education were more likely to use contraception during their first sexual intercourse (Cheedalla et al., 2020). In addition, the study conducted by Thelma et al. (2024) illustrates that well-implemented sex education programs can significantly contribute to lower teenage pregnancy rates and that it can promote healthy sexual attitudes among adolescents. However, research indicates that many students perceive RSE as inadequate in addressing their needs (NCCA, 2019). Primary school students recalled that their education primarily focused on biological changes during puberty. They expressed that by the age of thirteen they needed a more comprehensive program that better addressed sexual feelings and relationships (Kiely, 2023).

Students also emphasized the importance of how RSE is taught. They expressed a preference for teachers who were confident, non-judgmental, engaging and encourage active participation (Kiely, 2023). This highlights the role of educators not only in providing

information, but also in shaping students' comfort, understanding and ability to discuss sexual health and relationships openly. The effectiveness of RSE therefore depends not only on the content, but also on the pedagogical approach and the ability of teachers to facilitate meaningful discussions (Kiely, 2023).

2.1.3 Socialization through social media regarding contraceptive practices

A review conducted by Odgers et al. (2020) highlights that current research on the effects of social media on adolescent development is primarily focused on analyzing its impact on mental health, which leads to stagnation in the field (Odgers et al., 2020). Late adolescents between 15 and 19 years old spend a lot of time on social media, with recent estimates suggesting an average of 161 minutes per day (TeamAlert, 2023). As the social media use among adolescents increases, it is crucial to gain a deeper understanding of its potential consequences in order to establish clear guidelines for policymakers, educators and adolescents themselves (Odgers et al., 2020).

Beyond formal sex education, friends and family are the primary and most trusted sources of information for young adults' contraceptive decisions (Carter et al., 2012; Blackstock et al., 2010). Both the decision to use contraception and the choice of contraceptive method are often driven by the preferences and practices of friends and family (Ali et al., 2011). In addition, social media and the information shared on these platforms play an important role in shaping an individual's social network (Candice et al., 2020). Given the social networks influence on contraceptive choices, social media platforms can serve as valuable tools for gathering and transmitting information about contraception practices and sexual health (Merz et al., 2021; Gabarron & Wynn, 2016). Several studies have observed the influence of social media on sexual health behavior and the prevention of STIs. Results show that social media can increase the knowledge regarding STI prevention, but there is weak evidence for the effect of the knowledge transmission (Jones et al., 2014).

Social media also appears to contribute to contraceptive method knowledge transmission (Todaro et al., 2018). An increasing number of young women tend to use "natural" contraceptive methods which include withdrawal and fertility tracking apps on their phones (McNee et al., 2024). Social media plays a major role in the distribution of knowledge regarding this method of contraception (Lewis & Blake et al., 2021). At the same time, an increase in the number of abortions among young women is reported between 2018 and 2023 (McNee et al., 2024). There are several reasons to explain this, but research conducted by McNee et al. (2024) suggests that the use of less effective methods as described above may contribute to an increase in unwanted pregnancies. Social media can serve as a valuable tool for knowledge transmission but can also contribute to unreliable practices.

In sum, these theories show that sex education and social media act as socialization agents on young adults within the context of contraceptive use and knowledge. Meaning that the attendance of sex education and the use of social media have an effect on the behavior and knowledge of young adults and their contraceptive practices. Based on the theoretical background, I aim to test if RSE has an influence on contraceptive practices to prevent pregnancies and how RSE contributes to the knowledge regarding STI prevention. In addition, I aim to test if these associations may vary by the time spent on the internet. This leads to the following four hypotheses: "Young adults that attended RSE are less likely to experience early pregnancy" (H1a); "Young adults that attended RSE are less likely to experience early pregnancy, and the association may vary depending on the time spent online" (H1b); "Young adults that attended RSE have better contraceptive knowledge regarding STI prevention methods" (H1c) and "Young adults that attended RSE have better contraceptive knowledge regarding STI prevention methods, and the association may vary depending on the time spent online" (H1d).

2.2 Sex education, social media, and contraceptive use in context: The case of Ireland

For a better understanding of the contraceptive behavior and sex education in Ireland, I have observed changes in contraceptive use and early pregnancies within the Irish context. The WHO recently reported that adolescents in Ireland are using condoms less frequently during intercourse, with almost half of the sexually active 15-year-olds reporting that they do not use condoms during intercourse (WHO, 2024). This increases the risk of STIs and unwanted pregnancies (Bowers, 2024). For instance, HSPC (2024) reported a 25% increase in the number of chlamydia infection notifications between 2022 and 2023, with 52% of the cases were in the 15-25 age group. Despite the behavioral changes regarding condom use, the number of teenage pregnancies decreased in Ireland. In 1973, 3,048 women under the age of 20 had already become a mother. This number decreased to 798 teenage mothers in 2022 (CSO, 2023). This could possibly be related to the introduction of the RSE curriculum in 1995 (Mayock et al., 2007; Thelma et al., 2024).

However, after the implementation of the RSE curriculum, a number of challenges emerged. The implementation process was slow, resulting in delays that prevented schools from adopting the program at the same time (Mayock et al., 2007). This delay was partly due to quality control issues and difficulties in recruiting suitable qualified teachers to deliver the lessons (O'Brien, 2018). Moreover, students expressed dissatisfaction with the content of the curriculum (MacNeela et al., 2019). Their dissatisfaction increased because the program was outdated and did not reflect their lived experiences (Kiely, 2023). In addition, wider societal changes, including the declining influence of religion, changing gender roles and the increasing use of social media and digital technologies, further contributed to the discrepancy between the RSE curriculum and the actual circumstances within Irish society (Kiely, 2023).

The Catholic Church has a strong influence on the educational program in the Irish context. With 90% of primary schools under the Catholic ethos, not all schools include the RSE program in their curriculum (Global Education Monitoring Report, 2023). In 2018, the Minister of Education programs initiated a review of the curriculum to ensure that RSE meets the needs of adolescents in modern Ireland. This review of the curriculum should address issues that affect sexual wellbeing, that include homophobia, gender and stigma (Global Education Monitoring Report, 2023). However, due to strong opposition from conservative parents and religious organizations that don't want children being exposed to revised RSE content, there has been a delay in updating the curriculum. This results in content that currently is still outdated (Global Education Monitoring Report, 2023). Overall, developments in relation to sex education in Ireland make it an interesting country in which to study the subject.

3 Data

3.1 sample

I rely on existing, anonymized survey data from cohort '98, wave 3 and 4 of Growing Up in Ireland (GUI, Central Statistics Office, 2025). This cohort started in 2008 with 8,500 children of 9 years old. This group is aged 17 or 18 in 2016 and 20 in 2018/2019. Due to attrition, 5190 children participated in the study during the fourth wave, this represents 65% of all children who participated in all four waves (Growing Up in Ireland, 2021). This national longitudinal study of children and young people conducted by the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) and the Central Statistics Office (CSO) provides the Irish government with evidence-based data from children and young people living in Ireland. The publicly available data was already anonymized by someone else, and no data

could be related to the respondents. All data used for my research is saved on my device and not shared with others, see appendix I for the ethics and privacy checklist. This survey is suitable for my study because it includes data about social media use, Relationships and Sexuality Education (RSE) in secondary school, and questions regarding contraceptive practices and early pregnancies.

In the third wave of the longitudinal study, the participants were asked whether they attended sexuality education, whether they are religious and if they use social media. As this age group is within the reproductive age range, which begins at age 15 (Clark et al., 2013; WHO, n.d.), both the questionnaire content and the age category are highly relevant for the research questions. The fourth wave questionnaire includes items related to contraceptive practices and social media use. The respondents are asked questions about the best contraceptive method to prevent STIs and whether they or their partner have experienced an early pregnancy. In addition, they are asked how much time they spend online on weekdays. These questions provide more insight into the possible association between sex education and contraceptive practices and knowledge, and the possible stronger association moderated by the time spent online.

Table 1: Proportions for the analytical sample (Growing Up in Ireland, wave 3 and 4, N = 4151).

	Whole sample
Gender	
Male	2038 (49.1%)
Female	2113 (50.9%)
Age in wave 4	
19	38 (0.9%)
20	3785 (91.2%)
21 and over	328 (7.9%)
Catholic Religion	2255 (54.3%)
Attended RSE	3654 (88.0%)
Experienced or had a partner who experienced pregnancy	97 (2.3%)
Time spent online on weekdays	
<2 hours	796 (19.2%)
2-5 hours	2510 (60.5%)
>5 hours	845 (20.4%)

RSE = Relationships and Sexuality Education

Table 1 shows the descriptive statistics for the whole sample. Respondents with item non-response on key variables were excluded from the final analysis. This resulted in a total sample size of N = 4151.

3.2 Main measures

For my analysis, I rely on survey items from waves 3 and 4 of the longitudinal study. The young adults are asked questions regarding Relationships and Sexuality Education, as well as their contraceptive practices and knowledge. The main variable for RSE attendance is examined in relation to the experienced pregnancies and the knowledge regarding STI prevention. The operationalization of the variables is presented below. Gender, religious background and the time spent online for more or less than 2 hours and more or less than 5 hours on weekdays are used as covariates.

For my main independent variable, I make use of the question “Have you ever been or will you be taught Relationships and Sexuality Education (RSE) in secondary school?”. The respondents were asked whether they already had been taught RSE, will be taught RSE in the future, or have not been taught RSE in school. I examine participation in RSE with a dummy by coding one if they already were taught RSE, and zero if not or will be taught RSE in the future.

To analyze contraceptive practices and knowledge, I first rely on the question whether the young adults experienced a pregnancy or have a partner that experienced a pregnancy as the dependent variable. The answer categories are ‘Yes’ or ‘No.’ I examine the experienced pregnancy with a dummy by coding one if the answer is ‘Yes’ and zero for ‘No.’

To study the knowledge of young adults regarding contraceptive practices to prevent STIs, the respondents were asked which method is most effective to prevent STIs. The answer options included withdrawal, a condom, birth control pill, good hygiene, or do not know. I examine the knowledge of contraceptive practices to prevent STIs with a dummy by coding one for condom use and zero for other options.

For the analysis of the possible moderating association of social media on contraceptive practices and knowledge, the respondents are asked how much time they spend online during weekdays. The answer options vary between whether they spend no time online, less than 2 hours per day; 2 to 5 hours; or more than 5 hours per day. To perform several moderating analyses for the time spent online, the variable is divided into three separate dummy variables for those who spend more or less than two hours online, between two to five hours and those who spend more than five hours online. I examine the time spent online with a dummy for more or less than 2 hours by coding one for more than 2 hours and zero for less than 2 hours online. The dummy for the time spent online between 2 to 5 hours is coded one if they spend between 2 and 5 hours online; two for more than 5 hours and zero if they spend less than 2 hours online. I recode the dummy for the time spent online for more or less than 5 hours with a dummy by coding one for more than 5 hours and zero if they spend less than 5 hours online on weekdays. Given prior research that shows young adults spend on average around 160 minutes per day on social media (TeamAlert, 2023), a higher cut-off point of five hours is included in the moderation analysis to test for potential excessive use effects.

3.3 Empirical approach

In order to examine the relationship between RSE attendance and contraceptive practices among young adults, I conduct several linear regression analyses using SPSS. For these analyses two outcomes are measured, the variable for experienced pregnancy by the respondent or their partner, and the variable for STI prevention. First, I start with the examination of a bivariate regression, then I include the relevant control variables, and finally I analyze the moderating effect of the time spent online during weekdays, with control variables included.

3.3.1 Analysis of experienced pregnancy

For my analysis of contraceptive practices, first I analyze the association between RSE attendance and pregnancy experiences with six different models. The first model is a bivariate association between the variables for participation in Relationships and Sexuality Education (RSE) (X) and experienced pregnancy (Y) through a regression model. To test for a more robust association, in model 2 I include the control variables for the time spent online for more than 2 hours, the time spent online for more than 5 hours, gender and religious background. Finally, I analyze the possible moderating association of the variable ‘Time spent online’ in models 3 to 6. This association is tested by three separate dummy variables for the time spent online for more or less than 2 hours, between 2 and 5 hours and more than 5 hours on weekdays. In model

6 the interactions for the time spent online between 2 and 5 hours and more than 5 hours are combined. Again, I include the control variables in the moderation models.

3.3.2 Analysis of contraceptive practices to prevent STIs

To analyze the association between RSE attendance and contraceptive practices to prevent STIs, I first analyze the bivariate regression between the variables ‘participation in RSE’ (X) and ‘knowledge of STI prevention’ (Y). Then, I repeat the inclusion of the control variables to the bivariate regression analysis, followed by the moderating effect analysis using the three dummy variables for the time spent online in model 3 to 6.

Control variables might affect both my outcomes and my focal independent variables, allowing me to rule out some sources of confounding bias. For example, religious background or gender might be related to both attending sex education, social media use and contraceptive practices.

3.3.3 Conceptual model

With the use of linear regression analysis, I examine whether there is a moderating effect of the time spent online on the association between RSE attendance and the contraceptive practices and knowledge among young adults, figure 1 and 2.

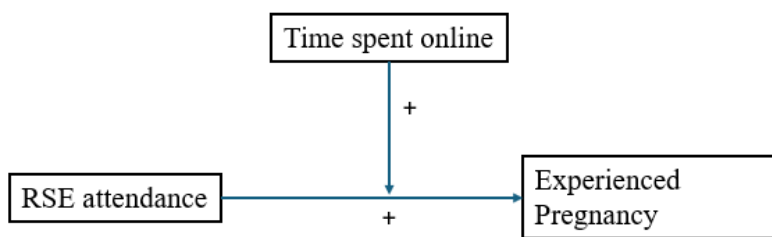


Figure 1: Conceptual model pregnancy experience

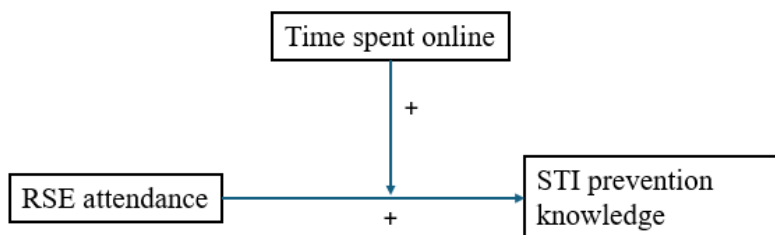


Figure 2: Conceptual model STI prevention knowledge

4 Results

To answer both research questions, I examine the association between the independent variable, attending RSE, and the dependent variables for experienced pregnancy and STI prevention knowledge. In addition, I examine whether this association varies depending on the moderating variables for the time spent online. The results are divided into two analyses. First, I focus on the attendance of RSE and the experienced pregnancy as outcome. In the second analysis I focus on the attendance of RSE in combination with the STI prevention knowledge as the outcome.

4.1 The association between attending RSE and experienced pregnancy

Table 2 shows six models where model 1 is a bivariate regression analysis for attending RSE in combination with the experienced pregnancy by the respondent or their partner. Model 2 shows the added control variables to the bivariate regression for time spent online, gender and Catholic religion. Models 3, 4 and 5 show the moderating associations of the time spent online for more than 2 hours, between 2 and 5 hours and for more than 5 hours per day on weekdays. Finally, model 6 demonstrates two interactions to moderate both the time spent online between 2 and 5 hours and more than 5 hours on weekdays.

Table 2: Models for the association between attending RSE and experienced pregnancy

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Constant	.010	.010	0.001	-.001	0.007	.001
RSE Attendance	.015*	.017*	.028	.030*	.021*	.028
RSE attendance X Time spent online >2 hours			-.014			
RSE attendance X Time spent online 2- 5 hours				-.014		-.010
RSE attendance X Time spent online >5 hours					-.021	-.008
Time spent online >2 hours		-.004	.009	.008	-.004	.005
Time spent online >5 hours		-.003	-.002	.010	.017	.014
Gender		.020***	.020***	.020***	.020***	.020***
Catholic religion		-.013	-.013	-.013	-.013*	-.013*

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 2 shows that respondents who attended Relationships and sexuality Education (RSE) are more likely to have experienced a pregnancy, or have a partner who experienced pregnancy, than those who did not attend RSE. According to Model 1, the estimated difference between

these groups is 1.5 percentage points and is statistically significant ($p = .036$). This result is in contrast with my expectation, meaning that the first null hypothesis cannot be rejected.

After including the control variables in model 2, time spent online for more than 2 hours or more than 5 hours per day does not significantly affect this bivariate relationship ($p = .612$) and ($p = .491$). However, gender does play a substantial role. Women who attended RSE are 2.0 percentage points more likely than men to report pregnancy experiences ($p < .001$). In contrast, respondents with a Catholic religion are not significantly associated with pregnancy experiences after attending RSE ($p = .056$).

The moderation analyses in models 3, 4 and 5 indicate that spending time online for more than 2 hours ($p = .612$), between 2 and 5 hours ($p = .918$) or more than 5 hours ($p = .730$) does not moderate the association between RSE attendance and pregnancy experiences. The sixth model does not show a significant moderating association after including both interactions for the time spent online between 2 and 5 hours ($p = .625$) and more than 5 hours ($p = .816$). With the results, the second null hypothesis cannot be rejected since there is no significant moderation for the time spent online. After including the controls, gender shows a positive significant association for women ($p < .001$) for all four moderation models. Those who have no catholic affiliation are less likely to experience early pregnancy after attending RSE ($p = .049$) for both moderation models 5 and 6.

4.2 The association between attending RSE and STI prevention knowledge

Table 3 shows four models where model 1 is a bivariate regression for attending RSE and STI prevention knowledge. Model 2 presents the added control variables to the bivariate regression for time spent online, gender and Catholic religion. Model 3 shows the moderation of time spent online for more than 2 hours, model 4 for the time spent online between 2 and 5 hours and model 5 for more than 5 hours on weekdays. Finally, model 6 includes two interactions, to demonstrate a comparison of the moderating association of both the time spent online between 2 and 5 hours and more than 5 hours on weekdays.

Table 3: Models for the association between attending RSE and STI prevention knowledge

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Constant	.855***	.796***	.833***	.843***	.809***	.833***
RSE attendance	.030*	.019	-.006	-.018	.021	-.006
RSE attendance X Time spent online >2 hours			.057			
RSE attendance X Time spent online 2- 5 hours				.059		.038
RSE attendance X Time spent online >5 hours					.095	.046
Time spent online >2 hours		.036*	-.013	-.014	.037*	.004
Time spent online >5 hours		-.027	-.027	-.079*	-.111*	-.102*
Gender		.014	.013	.013	.013	.013
Catholic religion		.016	.016	.017	.017	.017

*** $p < .001$, ** $p < .01$, * $p < .05$

The findings presented in table 3 report that respondents who attended RSE are more likely to report using an effective method to avoid Sexually Transmitted Infections (STIs) compared to those who did not attend RSE, see model 1. The estimated difference between these two groups is 3.0 percentage points and is statistically significant ($p = .049$). With this result, the third null hypothesis can be rejected, since young adults that have attended RSE are more likely to have better knowledge regarding STI prevention methods. Model 2 shows the added control variables and indicates that the time spent online for more than 2 hours has a positive significant association with STI prevention knowledge ($p = .024$). However, model 2 also demonstrates that the control variables for the time spent online for more than 5 hours per day ($p = .103$), gender ($p = .263$), and Catholic religion ($p = .277$) show no significant association with STI prevention knowledge.

Furthermore, models 3, 4 and 5 indicate that the time spent online does not significantly moderate the relationship between RSE attendance and STI prevention knowledge. Neither time spent online for more than 2 hours ($p = .696$), between 2 and 5 hours ($p = .205$), nor for more than 5 hours ($p = .064$) shows a moderating association. Also, the combination of both interactions for the time spent online between 2 and 5 hours ($p = .876$) and more than 5 hours ($p = .558$) indicates no significant moderating association, model 6. As there is no moderating association for the time spent online, the fourth null hypotheses cannot be rejected.

After including the control variables in models 4, 5 and 6, the time spent online for more than 2 hours has a positive association between RSE attendance and STI prevention knowledge in model 5 ($p = .022$). More than 5 hours online has a positive association between RSE attendance and STI prevention knowledge in model 4 ($p = .012$), model 5 ($p = .022$) and model 6 ($p = .041$).

In sum, both bivariate regression models for pregnancy experience ($p = .036$) and STI prevention knowledge ($p = .049$) show a positive significant association. However, there seems to be no significant moderating association for the time spent online on the interaction between RSE attendance and experienced pregnancies or STI prevention knowledge.

5 Discussion

The main findings in this paper illustrate how attending RSE contributes to the transmission of knowledge regarding STI prevention and that respondents who attended RSE are more likely to have experienced a pregnancy or have a partner who experienced a pregnancy. My analysis of the moderating effect of time spent online sheds light on possible variations in the association between the main independent variable and dependent variables. However, I find no significant moderating associations. This suggests that the time spent online does not significantly vary the associations between RSE attendance, experienced pregnancies, and STI prevention knowledge.

In relation to the concepts regarding socialization agents, there are several factors that influence the behavior regarding contraceptive practices. The first factor is gender roles. Research by Fennell (2011) demonstrated the role of gender regarding the decision-making progresses in contraceptive methods. My results show that gender has no significant relationship with knowledge about STI prevention methods. However, there is a significant effect for women who have experienced a pregnancy more often than men who have had a partner that experienced a pregnancy. Women reported 2.0 percentage points more pregnancy experiences than men after attending RSE ($p < .001$). One possible explanation is that these young adults are more likely to be sexually active at an early age. The pregnancy rates could possibly be higher if these young adults did not attend RSE (Layte et al., 2006; Palmer et al., 2019). Further research could provide more insight into this.

Despite the historically strong influence of the Catholic Church in Ireland, no significant association was found between Catholic affiliation and knowledge of STI prevention or the experienced pregnancies. Future research could revisit the role of the Catholic Church after a possible review of the RSE curriculum. Since this review aims to meet the needs of adolescents in modern Ireland, resistance of the Catholic Church may increase (Global Education Monitoring Report, 2023).

The second agent of socialization discussed in my paper is sexuality education. Research conducted by Lameiras-Fernández et al. (2021) has shown that school programs often mainly focus on preventing pregnancies and STIs. My data sheds further light on the influence of sexuality education as an agent of socialization on contraceptive practices and knowledge. The respondents that attended RSE are more likely to pinpoint the correct method to prevent STIs, a condom. This contributed to the societal relevance of my study, since the decreasing

number of 15-year-olds that use a condom and the rising number of young adults with STIs in Ireland (HPSC, 2024; WHO, 2024). This is essential for the development of effective sexuality education and for supporting adolescents to make healthier and more informed sexual choices.

The third factor of socialization highlighted in my research is social media. Prior research has shown that inaccurate information is often shared through the social network on social media or by influencers who are against the use of hormonal contraception and support natural birth control (Todaro et al., 2018). In my study, I did not find evidence for a moderating association of the time spent online on RSE and contraceptive practices and knowledge. However, it is useful to acknowledge that more research is needed regarding the influence of social media, especially regarding the knowledge of non-hormonal contraceptive methods (Todaro et al., 2018). This is needed since McNee et al. (2024), for example, examined the increasing number of abortions between 2018 and 2023. This study indicated that fewer abortion patients reported to have used an effective contraceptive method during intercourse.

With the rising number of unwanted pregnancies and abortion rates related to unprofessional contraceptive practices and the increasing use of social media (TeamAlert, 2023), policy makers should focus on new ways to communicate reliable and understandable contraceptive methods online. One promising example is Sense.info, a website for young adults which provides reliable information regarding sexual health. This platform was recently awarded for Excellence & Innovation in Sexual education 2025. They provide reliable, and academic information shared via social media platforms like TikTok to reach the target group (Rutgers, 2025).

Given the exploratory nature of my study, there are several improvements I would include in future studies. Ideally, I would have included more detailed questions in the survey regarding the age at which the respondents first became sexually active, the consistency of contraceptive use during sexual intercourse and the specific contraceptive methods they use. This would allow me to gain a more comprehensive understanding of the contraceptive behavior of young adults.

Moreover, it would have been beneficial to assess whether the reported pregnancy experiences were planned or not. This would provide crucial insight into young adults' reproductive choices and their use of contraceptive methods. With this additional knowledge, researchers may be able to better understand the relationship between RSE attendance and the outcomes for early pregnancies.

In addition, it would have been useful to include questions regarding the specific purpose for the use of social media among youth. For example, they can use social media for entertainment, communication, education or for health-related information. This could provide more detailed information regarding the content young adults are interested in and how social media serves as an agent of socialization.

As this is exploratory research, there was no randomization of participants regarding whether they had received RSE in school or not. In a more controlled design, third variables could be included regarding the educational level of the respondents, socioeconomic status and parental involvement in sexual education. This would allow me to provide better understanding of the mechanisms through which RSE and social media exposure shape the contraceptive practices and knowledge of young adults.

In sum, my evidence points to the need to further research the influence of social media use and the content that is shared online. Despite the fact that my results do not show a moderating influence by the time spent online, my study highlights the importance of RSE for sexual health knowledge and the need for further examination on how social media may contribute to contraceptive practices and knowledge.

6 Conclusion

The research reported in my article demonstrates whether there is an association between attending Relationship Sexuality Education (RSE) in secondary schools and contraceptive practices and knowledge of young adults, and if this association is different depending on how much time young adults spend on social media. Based on my findings, there is an association between attending RSE and contraceptive practices and knowledge. Those who attended RSE are more likely to pinpoint the correct method of contraception to prevent STIs. This suggests a positive association between RSE participation and sexual health knowledge.

Moreover, the results demonstrate that those who attended RSE are more likely to have pregnancy experiences or have a partner who experienced pregnancy. This can probably be related to the fact that these young people are sexually active at an early age. Pregnancy rates could be higher if these young adults did not attend RSE (Layte et al., 2006; Palmer et al., 2019).

In contrast with my expectations, I did not find a moderating association for the time spent online. This means that my study cannot confirm nor deny whether the time spent online results in different associations between attending RSE and the contraceptive practices and knowledge. However, as this is exploratory research, my paper has contributed to the literature on contraceptive practices and knowledge. Therefore, further research is necessary to investigate the potential influence of social media on the sexual health knowledge and practices of young adults.

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APPENDIX I - CHECKLIST ETHICAL AND PRIVACY ASPECTS OF RESEARCH



CHECKLIST ETHICAL AND PRIVACY ASPECTS OF RESEARCH

INSTRUCTION

This checklist should be completed for every research study that is conducted at the Department of Public Administration and Sociology (DPAS). This checklist should be completed *before* commencing with data collection or approaching participants. Students can complete this checklist with help of their supervisor.

This checklist is a mandatory part of the empirical master's thesis and has to be uploaded along with the research proposal.

The guideline for ethical aspects of research of the Dutch Sociological Association (NSV) can be found on their website (http://www.nsv-sociologie.nl/?page_id=17). If you have doubts about ethical or privacy aspects of your research study, discuss and resolve the matter with your EUR supervisor. If needed and if advised to do so by your supervisor, you can also consult Dr. Bonnie French, coordinator of the Sociology Master's Thesis program.

PART I: GENERAL INFORMATION

Project title: "Between TikTok and Textbooks: How Social Media and Sex Education shape Contraceptive Practices among Adolescents in Ireland."

Name, email of student: Joy van Pelt, 666989jp@eur.nl

Name, email of supervisor: Gabriele Mari, mari@essb.eur.nl

Start date and duration: April 4, 2025 till June 22, 2025

Is the research study conducted within DPAS

YES - NO

If 'NO': at or for what institute or organization will the study be conducted?
(e.g. internship organization)

PART II: HUMAN SUBJECTS

1. Does your research involve human participants. **YES - NO**

If 'NO': skip to part V.

- NO** If 'YES': does the study involve medical or physical research? **YES -**

Research that falls under the Medical Research Involving Human Subjects Act ([WMO](#)) must first be submitted to [an accredited medical research ethics committee](#) or the Central Committee on Research Involving Human Subjects ([CCMO](#)).

2. Does your research involve field observations without manipulations that will not involve identification of participants. **YES -**
NO

If 'YES': skip to part IV.

3. Research involving completely anonymous data files (secondary data that has been anonymized by someone else). **YES - NO**

If 'YES': skip to part IV.

PART III: PARTICIPANTS

1. Will information about the nature of the study and about what participants can expect during the study be withheld from them? YES - NO
2. Will any of the participants not be asked for verbal or written 'informed consent,' whereby they agree to participate in the study? YES - NO
3. Will information about the possibility to discontinue the participation at any time be withheld from participants? YES - NO
4. Will the study involve actively deceiving the participants? YES - NO
Note: almost all research studies involve some kind of deception of participants. Try to think about what types of deception are ethical or non-ethical (e.g. purpose of the study is not told, coercion is exerted on participants, giving participants the feeling that they harm other people by making certain decisions, etc.).
5. Does the study involve the risk of causing psychological stress or negative emotions beyond those normally encountered by participants? YES - NO
6. Will information be collected about special categories of data, as defined by the GDPR (e.g. racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data for the purpose of uniquely identifying a person, data concerning mental or physical health, data concerning a person's sex life or sexual orientation)? YES - NO
7. Will the study involve the participation of minors (<18 years old) or other groups that cannot give consent? YES - NO
8. Is the health and/or safety of participants at risk during the study? YES - NO
9. Can participants be identified by the study results or can the confidentiality of the participants' identity not be ensured? YES - NO
10. Are there any other possible ethical issues with regard to this study? YES - NO

If you have answered 'YES' to any of the previous questions, please indicate below why this issue is unavoidable in this study.

What safeguards are taken to relieve possible adverse consequences of these issues (e.g., informing participants about the study afterwards, extra safety regulations, etc.).

Are there any unintended circumstances in the study that can cause harm or have negative (emotional) consequences to the participants? Indicate what possible circumstances this could be.

Please attach your informed consent form in Appendix I, if applicable.

Continue to part IV.

PART IV: SAMPLE

Where will you collect or obtain your data?

My data will be obtained from [Questionnaires - Growing Up in Ireland](#)

The existing data I will use is collected in the Young Person Supplementary Questionnaire (17/18 years): [06-Young-Person-Supplementary-17_18-years.pdf](#) & Young Adult Self-Complete Questionnaire (20 years) [Cohort-98-at-20Yrs_Young-Adult-Self-Complete-Questionnaire.pdf](#)

Note: indicate for separate data sources.

What is the (anticipated) size of your sample?

The longitudinal study of cohort '98 started with 8,500 9-year-olds. I expect a slightly lower size of the sample in wave 3 and 4 because of attrition.

Note: indicate for separate data sources.

What is the size of the population from which you will sample?

The reference population is all children born in 1998 in Ireland (around 55,000). The sampling frame is the Child Benefit Register.

Note: indicate for separate data sources.

Continue to part V.

Part V: Data storage and backup

Where and when will you store your data in the short term, after acquisition?

After my green light on my proposal I will collect and store the data on my password-protected personal laptop and I will make use of the data in SPSS

Note: indicate for separate data sources, for instance for paper-and pencil test data, and for digital data files.

Who is responsible for the immediate day-to-day management, storage and backup of the data arising from your research?

I will be responsible for the day-to-day management, storage and backup of the data

How (frequently) will you back-up your research data for short-term data security?

I will back-up the research data weekly

In case of collecting personal data how will you anonymize the data?

The data is already anonymized before use

Note: It is advisable to keep directly identifying personal details separated from the rest of the data. Personal details are then replaced by a key/ code. Only the code is part of the database with data and the list of respondents/research subjects is kept separate.

Joy van Pelt

PART VI: SIGNATURE

Please note that it is your responsibility to follow the ethical guidelines in the conduct of your study. This includes providing information to participants about the study and ensuring confidentiality in storage and use of personal data. Treat participants respectfully, be on time at appointments, call participants when they have signed up for your study and fulfil promises made to participants.

Furthermore, it is your responsibility that data are authentic, of high quality and properly stored. The principle is always that the supervisor (or strictly speaking the Erasmus University Rotterdam) remains owner of the data, and that the student should therefore hand over all data to the supervisor.

Hereby I declare that the study will be conducted in accordance with the ethical guidelines of the Department of Public Administration and Sociology at Erasmus University Rotterdam. I have answered the questions truthfully.

Name student: Joy van Pelt

Name (EUR) supervisor: Gabriele Mari

Date: 18-3-2025

Date: 22 May 2025

