

# Understanding how sexually active women think about fertility, sex, and motherhood

*Jo Murphy-Lawless, Laury Oaks and Clare Brady*

RESEARCH

SEPT 2004



## Understanding how sexually active women think about fertility, sex, and motherhood

*Jo Murphy-Lawless, Laury Oaks and Clare Brady*



## Foreword

It is a great pleasure to introduce this important research report which provides an insight into how sexually active women think about fertility, sex and motherhood.

This research aimed to explore how sexually active young women think about their fertility and fertility decisions, such as contraceptive use and sexual risk-taking. It describes how fertility decision making is related to women's life aspirations and women's changing roles in education, careers, relationships and motherhood.

The Agency recognises the importance and value of high-level qualitative research that allows us to address important questions designed to explore and discover rather than to simply quantify. These findings enable us to understand more clearly the factors related to the onset of sexual activity, how women deal with sex and contraception and the role that men play in women's contraceptive and reproductive decision making. This research further describes how factors such as age, relationship status and socio economic status affect attitudes toward fertility, motherhood, contraception and crisis pregnancy.

More importantly, the findings of this study, based on robust data, allow for effective planning and development of appropriate preventative and supportive initiatives. A further major asset of these findings is that they provide important information and direction for the Agency's communication initiatives—with respect to both crisis pregnancy prevention and support.

An essential part of our research activities involves disseminating research findings to as wide an audience as possible. As we move from research into practical solutions which will make a real difference to people's lives, it is our hope that these findings will be of benefit to service planners, policy makers, statutory and non-statutory service providers, researchers, practitioners, educators and the general public. An important strand of our vision is to ensure that the findings from the Agency's research programme combine to build an accurate and compelling picture of sexual health and crisis pregnancy, one that does not cloud the complexity of sexual behaviour in a changing modern Ireland.

I would like to thank the authors of the study, Dr. Jo Murphy-Lawless, Trinity College Dublin, Associate Professor Laury Oakes, University of California, Santa Barbara and Ms. Clare Brady, Trinity College Dublin, for their expertise and commitment in conducting the research to such a high standard.

I would also thank and acknowledge the input of the Agency's research staff, Dr. Stephanie O'Keeffe and Ms. Mary Smith, and Research sub-group members, Dr. Linda Hogan, Mr. Anthony O'Gorman, Dr. Margret Fine-Davis, Dr. Davida De La Harpe, and the Agency's Director, Ms. Sharon Foley.

Most important of all, we sincerely thank the 66 women who participated in such a sensitive piece of work – one which helps the Crisis Pregnancy Agency to capture the reality of sexual and reproductive decision making and to plan its work accordingly.

It is my sincere hope that the findings of this report will contribute to further development of appropriate responses and relevant services for crisis pregnancy and its prevention in Ireland.

*Olive Braiden*  
*Chairperson*

*About the authors*

Jo Murphy-Lawless is a sociologist who has published extensively on issues of women and reproductive health in the Irish and international contexts. Currently in the School of Nursing and Midwifery Studies, Trinity College Dublin, she is the author of *Reading Birth and Death: a History of Obstetric Thinking* (Indiana University Press 1998).

Laury Oaks is Associate Professor of Women's Studies, Anthropology, and Sociology at the University of California, Santa Barbara. She is co-editor with Barbara Herr Harthorn of *Risk, Culture, and Health Inequality: Shifting Perceptions of Danger and Blame* (Praeger 2003) and author of *Smoking and Pregnancy: The Politics of Fetal Protection* (Rutgers 1998).

Clare Brady studied at Trinity College Dublin from 1994 to 1998, before practising as an occupational therapist for five years in the Irish health services. She has also worked as a research assistant on various projects with Dr Jo Murphy-Lawless since 1998. Latterly, she has relocated to Edinburgh and now works in theatre administration.

*Acknowledgements*

We would like to thank all the women who helped us during the fieldwork for this project. We also want to thank the women who participated in the interviews; they consistently displayed great courage, great humour and great resilience. A special debt of gratitude is owed to the Crisis Pregnancy Agency and especially to Stephanie O'Keeffe for support and enthusiasm throughout. Finally, thanks are due to Hera Cook for her comments on earlier drafts, to Mira Gordon for assistance with background research, and to Oisín Murphy-Lawless for editorial help.

*The views expressed in this report are those of the authors and do not necessarily reflect the views or policies of the sponsors*

## TABLE OF CONTENTS

<b>Executive Summary</b>	<b>7</b>
<b>1.0 Introduction: women's changing roles in Irish society</b>	<b>9</b>
<b>2.0 Methodology</b>	<b>15</b>
2.1 Qualitative interviews and purposive sampling	15
2.2 Sampling frame and fieldwork issues	17
2.3 Final sample size	18
2.4 Approach to data analysis, presentation of findings and a composite view of our interviewees	20
<b>3.0 Openness about sex and women's changing roles in contemporary Ireland</b>	<b>21</b>
3.1 How open is open?	21
3.2 Changing Irish mores and materialism	22
3.3 Women's memories of public debates and discourses on sex and reproductive rights	23
3.4 Media coverage: Sex and the City	24
<b>4.0 Sex education</b>	<b>26</b>
4.1 Parents	26
4.2 School sex education	27
4.3 Siblings, friends and peers	28
4.4 Teen magazines	29
<b>5.0 Dealing with sex and contraception</b>	<b>29</b>
5.1 Early experiences of sex and contraception	30
5.2 Negotiating access to contraceptive services	31
5.3 Negotiating sex and contraceptive needs with men	33
5.4 Sex outside established relationships	36
5.5 Emergency contraception	37
5.6 Cost of reproductive health services	39
<b>6.0 Safe and unsafe sex</b>	<b>41</b>
6.1 Safe sex and sexually transmitted infections (STIs)	41
6.2 Taking risks with unprotected sex	42
6.3 Choosing not to have sex outside marriage	43
6.4 When unsafe sex results in a crisis pregnancy	43
<b>7.0 Motherhood becomes a foreign country</b>	<b>47</b>
7.1 Notions of motherhood	48
7.2 Careers and lifestyle vs. babies	49
7.3 Pressure to have children	50
7.4 Priorities in deciding to have a baby	50
7.5 Making the choice not to have children	51
7.6 Ideal age at which to become pregnant and ideal number of children	52
7.7 The strain of becoming a mother	52

<b>8.0</b>	<b>Reforming reproductive health services</b>	<b>53</b>
8.1	Cultural changes around sex	53
8.2	Levels of service provision in clinics	54
8.3	Information and public health campaigns	54
8.4	Building information and access for young teenage women	54
8.5	Contraceptive services for those under the age of consent	55
8.6	Abortion support services	55
8.7	Maternity services	56
<b>9.0</b>	<b>Other policy measures</b>	<b>56</b>
9.1	Sex education	57
9.2	Maternity leave	57
9.3	Affordable childcare, flexi-time and other family-friendly initiatives	58
9.4	Community-based health clinics and outreach groups for women	58
9.5	Support for men	59
<b>10.0</b>	<b>Women’s reproductive decisions: what the literature says about these dilemmas</b>	<b>60</b>
10.1	Contraception and sexual freedom	61
10.2	Rights, “choice” and access to health services	63
10.3	What constitutes safe sex for women	64
10.4	Combating double standards about sexual practice that confront younger women	64
10.5	Women as mothers: supported or unsupported?	65
<b>11</b>	<b>Conclusions and recommendations</b>	<b>68</b>
	<b>References</b>	<b>71</b>

## Executive Summary

The subject of this report is the perceptions of Irish women in the general age range of 20-30 about fertility, sex, and motherhood. The report captures the meanings young women attribute to their fertility and fertility-related decisions in relation to life-objectives and women's changing roles in education, careers, relationships, and motherhood. The report uses data drawn from qualitative interviews (twenty individual case studies and twelve focus groups; the total sample is 66 women with an age range of 19-34). The research reflects the views of a diverse group of women by socio-economic status, geographic location, and relationship history. The data demonstrate a need for greater support for young Irish women in the range and variety of their decision making about fertility, sex and motherhood.

### Significant findings include:

- Women sense a shift in openness about sex and sexuality, yet see this as primarily media-driven and not fully displayed throughout Irish society, with particular differences seen between rural and urban areas
- Women's roles have transformed over the last generation and women have more life-choices today, yet women's choices are constrained by social class, and not all women identify change as positive
- Men are now more "in tune" with women's needs around sexual and reproductive health issues and parenting, yet men have been ignored or mistreated in clinic settings, when women wanted them to be treated as full participants in joint counselling on contraception or crisis pregnancy
- The "X Case" and the declining role of the Catholic Church mark major events in the lives of young women, shaping their attitudes and experiences. Young women have moved into adulthood more firmly convinced that sexual and reproductive decisions should be part of a person's private actions, with the freedom to decide as they think best
- Sex education remains inadequate. Generational differences lead women to conceal their attitudes and sexual activity from parents. School-based sex education provides little information, and focuses too much on biological aspects of sexuality
- Relationship status, emotional readiness and fear of pregnancy are factors that influenced women when they became sexually active. Some respondents reported that they first began having sex as teenagers, and others in their very late teens or early twenties
- Dealing with sex and contraception is stressful and problematic for most women, and the burden of responsibility for contraception rests primarily on the shoulders of women. Social stigma about promiscuity is pervasive among women from both urban and rural areas when obtaining contraceptives and having contraception ready (being on the pill or carrying condoms) when not in a relationship
- Emergency contraception (EC) has been used by the majority of women sampled; women reported significant problems related to obtaining EC
- Both young teenagers and women earning low wages who don't have a medical card find it very hard to pay for contraceptive services



- “Safe sex” is seen as related to sexually transmitted infections (STIs), yet applies equally to pregnancy prevention for young women. Fear of pregnancy overshadows fear of STIs for the vast majority. But fear does not prevent those who have access to contraception and knowledge from taking risks, especially if they are drinking or find risk-taking part of the excitement of a sexual encounter
- A lack of coherent support exists for women facing crisis pregnancy. Crisis pregnancy is familiar to women, if not personally, through friends and family members. The meaning of crisis pregnancy has changed; pregnancy does not force a woman into marriage as it once often did. But the experience can still be isolating or cause significant family upheaval
- The main priorities for women who seek to have children are secure economic circumstances and social support. Most women who expressed an interest in having children said they would consider having children in their early 30s. Those in rural areas noted that their housing costs were lower and their extended family support higher than that of many urban women. Women feel an expectation to become mothers, yet those women who desire to remain childless perceive this as a less socially-stigmatised choice than in the past
- Discomfort with the name “family planning” was reported, as reproductive health and contraceptive services are not always directly related to planning a family. Some younger women refused to attend clinics due to the name
- Action to create affordable childcare is seen by women as of utmost importance. The lack of affordable childcare and the problem presented by women’s need and desire to work shape women’s perceptions that it is difficult to consider having children

**Recommendations are as follows:**

- Rebranding family planning clinics to meet the needs of a broader range of women and girls
- Training protocols for general practitioners (GPs), chemists, and family-planning clinic staff to prevent clients feeling stigmatised when they ask for contraceptives
- Developing protocols for incorporating partners in consultations, where women request this, while remaining careful to protect women’s decision-making
- Renewed public health campaigns and information on
  - STIs
  - Contraception
- Provision of condoms in packets stamped “Free” in clubs to help increase condom usage
- Mobilising text messaging and similar technologies to extend the information base available to young women and young men
- Development of strategies for making contraceptives available for sexually active women under the age of consent
- Examining the current cost and provision structures of contraception and emergency contraception to bring down the individual cost for women
- Greatly-improved maternity services and support services in the community to meet the support needs of new mothers and their babies

- The issue of support services for women seeking terminations should be revisited, as well as examining how counselling and support can be made more accessible for women who leave the state for terminations
- In public education campaigns and literature, emphasise the role of decision making for women and decrease the emphasis on “choice”, as many women do not experience their decisions as “choices”
- More government-sponsored services of sexual-health support groups at the grass-roots level for women
- Comprehensive wide-ranging programme of sex education that would be considered as part of core developmental skills and so be delivered in an ongoing way from primary school through secondary school
- A more wide-ranging and supportive system of maternity leave to deal with SMEs and the growing reality of women’s involvement in both the self-employed labour market and those industries where short-term contracts are more prevalent
- Action to create affordable childcare
- Action on extending flexi-time and other family-friendly policies
- Promotion of messages that encourage greater respect for the broad range of women’s decisions around motherhood, in line with the vast diversity of women’s experiences
- Promotion of messages that combat double standards about young women’s sexuality and the meaning of women who are prepared to provide and use contraception if they require it
- Community-based clinics delivering free reproductive-health care and contraception are vital initiatives in disadvantaged areas
- Policies to support men in respect of their information needs on reproductive and sexual health issues.

## 1.0 Introduction: women’s changing roles in Irish society

This research focuses on the perceptions of younger adult Irish women about fertility, sex, and motherhood. These are issues that remain deeply complex both despite, and because of, the rate of change our society has been undergoing. Information such as the increase in the reported use of contraception (Health Promotion Unit 2002) and the 31% of births outside marriage (Central Statistics Office 2003a) may suggest greater openness in Irish attitudes to sex and sexual activity. At the very least, such figures suggest that women are making significant personal decisions about sex and fertility, confident that they can act on what they see as most desirable. We also know from British Department of Health statistics that a total of 6,490 women who travelled from Ireland to Britain for abortions gave their home addresses as Ireland in 2002. This is an indication of how some women are deciding to deal with what they experience as a crisis pregnancy.

Yet there is unease about many consequences of these wide-reaching changes. There is a sense that in taking the relatively untrodden paths for Irish women of personal, social and economic independence, combined with greater sexual freedom, women are not being sufficiently supported. There is also a sense that sexual and reproductive health-care issues have not been resolved sufficiently to enable women across the range of ages and socio-economic locations to have equally realisable options for themselves.

A brief and random glimpse at recent articles in the national press highlights some of these complexities as they currently manifest themselves in the lives of women of child-bearing age:

- “Traditional family life forced to undergo many changes” (Irish Times, 6 September, 2003)
- “One in four 15 to 17 year-olds have had sex – poll” (Irish Times, 19 September, 2003)
- “Women ‘leaving jobs to save on childcare costs’ ” (Irish Examiner, 7 October, 2003)
- “Baby left in bag” (Irish Daily Star, 14 October, 2003)
- “IFPA says numbers down for UK abortion” (Irish Times, 31 October, 2003)
- “The word Ahern is the best contraceptive” (Evening Herald, 4 December, 2003)
- “Are ‘geriatric’ mothers presenting a medical challenge?” (Irish Times, 20 January, 2004).

As an introduction to the research, we will explore some of the implications of these articles.

Beginning with the article on changes to the “traditional family”, its author observes that over 25% of households are now headed by a lone parent or cohabiting couple (FitzGerald 2003). This change in the style of family formation signals the huge shift in social attitudes to marriage that has taken place within a brief thirty-year period. During this time, the state has been slow (compared with other European societies) to remove obstacles to legal separation and divorce, and to acknowledge the status of babies born outside marriage.

The concept of the “traditional family” has had a special resonance in Ireland, where larger families, instituted through marriage, have prevailed as an acceptable social trend from the mid-nineteenth century down to the 1970s. This was entirely dissimilar to the rest of Europe, where the so-called “demographic transition” to smaller families, associated with the growth of modern industrial society, began in the nineteenth century. Small family size was an established norm by the mid-twentieth century. By contrast, in Ireland the role of the woman as wife, mother, carer and nurturer of the large family continued to dominate the public discourse almost unchanged into the late twentieth century (O’Connor 1998, Murphy-Lawless and McCarthy 1999).

After Ireland’s entry into the European Community in 1973, far-ranging new statutes began to unlock women from an enforced dependence on the role of wife and mother as the most realistically available and publicly-sanctioned adult role. But even then, powerfully configured institutional actors in Irish society, including the Catholic Church and the state, through its judiciary and Garda Síochána, continued to try and reinforce that role. The importance of punishing women who were seen to stray from the socially accepted role, or to oppose it, was knit into the social fabric (Inglis 2003). The case of Eileen Flynn stands out as a vivid illustration: She was a secondary school teacher who was also unmarried and living with her partner when she became pregnant. Her employers, a religious order of nuns, dismissed her and her dismissal was subsequently upheld in 1985 by an Employment Appeals Tribunal (*ibid.*: 125-6). As we shall see below, within a decade this kind of action and judgement would have been unsustainable in the courts, given the “Celtic Tiger” economy’s demand for greatly increased female workforce participation.

The statistics on family formation reveal how rapidly this terrain has been transformed. We can measure the change to our Irish "traditional family" by three key factors:

- the trend towards fewer children
- the percentage of births outside marriage
- the age of women giving birth to their first child.

Thus by 2002

- 40% of births were to first-time mothers
- 31% of births were to women with one child
- 17% of births were to women with two children
- 6% of births were to women with three or more children
- 31% of babies were born outside marriage
- 25% of women giving birth outside marriage were aged 30 years and over.

*(Central Statistics Office 2003a)*

The total number of babies born in 2002 was 60,521, the largest total since 1987. Even though this does mark a higher birth rate than for some time, women are actually having smaller families, as evidenced by the predominance of first- and second-order births. With such a tiny minority of women now giving birth to more than three children, the large family that was so prevalent from the mid-nineteenth century has slipped off our social and cultural landscape<sup>1</sup>.

The growing percentage of births taking place outside marriage is especially striking in a society that, even in the recent past, has treated women in such circumstances very harshly (Inglis 2003). That nearly a third of all babies are born into non-traditional family forms, would appear to indicate that there is little or no social stigma to becoming pregnant, especially if a woman is in a relationship. The Irish figures are comparable to figures for seven other EU countries that have either the same or much higher levels, with Sweden and Denmark having the highest percentages of births outside marriage at 55% and 44% respectively (Eurostat 2003).

But it would also appear that there remain ambivalent and often deeply painful reactions to an unexpected or unwanted pregnancy in Ireland, whether within or outside marriage. Despite a reported small drop in the number of Irish women travelling to Britain for abortions in 2002, the Irish Family Planning Association has questioned whether the latest official figures (6,490 women giving Irish addresses) represent a genuine trend towards a reduction in crisis pregnancies (Reid 2003). The lack of scope for a woman to make safe decisions about pregnancy is highlighted by incidents like the abandonment of the three-day-old baby in the car park of the South Infirmity Hospital in Cork in October, 2003 (Phelan 2003).

An Irish Times/MORI poll of September, 2003 confirms that having sex outside marriage as part of a pattern of short-term relationships is becoming more common. 25% of young

---

<sup>1</sup> The total period fertility rate (TPFR), is the projected number of children a woman would be expected to have between fifteen and forty-nine years of age. In demographic projections, if the TPFR is 2.1 or above, the population is said to be able to replace itself in the long term. For a very long period, our TPFR was the highest in Europe by far (Murphy-Lawless and McCarthy, 1999). In 1992, the TPFR for Ireland fell to 1.99, just below replacement level. It continued to fall to an all-time low of 1.85 by 1995, when the trend reversed and it began to inch back up. In 2002, we reached replacement level at 2.1, bucking the general trend across Europe. The TPFR for the EU as a whole in 2003 was 1.47. The recent increases in the total number of births in Ireland and its TPFR reflect in part the growing number of non-national women who may be applying for refugee or asylum-seeking status and who also give birth here.

people between the ages of fifteen and seventeen (the latter being the age of consent) reported having sex in this poll. Half of this growing minority reported having had three or more sexual partners. The poll also highlights that one in eight of those having sex between the ages of fifteen and seventeen are not using contraception. Across the age of 15-24 years, the poll indicates that some 40,000 young adults are engaging in unprotected sex (Brennock 2003). This suggests that a greater openness towards having sex is not sufficiently balanced by effective education about sex and sexual health.

There are still other kinds of mismatches for women who are having children. The current emphasis on women in the workplace has brought participation rates up to 49%, up from 28% two decades earlier (Central Statistics Office 2003b). It also appears to have contributed to a pattern of delayed childbearing, with women choosing when and how to become pregnant in line with their other life choices, including the pursuit of work, careers and other constraints such as the price of housing. First-time mothers aged 30 years and over have become the fastest-growing category of women in Irish maternity hospitals; they accounted for 29% of all births in the National Maternity Hospital in 2003. Hence we find the label "geriatric mothers" discussed in another recent newspaper article (Holden 2004).

Mothers in the workforce are facing challenges over combining employment with childcare and the costs of childcare. Although there has been a very large expansion in the numbers of childcare workers (Central Statistics Office 2003), the cost of childcare has become a critical issue for employed women. With costs reportedly averaging €200 per week in the Dublin metropolitan area and €100 per week outside Dublin, it is argued that the benefits to women with children in active employment are considerably reduced for them because so much of their wage goes to cover these costs (Lehane 2003). As yet another Budget in 2003 revealed lack of government support for a co-ordinated national scheme of affordable accessible childcare, it was noted that the many pressures on new parents must inevitably translate into a falling birthrate (Ruane 2003). Pressures included the cost of housing and its location, most often away from the extended family network.

If Irish women begin to say 'no' to childbearing to the extent of their European neighbours (where one-fifth of women now choose not to have children), this country, too, will enter into what is being termed the "second demographic transition", placing it permanently below replacement fertility. Douglass (in press) argues that this transition raises important political and social issues. Population aging, one of the consequences of fertility decline, will pose as many challenges as potential benefits. Amongst the latter might be the opportunity to consider the current phenomenon of international migration and to utilise the United Nations strategy of "Replacement Migration" to deal with declining populations (ibid.). Douglass goes on to review factors in the changing roles of women that appear to be contributing to declining fertility across Europe:

- democratisation (building and sustaining an accountable, transparent democratic system)
- individualisation (the growing emphasis on the individual as the main social unit)
- urbanisation (the shift from a rural base to a predominately urban location for the majority of the population)
- secularisation (the move away from religious structures, practices and beliefs as the dominant social thread in a society)

- economic rationalisation (a post-industrial economy utilising skilled workers and new forms of services, leading to an expanded female workforce)
- birth control technology (effective and accessible forms of contraception).

These are factors identifiable in the Irish context but in an uneven and often inconsistent manner, possibly related to the speed with which we have taken on many of these changes. Inglis (2003:236-237) argues that the shift from the post-Famine Catholic culture of 'self-denial and self-sacrifice' to a culture of 'self-expression and self-indulgence' is no older than twenty years. Inglis relates the experimentation with sex outside marriage at least in part to the availability of films and television programmes, which exposed younger Irish people to a sexualised version of love and romance.

Progressively through the 1990s, Ireland was transformed to give the appearance of being a successful modern consumer society, in line with its European neighbours. Part of that move involved a far more liberal and officially countenanced regime in relation to sex. So, for example, domestically produced Irish women's magazines and newspaper self-help columns openly advised and discussed a spectrum of sexual dilemmas that had never before reached print here.

The pace of change in enabling young women to develop safer strategies around sexual practice and sexual health was expedited by a rapidly expanding economy, supported by a small voluntary sector, which worked hard to increase its coverage and scope. In 1988-1999, the Irish Family Planning Association set up a stall in Dublin in the Virgin Megastore, in a pioneering move to sell condoms at a subsidised price to anyone, and to challenge legislative prohibitions. The opening up of British chemist and supermarket chains from the mid-1990s made it possible to purchase condoms in a more anonymous commercial setting; the competition pushed indigenous Irish chemists to stock and display condoms more widely. The expansion of family planning services in more areas of the country and of student health services offering reproductive healthcare to young women helped to create new contexts for the discussion of safe sexual practices.

Despite these developments, women continued to receive mixed messages about the multiple meanings of fertility, sex and their role as sexually active women. The strong message from the state in the early 1990s was that it was prepared to try and retain control over women's bodies. The "X case" in 1992, in which a fourteen-year-old female victim of sexual assault faced a High Court injunction, sought by the Attorney General, in order to prevent her travelling to Britain for an abortion, comprised the most telling example. The case's ensuing controversy and referenda sent clear signals to young women that if they should have to confront a crisis pregnancy, they would need to deal with it from a position of personal and social isolation. Even government action to loosen the constraints on the sale of condoms in 1992 and 1993 – first lowering the age limit for purchase, and then licensing their sale through vending machines – implied a measure of control. These were primarily public health measures reflecting concerns about the transmission of HIV. They did not focus on the need to protect women from pregnancy.

At the same time, two other major social and cultural developments in Ireland that had impacts on the lives of young women were:

- the continued expansion of third-level education, permitting a record number of women to train for their chosen careers

- the progressive disintegration of the moral authority of the Catholic Church, due in large measure to its own sexual abuse scandals.

What these developments helped to reinforce was that women enjoyed a growing freedom to shape their own private lives and this included engaging in sex as their personal decision.

The study by Mahon, Conlon and Dillon (1998) on crisis pregnancy was ground-breaking because it was government-sponsored research that was centred on women's experiences. The ensuing consultations on the Green Paper in 1999, and the All-Party Oireachtas Committee on the Constitution recommending the establishment of the Crisis Pregnancy Agency were important because they continued that emphasis on the greater visibility of women's experiences.

Cook (2004) has demonstrated that the real sexual revolution in Europe, women's autonomy in decision making about sex, has only begun to be achieved in the last quarter of the twentieth century. This is when the history of the Northern European Marriage System, where sex and children had to be confined within marriage, was finally interrupted. What Cook shows is that women in countries that secularised rapidly in the twentieth century (e.g. Britain), still confronted substantial problems of contraceptive access up to and including the 1970s. The implicit and often explicit argument that accompanied the expansion of "family planning" facilities was that women might have sex outside marriage, but that this was tolerated on the grounds that the woman and her sexual partner were going to marry, hence the continued use of the name "family planning".

The struggles around the liberalisation of contraceptive access from the 1960s to the 1980s in Britain focused on whether greater availability would increase female "promiscuity", that is, women choosing to have sex entirely outside the confines of a relationship (Cook 2004). It is worth noting this intensity of struggle for women to achieve autonomy in their decision making and its timeframe in the country which is our nearest neighbour.

Of course Ireland has been the longest lasting "outlier" of the Northern European Marriage System, with its own peculiar cultural patterns, and women in Ireland were subject in these same decades to much more punitive public discourses and constraints. But change, when it came in Ireland, did so with unexpected rapidity.

By the mid-1990s, the struggles over greater openness in Ireland about sex and women's changing roles were curiously telescoped with bitter public debates and protests about abortion alongside a more liberal, often commercially-driven climate of sexual availability. For younger Irish women, events have moved very fast indeed in the late 1990s and early years of the twenty-first century. Perhaps this is exemplified best by an Irish television network, TV3, carrying the most explicit portrayal in popular culture of women choosing to engage openly in sex on their own terms: *Sex and the City*.

Many of the events and developments just described in this section were often overlapping and therefore difficult to interpret in terms of their effects. But they form some important, albeit ambiguous, contexts for women who participated in this current research project. As we shall see in the data chapters, young women have worked to construct new identities and possibilities for themselves around fertility and sex. Many younger Irish women are attempting to make often difficult transitions, separating sex

from marriage and no longer thinking of sex as a “pre-marital activity” (Cook 2004) with the person they assume will be their long-term partner. They are, of course, attempting to distinguish between having sex and having children. They are endeavouring to take on the work of defining their life choices in ways that at first glance, appear to be strikingly different from their generation of mothers, as exemplified by a comment from one of the project participants:

I think women are becoming more selfish now, but not in a bad way. Whereas before they gave their all to their family and their partners, and then there was nothing left for themselves, they just had no self worth ... they were worn out, they were burnt out ... We're seeing that, you know, we can be a mother, we can be a career person ... we can have a family, we can be our own person as well, have our own interests, and set aside time for that. Whereas before ... you were a mother, full stop. Like, that's not what you did, it's who you were. (Shop manager, 22, Dublin)

In many ways, this respondent is setting out an ideal worldview. The realities of the hard work of pursuing these new objectives and multiple roles are what we will explore in this report. In broad outline, this report sets out the meanings that sexually active, younger Irish women, within personal psychological, relationship and social contexts, attach to:

- their fertility
- fertility-related decisions such as contraception usage and sexual risk-taking.

## 2.0 Methodology

### 2.1 Qualitative interviews and purposive sampling

This research project is based on qualitative interviews, which were obtained from individual case-study interviews and from focus groups. All interviews were taped onto audio cassette and transcribed.

Our target population was women aged 20-30 who had not yet had children, but who might or might not be in a relationship. There was a presumption that respondents would already have been sexually active.

In focus-group interviews, a semi-structured qualitative approach with a list of themes was developed to help establish an understanding of how women from the ages of 20-30 make sense of their fertility in light of contemporary social processes in Ireland. Individual case-study interviews built on those themes in greater detail and were important to develop insights into decision making, planning and risk taking in relation to fertility. A particular objective in the individual case studies was to contextualise women's feelings about these issues vis-à-vis their relationships.



'Having choices' and 'making choices' are now commonplace expressions in the more highly individualised society that has grown up in Ireland. We were especially interested in exploring women's sense of making choices about the critical issues of having sex, being in relationships, becoming a mother, and balancing work with other interests. The list of themes that we wanted to include about women's lives and their attitudes to key life events was as follows:

- history of contraceptive use
- history of pregnancy – if any
- school sex education
- meanings of sex and sexuality
- relationship status
- relationship history
- views on what "safe sex" means
- decisions on contraceptive use
- attitudes towards sexual risk taking
- issues around crisis pregnancy resources
- issues around desire to have children and desired number of children
- desired age of child-bearing
- plans for the future (work, training, education)
- employment patterns, economic change and security about economic future
- attitudes about family-friendly supports in the labour force such as childcare, flexi-time, maternal and paternal leave
- cost of housing
- costs of rearing a child
- the rise of individualism in Irish society.

Many of these are highly sensitive issues and this dictated our use of purposive sampling. With a purposive sampling framework, the respondents from the target population purposively choose to be involved in a particular study. In other words, this is not the traditional random sample that is associated with quantitative research. A purposive sampling framework assists and encourages the active participation of respondents. They know that their stories and perspectives will contribute to a rounded picture of the overall problem under study. Once they have indicated an initial interest in being involved, potential respondents in this type of research require a full discussion of what the project might require. This allows a review of potentially troubling emotions, which may arise in recounting sensitive issues, and a consideration of confidentiality issues and guarantees around those points. If the individual agrees to participate, it is made clear that although there is a series of themes to be explored, the respondent will determine the nature and pace of the interview. Devers and Frankel (2000) give a clear rationale for the use of purposive sampling:

Purposive sampling strategies are designed to enhance understandings of selected individuals or groups' experience[s] or for developing theories and concepts. Researchers seek to accomplish this goal by selecting 'information rich' cases, that is individuals, groups, organizations, or behaviors that provide the greatest insight into the research question (2000:264).

This is the approach we pursued in constructing our sampling frame.

## 2.2 Sampling frame and fieldwork issues

Our original target was to interview 78 women who were not married at the time of interview and who did not have children, to be divided as follows:

- eighteen individual case study interviews (18)
- twelve focus groups (60).

We sought to include a diversity of women in respect of these factors:

- socio-economic status
- geographical location.

These were necessary distinctions because the current research literature speaks about perceived differences between social classes and between urban and rural areas on issues like access to contraception, attitudes to career and motherhood.

We thus sought to interview in the following locations:

- the largest metropolitan area - Dublin
- a suburban area near the Dublin metropolitan area
- a small city in the country
- a small town
- a rural area.

Initially letters were sent out to statutory, voluntary, and community organisations dealing with women's issues in the geographical locations that we had identified, requesting their help in recruiting a sample of women. We also made telephone contacts with a number of young women's professional networks and organisations. Throughout the fieldwork phase, the organisations and networks we approached were supportive and enthusiastic about the project. There was a strongly expressed feeling that these were issues that women often discuss with their friends and that formal research would give them a voice in policymaking. A number of women contacted us individually, having heard about the project through friends and asked to be involved. That kind of "snowballing" greatly increased our scope for potential interviewees so that we had an initial agreed-upon list of respondents and then a fill-in list.

Despite this enthusiasm to participate, there were problems, especially in organising interview groups. For the age group we needed to interview, most women were working and also involved in relationships. Free time was at a premium. Dates which we had agreed upon for several of the groups had to be re-scheduled to accommodate clashes, because women who wanted to be involved were experiencing time pressures. However, this rescheduling also resulted in other women withdrawing on the day because of further unanticipated time clashes.

We sensed no reluctance in respect of the actual material to be discussed — the freewheeling dialogue that characterised group interviews indicated that the issues under discussion posed no significant problem. At the conclusion of a session many women said that they had enjoyed the experience. Yet with the exception of three groups, numbers in the group interviews were consistently down from those who had agreed to attend and participate.

The case studies were much easier to organise, although some women did withdraw from agreed meetings and needed to be replaced. In three instances, women who were unable to participate in focus groups because of time problems asked if they could set another time to do individual interviews and were accommodated in that way.

### 2.3 Final sample size

Our overall numbers of respondents are as follows:

- twenty case studies (twenty women)
- twelve focus groups (46 women in total).

The total number of interviewees was 66 women. The age range, (19-34), was wider than anticipated. But given the pronounced trend of women to begin child-bearing in their early thirties, as discussed in Section 1 above, it was seen as appropriate to retain these several women who were more than 30 years of age.<sup>2</sup>

The profiles from the case studies in order of interview are as follows:

**Table 2.1 Details of respondents in case studies**

Age	Location	Occupation
26	Small town	Health worker
30	Metro area	Teacher
29	Small town	Community worker
30	Rural area	Trainee solicitor
25	Suburban area	Office worker
32	Metro area	Systems analyst
33	Small town	Self-employed small business
24	Metro area	Health worker
20	Suburban area	Student
24	Suburban area	Voluntary worker
34	Small town	Civil servant
31	Metro area	Computer operative
34	Small city	Animal groomer
20	Small city	Bank clerk
31	Small town	Unemployed
33	Rural area	Self-employed small business
28	Small town	Civil servant
29	Metro area	Financial adviser
29	Metro area	Marketing worker
30	Small city	Catering manager

<sup>2</sup> Some women who had children and who were keen to participate were included in the final sample; the authors felt that the views of these women, especially in relation to crisis pregnancy, enhanced the data.

The geographical dispersal for the group interviews was as follows:

- Dublin — three groups (nine respondents)
- suburban area — two groups (eight respondents)
- small city — three groups (thirteen respondents)
- small town — two groups (six respondents)
- rural area — two groups (ten respondents).

The age range and occupational status of respondents in the group interviews are laid out in Tables 2.2 and 2.3:

**Table 2.2 Age range of group interview respondents (n)**

Age	Number
19	2
20-24	12
25-30	29
31-34	3
<b>Total</b>	<b>46</b>

**Table 2.3 Occupational status of group interview respondents (n)**

Status	Number
Professional	1
Lower professional	12
Non-manual	18
Skilled manual	2
Semi-skilled manual	2
Unemployed	2
Student	9
<b>Total</b>	<b>46</b>

**Table 2.4 Relationship status of all respondents, case studies and group interviews (n)**

Relationship status	Number
Single	23
In a relationship/ co-habiting	29
Engaged to be married	7
Married	7
<b>Total</b>	<b>66</b>

#### 2.4 Approach to data analysis, presentation of findings and a composite view of our interviewees

The “foreshadowed problems” (Hammersley and Atkinson 1983:28), discussed in the introduction, led to the generation of the interview themes laid out in Section 2.2. Once all interviews had been conducted, the fully transcribed data was systematically examined to understand the range and variation in reported experiences of the interview themes. Categories of analysis were thus identified and developed, leading to the headings presented in Sections 3 to 9. It was important to bring out both dominant patterns of behaviour and divergences from those patterns, in addition to respondents’ knowledge, beliefs and attitudes.

The individual case-study interviews enabled us to explore in-depth, sensitive aspects of women’s decision making around being sexually active, without in any way compromising their need for protection in the interview setting. By contrast, the more general focus of the group interviews facilitated an interaction amongst respondents as they spoke about, and commented on, the dilemmas and problem-solving that women are dealing with in relation to sex and fertility. However, in presenting the findings we have chosen to interweave data from the case studies and group interviews. This allows both the intimate perspective of individuals and the opinions and exchanges from the groups to maximise understanding of each category of analysis.

A general picture of shared experiences of the younger Irish woman today emerges from the case studies and the group interviews. The following profile is typical, and provides a useful summary.

A young Irish woman will have had a cursory school education on sex. At best, her parents will have encouraged her to use contraception from her late teenage years. More probably, they will have spoken with her about the “facts of life” in her early teenage years and then cautioned her to “protect” herself and warned her that pregnancy outside marriage could prove ruinous. She will have learned what she needed to know about sex from siblings and cousins (if she had them), from friends, from magazines and the media. She will have remained very cautious about what is perceived as the threat of becoming pregnant in her sexual encounters. She will most commonly use the contraceptive pill. At the same time, her use of contraception will have varied with her relationship status, as will the type of contraception she has used. As she has

grown older, it has been far easier for her to approach reproductive health services and seek out what she needs. In general this has been a straightforward process, but if she needed to access emergency contraception she may have encountered difficulties of access and less-than-supportive attitudes. She will be irritated at the expense of contraception and the cost of regular medical check-ups if she is using the pill. Although in global terms, she knows of the dangers of sexually transmitted illnesses (STIs), she is less likely to be practically concerned about preventing their transmission. An unwanted pregnancy remains her single biggest concern about having sex. She observes family and friends dealing with the multiple roles of work, relationships and children and although, for the most part, she wants children, she is not sure how they can be accommodated. She is concerned about the expense of rearing them, the cost of housing and childcare, and the strain on other aspects of living. She is nonetheless a confident and assertive woman.

This moves us away from an idealised account of this generation of Irish women and closer to the realities they negotiate.

### 3.0 Openness about sex and women's roles in contemporary Ireland

Clear indicators of greater openness in general for women in Irish society were laid out in the introduction. They have far more scope to pursue their life choices and more openness about sex and sexual relations. But how far has this process come? What are its positive and negative effects for women?

#### 3.1 How open is open?

There was a generally cautious view that we are a more open society now, both about sex and women being sexually active. The media is seen as a source of openness: "It's the media that publicise it a lot" (Shop assistant, 24, Dublin). Media exposure is seen as helpful because it encourages people to talk more openly. Furthermore, women's roles in society are viewed as having evolved, and women are seen as having more life choices now:

People with great careers had to give up their careers when they had babies, the marriage laws, but we just don't have those restrictions now (Student, 24, small city).

I think it is easier for a woman to be more sexually active now than in the past. There are a couple of things that have made that easier I suppose, access to contraception (Project manager, 25, rural area).

I think we're getting that way [more open], we're not quite, but we're getting that way (Student, 25, small city).

One respondent, reared in a single-parent household, identified a lack of stigma for the woman who is sexually active and who becomes pregnant outside marriage:

Whereas my mum twenty years ago would have had to have been mum to both myself and my sister and Dad to both of us and breadwinner ... now, there's not the stigma attached to it (Shop manager, 22, Dublin).

It is also easier for women to talk amongst their friends now about sex:

People are definitely more comfortable talking about it [sex] in the last ten years (Local authority worker, 27, small town).

Twenty- to thirty-somethings that I would know talk about it, on a much more comfortable level (Catering manager, 30, small city).

However, what openness that has been achieved is seen as either partial or hedged round with problems. The sentiment that “we like to think we are, but I don’t really think so” (Trainee solicitor, 30, rural area) picks up on the range of issues not yet resolved. One of these is a still existing distinction between urban and rural areas. In the latter openness is probably contingent on secure personal and social circumstances:

The whole sexual dimension is very closeted in rural areas in comparison with larger urban areas or towns (Health-board worker, 30, rural area).

I think sex in rural Ireland is still a taboo subject ... I think values are changing and the culture is changing but I think it’ll be another generation again (Occupational therapist, 27, small city).

Class is also an issue. With far fewer economic, educational and cultural resources to avail of, compared with better-off women of her generation, one inner-city Dublin woman said of women’s changing roles:

I think it really hasn’t changed that much since my Ma’s day, not greatly. You probably have more choices in theory, but you still don’t have the option of accessing the services that’s needed. (Community worker, 30, Dublin).

Two women identified a source of confusion for young women which has accompanied this greater openness:

I think there is more openness, you are able to discuss the very fact that you are a sexual being, and things like the ability to enjoy sex. But there’s also sort of a level of insecurity and discomfort about that ... there’s more ‘shoulds.’ You should enjoy sex. You should want to have it a lot, or more than you did. There’s also the kind of Cosmopolitan culture that I think is going round, where young girls are under pressure to be a certain type of woman. (Teacher, 30, Dublin).

I don’t think there’s any real boundaries put in place, and I think boundaries are very important ... there’s so much confusion on all sides. It just seems to be that lack of knowing your place or your position or your rights or your authority, or where you belong. (Voluntary worker, 23, Suburban area).

### 3.2 Changing Irish mores and materialism

Respondents did see Ireland as a far more materialistic culture now, a change that in many ways they welcome. The chance for nearly all respondents to have foreign holidays and even to travel more widely is seen as a welcome aspect and adds to the choices they have as women with expanded roles. But expanded material expectations have an impact on one’s expectations of being a mother as well as a provider and on the size of family one sees as desirable, given the expanded material expectations for one’s children:

Just the society that we live in today, you have to keep up with the Jones' and a lot of materialism is part of society today. Like, as regards kids, as regards clothes and schools and university and whatever, so that's why women, they want the best for their kids. But then at the end of the day, if a woman, if they can't afford it, they have a choice [to not have children] (Nurse, 27, small city).

When I was growing up, there was six in my family, and when I went to school my family size was actually comparatively small in comparison to a lot of my peers. But now most people going to school I'm sure have two or three [child] type families. I think the economic boom means that there's a more material emphasis, and getting foreign holidays and stuff like that, and bringing up your children with maybe third-level education, and things like that (Project manager, 25, rural area).

### 3.3 Women's memories of public debates and discourses on sex and reproductive rights

This is a generation of women whose coming of age in respect of sexual awareness was marked by events in the 1990s, when two of the most influential agents of social control were embroiled in public controversies about their positions and actions :

- the Catholic Church and confrontations over its sexual abuse scandals
- the State and the 'X case'.

When women were asked about their memories of key public events that made them aware of a struggle for personal freedom around sex, their replies centred on these two events.

The decline of the Catholic Church's power to reinforce its views about appropriate sexual mores is seen as a largely positive development. This is especially so in relation to the freedom of a woman to be able to make decisions about sex and to choose family size, unlike "years ago, if you didn't have a larger family then there was something wrong!" (Farmer, 28, rural area).

The sex abuse scandals of the Church are identified as the reason for its failure to be a force any longer in respect of sexual morality:

The Catholic Church aren't as vocal on it [sex] because I think they're more wrapped up with defending their whole sexual abuse cases ... I don't think they have time to be preaching from the pulpit about sex, because they'd have to take an about turn (Trainee solicitor, 30, rural area).

This same respondent, who had been living with her partner for several years and was married just before she participated in the research, wanted a church wedding. However, she refused to do the premarital course, once she had spoken with her local priest about the content of the course. She spoke of her reaction to what she saw as inappropriate teaching and "a really frightening lack of insight into a sexual relationship and communication" (Trainee solicitor, 30, rural area). She was also struck by an inappropriate exercise of authority to insist on a pre-marital course as a prerequisite for a church wedding. She argued this was out of touch with where women and men are now in making their own decisions. She recounted what the priest said and her reaction:



[The priest said] 'Right. OK then. It's part of my job, I have to recommend it, and you don't want to do it and I'm not going to stand in your way. I will let you be married anyway.' And that kind of shocked me that there was this whole permission aspect to it, as in 'I think you're a suitable person to be allowed get married.' And I kind of wonder about people who maybe aren't as vocal or aren't as questioning or aren't as forthright in their views about sex with the whole church and marriage thing (Trainee solicitor, 30, rural area).

The X case represented a shock for many of the respondents, who would have been in their teens and the beginning of young adulthood when it became public:

I just remember thinking if that was me and I was in that situation, and not in a position to stop it and all you'd want would be to end the nightmare (Sales manager, 29, Dublin).

I remember feeling almost embarrassed to live in a country where what I personally see as a human right, it's a choice that you're entitled to make, and this child was not allowed to make that choice, and her parents weren't allowed to make it for her. And I just remember being frankly embarrassed. That we're despatching our problems to England, and in this case she wasn't even being allowed to be despatched, it was shocking (Scientist, 28, small city).

I was very angry, but I had been angry for a long time about the whole situation and I think it was disturbing. I found it quite frightening that the state could be so controlling and so cruel and in a sense so arbitrary (Teacher, 30, Dublin).

The X case helped to frame a resistance to the state's control of reproductive issues that had been seen as its right. This generation of young women appears more likely to view state control to limit their own decision making as unacceptable. They have moved into adulthood more firmly convinced that such decisions should be part of a person's private actions with the freedom to decide as they think best. For them this is a strong aspect of individualisation:

I'd much rather be a young woman today, than a young woman growing up in the 1970s, or the 80s. So I think that women, and before that time, were really in the dark and they, they couldn't even identify what they wanted, and they certainly couldn't mention anything they wanted in terms of sex, sexuality and choice. Whereas women today can (Teacher, 30, Dublin).

### 3.4 Media coverage: Sex and the City

This television programme, in particular, is emblematic of how swiftly matters have changed and how much freer women now feel in speaking about sex. It came up frequently in the interviews for having "very good messages" (Nurse, 27, small city):

It's funny, the sort of situations they get into and the people they meet. But it's good that they can talk all about sex. That's what goes on today. People will just talk about sex. Definitely among my friends, you can just say whatever, there's no hush hush (Student, 20, Dublin).

I think it's a great programme and I would watch it religiously every Thursday night! Maybe, it is very blunt, it is very kind of out there ... these women do exist, you know. They aren't completely fictional, there are women like them, they do represent women ... I think it is liberating for women, the kinds of issues that they do bring up. It makes it easy to talk about sex and sexuality (Project manager, 25, rural area).

It can be very funny. That's why I like it. I think most of the girls growing up now have a mind of their own. I mean, because I know girls out there, and they're with fellas and they totally want their house, and then their children will come later, and they use contraceptives all the time. They're really sensible (Voluntary drugs worker, 28, Dublin).

Yet one respondent, who had had to deal with a crisis pregnancy, was struck by how little depth there was to the media's open attitude:

But that's not ... That's television. That's not reality. It's all very well to look at that and you know and see other people doing it [having sex] but when it's in front of you, you know, when it's close to touch, then there's a bad attitude around. Definitely. Without a doubt. I mean when I was pregnant, I mean people would stare at you. They would literally, their mouths would be open. You know, like? So to me, in reality, the attitude is bad towards it (Bank clerk, 20, small city).

Another woman spoke about how the portrayal of sex in a speeded up and more materialistic Ireland is making it harder to get our bearings:

We live in a culture that is a 'McDonald's Culture' which is to say that everything is fast ... fast ... fast. This has become a country so very different from the one five to seven years ago. Sex and body image are pushed on us all to sell things from toilet roll to ice-cream, and one can't turn on the telly or open a magazine without sex being there each and every time. Sex is portrayed as something that is great and casual. It would seem that everyone is doing it, and if you're not there is something wrong with you. The problem is there are no warnings or guidelines to help us make an informed decision about what is a very important area of our lives (Unemployed, 31, small town).

We can conclude that women observe a greater openness about sex and a greater freedom in their personal capacities to make decisions about their lives in general and sex in particular. Their sense of themselves as autonomous individuals is far stronger. Major players such as the Church and state have been challenged about the authority they once exercised over women's lives. However, greater openness and greater freedom may only be available theoretically to women, for these are dependent on women's class location and their geographical location. Women who are poorer and women who live in rural areas experience more limitations on their decision making. But for women in general, the work of learning how to negotiate new boundaries or no boundaries, in relation to sex and fertility in a growing materialistic culture, poses its own problems. "Choice" appears to lead them towards a consumerist way of life that also affects how they feel they should be thinking about sex.

## 4.0 Sex education

Learning about sex is done within the family, either implicitly or explicitly, and in schools. It is also done through conversation with one's peers and observation of them and through popular publications. This section reports on respondents' experiences of their sex education.

### 4.1 Parents

Sex education from the family, virtually always one's mother, is seen as problematic. There are two aspects to this: Firstly, embarrassment on the part of parents and children alike in discussing sex, when as a society we are only beginning to be more open. Secondly, the sense that children, as they get older, are seeking their independence from parental perspectives and are unlikely to accept what parents say. These are two typical experiences of a mother's efforts to explain about sex and contraception:

There was one sit-down session, that was really broad and general, and pretty much went through everything. And she was really embarrassed, and I was kind of sitting there just being embarrassed for her ... then throughout my life, she'd just kind of say 'Now you are being careful?' ... and she'd do it in the most delicate ways, like 'Take care of yourself' (Shop manager, 22, Dublin).

I remember my mum sitting me down once when I was about seventeen, and telling me that soon, myself and my boyfriend might kiss, but it wasn't to go any further, and in about five years time, if we were still together, she'd sit me down and give me a talk about contraception. Which I thought was hilarious, because at the time I was on the pill! (Scientist, 28, small city).

Fear of pregnancy was palpable in virtually all parental reactions and the message ranged from one of "if it happens to you, you're out on your ear" (Student, 26, small city) to two mothers who distributed condoms and contraceptive pills respectively, urging their daughters to enjoy sex, but not to become pregnant. Several older respondents mentioned concealing from their parents that they were sexually active or preserving a guise of not having sex with their boyfriends and even not living with them:

When I was nineteen, I moved in with my boyfriend like. Now I didn't tell my mother for a year (Restaurant worker, 29, small city).

Honesty about one's relationship was not necessarily welcomed either:

We didn't live together until we'd been together four years, but it was still frowned upon. It's only recently that they've kind of accepted the whole thing. I think they should be grateful that I've had the one partner for seven years. But still I remember meeting them at the beginning, staying weekends at his house after six months, and I used to be called every name under the sun (Local authority worker, 26, small city).

Yet in general, parental attitudes and responses are also seen in a positive light for some respondents, as contributing to one's sense of who one is, of giving one a sense of confidence, a sense of values and skill that are all welcomed: "that's family driven" (Customer services, 24, Dublin).

There is great scope for changing and being more open and supportive in relation to sex:

It depends on the parents to be that comfortable with themselves and their kids, to be able to be that open (Administrator, 26, Dublin).

It was also suggested that if good quality information were available in the schools, teenagers would perhaps “feel more free to come home and say ‘Oh we talked about this at school today’” (Student, 24, small city).

#### 4.2 School sex education

There was one positive account of a school teaching session on sex education:

We went to a convent school, and we were all fully expecting the talk of ‘Keep your knees together young ladies!’ But we had a speaker in, I’m not quite sure where she was from, possibly the Catholic Marriage Advisory Council. And she was excellent. She went through all the different options, in a very, very matter-of-fact way. And she answered questions really well ... and I was really very impressed by that. So when the time came for me to make my own decision on what I wanted, I used condoms because of that talk (Computer operative, 31, Dublin).

Otherwise, school sex education lessons were uniformly disappointing across the entire age range. “We barely got sex education” (Shop manager, 22, Dublin) sums it up. Two respondents, separated by fourteen years, in which period we might have expected more wide-reaching changes in school curricula, reported experiences of the same order:

You got like one talk for forty minutes. That was it. Like you didn’t get any hormonal changes or any of that. Like I developed early. I had my first period when I was in the last year in junior school. So of course there’s nothing ever said in that. So no, there was nothing (Animal groomer, 34, small city).

We had very bad sex education in secondary school ... it was very detached ... I remember it was a video, and you watched the video, and it was a much older woman ... I think you’re interested, but you can’t relate to it (Student, 20, suburban area).

Classes were taken by teachers who taught religion, biology, or career guidance and the “syllabus” tended to include only the following elements:

- menstruation and first periods
- biology of reproduction
- biology of boys
- video on abortion
- STIs.

So “it was very much biological and functional and never put in a relationship context” (Scientist, 28, small city), and permitted no exploration at all of emotions and feelings. These lessons were often so de-contextualised as to be meaningless:

We didn’t get any sex education. The only thing, we were taught about STDs [sexually transmitted diseases], but we weren’t taught how you actually get an STD! There was just ‘This is what they are’ (Student, 24, small city).

When I was at school a woman came in and taught us about sex with matchstick men. Like it was so ludicrous (Civil servant, 28, small town).

Many reported how difficult it was, embarrassing for teachers and students alike, with the latter seeking to make fun of the former. One respondent reported that boys and girls were separated for PE, because of embarrassment, but not for sex education and she felt it made it worse still for everyone. One respondent reported having teaching on periods in sixth year, a completely irrelevant topic by that time for all women students.

There was often an emphasis on the fear of sex outside marriage because it might result in pregnancy:

The whole thing was you didn't do it outside marriage. I remember my sixth class teacher talking about 'you see those girls, hanging around the town centre ... the girls with prams.' ... and it was very firmly in my mind that there were 'girls with prams.' And they were something that we didn't become because 'we're not that kind of people' (Health worker, 26, small town).

Respondents argued that there is a place in school curricula for what, in theory, could be a useful discussion on safe sex and deciding what one might need in order to feel confident in negotiating safe sex:

It should be made easier to talk in class to the teacher, because there's so much embarrassment about it in class. And to take that embarrassment, laughing, away, and just be able to talk freely, and get the message through (Student, 24, small city).

I think teenagers are very eager though. I think that they're not really embarrassed if they have a comfortable teacher. Like, they're all eager, everyone is eager to talk about it (Student, 20, small city).

Misplaced and roundabout approaches increased embarrassment and, sometimes, hilarity, as with this account of final-year secondary students being warned of the dangers of attending university outside Ireland:

We were taken into a room and given a special talk about what might happen if you were leaving the Republic. It consisted of 'A lot of people have 'digs', and 'flats' and they might hold parties. And you might be in a party. And most of those flats have electric meters, and you have to put in a 50p to keep the electricity going. And sometimes you forget to put in the 50p, and sometimes the lights go dark. You see? And then you're at risk as a Catholic girl.' Because you know! And the advice was to jump on a table. And wrap your skirts around you. And this was given to those of us who were leaving the state to go to university (Teacher, 30, Dublin).

#### 4.3 Siblings, friends and peers

With parents and schools playing a less effective role, reliance on one's peer group is the most common approach to becoming informed about sex. However, it was observed that as a teenager one can be subject to misinformation as much as accurate information. Also having sex as a teenager can be a secretive undertaking and, given a general climate of disapproval, one might not confide at all.

Thus one respondent recounted how she and her best friend talked about everything except sex from twelve years of age. When she had sex during her Leaving Certificate year, although she was using a condom, the condom broke. She felt that she had to work out for herself where to go to get emergency contraception and said nothing to her friend:

Never told her this. And we were out in the pub, I'd say maybe 22, 23, talking one night drunk and it came up and I turned round and said 'Wait till I tell you what happened to me' and when I told her, the same thing had happened to her, the same year, and she hadn't told me. Both of us went through it on our own and didn't tell each other (Student, 25, small city).

Respondents who had older siblings could rely on them in part, even if only by rooting through their personal things. It was a huge help if one were able to ask friends or siblings what to do and where to go. One respondent in her teenage years was able to rely on an older sibling, who was part of a peer-education project on sex and sexuality, and who did give her up-to-date and accurate information.

#### 4.4 Teen magazines

The other source of information women mentioned is British teen magazines, such as *Just Seventeen* and *Nineteen*:

Like *Seventeen* and *Bliss* and terrible things like that. When you read them now, you're going 'Dear lord! They're selling this to twelve year olds!' (Scientist, 28, small city).

These could be seen as troubling material by adults and were usually read with one's friends or sisters or on one's own. However one respondent with three sisters, described the excitement of waiting for their favourite magazine to come out, one which had actually been banned in their school, but of which their mother approved:

We used to get *More* every two weeks, and most of the magazines. And then they were banned in the school, and my mum was saying just don't bring them in, she didn't have a problem with it, she'd rather us know (Student, 25, small city).

In conclusion, parents and schools were deemed far less adequate sources for sex education and inevitably women turned to their own peer group to build their knowledge. The hazards with this approach were incomplete and inaccurate information which might to an extent be corrected for by teen magazines. What women identified as crucially lacking was a holistic approach to sex education, which took into account feelings and emotions as much as biology.

#### 5.0 Dealing with sex and contraception

Working out how to handle oneself as a sexually active woman was a long learning curve for all respondents. One's relationship status and emotional needs evolve along with one's knowledge base about sex and contraception. This section examines important interrelated issues about these aspects.

Some respondents disclosed having sex as teenagers; some self-reported as having been 'late developers', beginning to have sex in their very late teens or early twenties. Almost all women had used the contraceptive pill. Five women mentioned moving to different forms of contraception because of adverse physical reactions to the pill,

concerns about side effects, or difficulty in remembering to take it. One woman has always used condoms because of concerns about side effects of the pill. Types of contraception cited in the interviews were as follows:

- contraceptive pill
- condoms
- emergency contraception
- injectible contraception (two)
- coil (one)
- diaphragm (two).

However the pattern of usage varies widely and is very context dependent, as we shall see below.

### 5.1 Early experiences of sex and contraception

Despite peer pressure to appear sexually successful with boys and men, having sex for the first time is not an experience that you necessarily talk about, not least because you assume as a teenager that you know less than your friends:

I was coming at it from the point of view where I assumed everybody knew so much more than me. And then it started dawning on me that no ... not even necessarily that they knew as much as me (Health worker, 26, small town).

It was basically just us, trying it and going it alone and seeing how you got on with it (Office worker, 25, suburban area).

This highlights both the greater vulnerability and the needs of very young women who are having sex. We have already encountered above a possible reluctance to talk about the specifics of having sex in one's earlier years, how one organises contraception and so on. The sense is that these initial encounters are done without much reinforcement and information-sharing among peers.

Fears about getting pregnant are consistently reinforced by parents and schools, reflecting a general sense in Ireland that an unplanned pregnancy outside a cohabiting or marital relationship spells disaster. This can put a brake on even having sex:

I didn't actually become sexually active 'till I was nineteen. I was going out with somebody from sixteen, but I wanted to wait 'till I was over eighteen and I wanted to wait until I had finished school. That was a conscious decision. I suppose just the fear of getting pregnant, and I didn't want to get pregnant at school. That was always my biggest fear and still is my biggest fear about sex – pregnancy, and 'God it's not the right time to get pregnant' (Civil servant, 28, small town).

Several respondents spoke of how their fear of pregnancy had induced almost an obsession about using contraception:

For me I know that I got through my teens with, almost like a mantra of 'Don't get pregnant, don't get pregnant, whatever you do, don't get pregnant.' It's only in the last couple of years I realised that's still going on in my head and I have had unprotected sex once in my life. Unprotected from a pregnancy perspective. I have almost always been on the pill or using a diaphragm or something like that (Self-employed, 33, small town).

At the same time, this fear of getting pregnant did not translate for most respondents into consistent contraceptive usage, underscoring firmly the fact that fear alone is not an adequate basis for the practice of safer sex. With the exception of one respondent, all had experiences of unprotected sex.

Use of the pill is inevitably dictated by the need to feel secure about not becoming pregnant once a woman is sexually active. Yet its use is unlikely to be consistent.

Some respondents had already been on the pill to help them with painful periods when they became sexually active for the first time. Information and support from older siblings or mothers meant that some went on the pill because they wanted to become sexually active. Some felt able to go to their GP and ask to be put on the pill. One woman had been on the pill to regulate her periods but had stopped it when she first had sex and so used condoms. One had already decided before she ever had sex that condoms were the sensible choice for her.

But adjusting to the pill did take time for some respondents and for others it was an unsuccessful experience:

The time I was on the pill, the three different types of pill I tried, each of which gave me an interesting selection of side effects and complaints etc. The first one gave me panic attacks, to the extent that I was curling up in a corner unable to move. The second one I bled all the time. The third one I put on a stone and a half, and developed a very interesting pelvic pain condition that didn't go away for a year and a half. I had to get acupuncture for it. I went to see five specialists (Computer operative, 31, Dublin).

I was on the pill on two separate occasions, and on both occasions I was in a relationship. The first time I took it, for the first month or so, it didn't agree with me, but I got used to it and that was fine. The second time, and it was still the same brand, it didn't disagree with me at all, and it didn't have any negative side effects (Systems analyst, 31, Dublin).

## 5.2 Negotiating access to contraceptive services

If women decide to use the contraceptive pill, as did the majority of respondents in this study, they need to go to a medical facility. If they are using condoms they need the confidence to purchase these at commercial outlets, especially if they think their sexual partner will not do so. They also need to be confident about exchanges with men about using contraception and having sex.

Many respondents reported having had successful first-time experiences with both family planning clinics and with GPs. Some found GPs preferable because they knew them locally. Some found clinics preferable because they were anonymous. But whichever provider was involved, these factors appeared to be the most common in women's successful first encounters:

- confidence in oneself and one's decision to have sex
- a good information baseline
- accurate advice from family members and friends
- supportive responses from service providers.



Without that framework, it becomes harder:

It takes courage even to go in and lift a leaflet on contraception ... It needs to be brought down to a level where people aren't intimidated to be actually open and honest about it (Project manager, 25, rural area).

Despite what we know statistically about the extent of sexual activity amongst young people, there is a perceived stigma or a fear of being stigmatised about having sex. This can colour these early experiences of accessing contraception, especially for younger teenage women:

Even the first time that I was going to get the pill, and I was only getting it because of my period ... I still didn't go to the family doctor, I went to a different doctor, even though I was at home. Just because it felt a bit weird going in and getting it. I went to a different chemist than I normally go to. (Ban garda, 22, small town).

A younger respondent categorised her experience with her GP as a better one than going to the family planning clinic. With the latter, the only reason you could be going there would be to do with sex and that conveys a poor image in a society that often still disapproves of sex:

I went to my family doctor ... and I just said 'I'd like to go on the pill please,' just like that, and he goes 'Alright so.' and 'What age are you?' and he was very matter-of-fact and he was great. And since then, I mean, I went to family planning clinics and it was kind of like doing something seedy nearly (Shop manager, Dublin, 22).

This image of the family planning clinics was confirmed as being off-putting, but there may be difficult choices to be made between the relative anonymity of the clinic and the sense of stigma in going there:

I think it's a service [contraception] you have to go looking for rather than one you know is already there. Like you know you go to your GP if you want to talk to him, but not everybody's going to go there ... my GP has been my family one since I was little and I don't really want to talk to him about my sex life! So the next step on is probably the family planning clinic. I know when I was seventeen, eighteen, you'd need a gang of your friends to go into the family planning clinic. And you could just be coming for a check up, but it was this big stigma that everyone thought you were going in there because you were having sex (Shop assistant, 24, Dublin).

There was also an anxiety of being patronised by family planning clinic staff:

It's like being in school and being sent to the headmaster's office. That's the kind of feeling you have. You weren't made to feel like it was OK that you were there (Unemployed, 28, Dublin).

I felt they were more judgemental at \_\_\_\_\_ compared with the student health service (Scientist, 28, small city).

If you're younger, they lecture you (Student, 24, small city).

Going to a local chemist can be just as difficult, especially in a small locality:

There's huge issues around confidentiality and embarrassment around going into a local chemist for contraception ... and the person that works in the doctor's is your neighbour or whatever (Health board worker, 30, rural area).

One respondent has worked in a local chemist in a rural area and spoke about her experience of trying to be supportive to younger women seeking contraceptive advice:

I've worked in a pharmacy as a part-time job, people would feel 'Oh she's heard this before. So I don't mind saying it to her, she won't judge me' kind of thing. But I'm just concerned about the amount of young girls that I saw when I was working in the pharmacy coming in for the morning-after pill. And you know, being highly embarrassed about buying condoms, because their boyfriend wouldn't buy condoms, and not asking for KY jelly (Trainee solicitor, 30, rural area).

Women who were students were able to use student health services, which appeared to be an easier experience, more likely to be free of this sense of stigma. It appears that early experiences of seeking contraception can be mixed with acute embarrassment and uncertainty about the attitudes and responses of service providers. As women mature, they can deal with these ambivalences, but it is a huge challenge to ask a younger woman to do so.

### 5.3 Negotiating sex and contraceptive needs with men

Dealing with men about sex and contraception can be complex, but it is also part of what a sexually active woman can do to set out her own needs and boundaries.

These centre on the emotional aspects as much as the physical aspects. Many emotions and feelings are part of sex for women, even in the context of short-term relationships:

There's all kinds of identities tied up with sex. And most of the issues around how women field sex. I think sex is still used as a tool in some sort of way. Whether that's a woman who won't have sex with a man the first time she goes out with him because she might be perceived as easy. Or 'I won't have sex with him because then he's more likely to ring me again, because he won't have got what he wanted the first time' (Community worker, 29, small town).

I think that women do want something with some more feeling attached. Something a bit more emotional. And it doesn't have to be committed for the next however many years, but it's with somebody that you feel that you trust. You feel that you're comfortable with, that you feel they're not going to do anything after you've opened yourself up like this. Because sex is something like this I think. Where you open yourself up to, to be quite vulnerable. And I think that's what women want. And that's where it comes into short- or long-term relationships (Catering manager, 30, small city).

Thus women need to develop skills in handling sex with men, especially if sex takes place before a relationship is well established:

For many years I thought that ... to have a boyfriend, you would have sex with him. So not that it would be forced or anything like that, but just, it was part of life and something that I just had to deal with. If I had a boyfriend, which I wanted, I would be having sex with him, because I chose to be a grown-up (Self-employed, 33, small town).

Trust comes into the equation very quickly when having to negotiate with a male partner about the issues of contraception. For this reason, the pill may present an easier option at the outset because it is something a woman can do for herself, rather than leave the issue to a potentially unreliable male partner:

I take the pill because I'm happier knowing I'm in control (Animal groomer, 34, small city).

It's very scary now! I mean, trust is one thing, you can trust your partner but like, you might have to nag him to leave out the bins or whatever! You might trust him but! (Financial adviser, 26, small town).

If a woman chooses to have a man use condoms, she may have to negotiate this as well:

I think it's just like choreography or scripting. It's like, where do you say 'Ok, Now you're going to put on a condom.' And I actually developed this habit really early on ... what would always happen is you get somebody to put on a condom, and of course that would, um, dampen their fervour a little bit. So what I used to do is go 'Ok look, will you just put on the condom now, and forget about it, but you're not going near me for another while' ... and that made a huge difference (Health worker, 26, small town).

Women are more confident that they can insist on men using condoms:

It can't be a last-minute thing, it's got to be done at a certain point ... Last year or the year before, this guy, and ... he's nearly forty, and he wasn't going to use a condom, and I was like, I was really shocked, really, really shocked. It was like 'Are you mad?!' And he was going 'Oh never thought of it.' ... He doesn't know where I've been, he doesn't know who I've slept with, and who they've slept with. I was really shocked. I thought that just wouldn't happen any more (Student, 26, small city).

Yet even in established relationships, because most forms of contraception are centred on the woman, the responsibility for dealing with contraception tends to remain with her rather than being shared by sexual partners:

I think it's more that women kind of expect to deal with it. And it's just kind of expected that's what they'll do. Women expect to shoulder the whole lot ... I mean, sometimes I feel like 'Fucking hell, that's me having to sort it out again.' But I don't know what the other options are you know, unless my partner was to sort out condoms, and I don't particularly want to use condoms when I'm in a relationship (Community worker, 29, small town).

One's relationship status does have an influence on choice of contraception. A commonplace reaction appears to be that the contraceptive pill is the most appropriate form when a woman is in a relationship. But if that relationship ends, not using the pill accomplishes several things:

- it gives the body a "break" from what is perceived to be a chemical that one should not use long term
- it helps to mark the end of the relationship emotionally for a woman by ceasing to use contraception
- it may also protect the woman from feeling that she is looking just for sex.

I was always conscious of the fact that, particularly as I'm a smoker, that there's always an issue around the pill and smoking ... So, yeah ... for me it was always ... if I wasn't in a relationship I would get off the pill. Principally for health reasons (Systems analyst, 30, Dublin).

In terms of contraception and safe sex, first of all I did spend quite a bit of time on the pill. But then I think you're reluctant to go on the pill when you're not in a relationship. There's a real feeling of declaration about that, do you know what I mean? And I'm conscious I'm still feeling it now. That going on the pill if you're not in a long-term relationship says 'I'm a big fucking slag!' (Health worker, 26, small town).

However, this leads to a diverse pattern of contraceptive use where, if a woman is having sex and not in a relationship, she will ask the man to use condoms or possibly will rely on emergency contraception if she is not prepared with contraception and then only proceeds back onto the pill when she defines herself as once more in a relationship, as distinct from having sex:

I find it very hard with contraception because I'm single like. So I always think that when I am single, I don't like sleeping around like. So then it usually starts that I meet somebody, and I'm going out with them however briefly, so it nearly always starts off with the morning-after pill. And then I'll probably go on to condoms, and then I go onto the pill and that's the way it usually starts. And then you have the odd nights where you either use a condom or you have to get the morning-after pill. So I'm very inconsistent like. But usually in long-term relationships, the pill would be, yeah I'd be conscientious enough about that (Nurse, 26, small city).

I think women have this feeling that they shouldn't stay on the pill for long periods of time, so as soon as a relationship ends, it's like 'Well should I stay on it, or shouldn't I?' Lots of people come off it and then go through a series of not using any protection at all. And then after a while maybe going back on the pill again (Community worker, 29, small town).

A summary of this pattern drew rueful nods of recognition from respondents in subsequent interviews. It also raised the issue of the distance between the layered realities of women's lives and what can be a highly idealised public health model of contraceptive use, where the presumption is that if the information is provided and services are accessible, women will be making reasoned choices:

I think most people's story would be like that. And that's why I'm laughing because it would be mine (Catering manager, 30, small city).

And it's a question of when you finish a relationship, do you go off the pill, or do you stay on it? And then do you stay on it for six months when you're not seeing anybody? For a lot of friends that was the question, whether you should allow your body go back into its natural rhythm again, or whether you should just stay on the pill, for another year, or two, or ten ... until you meet someone (Occupational therapist, 27, small city).

What is not clear from these accounts is how women come to have a mixed history of both insisting on condom usage and yet not carrying condoms for casual encounters or insisting that the man in a casual encounter go and purchase condoms prior to their

having sex. Perhaps this is both context-and location-dependent. There appears to be a reliance on emergency contraception if, for whatever reason, a woman opts to have sex without condoms for casual encounters.

#### 5.4 Sex outside established relationships

It is now more possible for women to say they want sex on their own terms and without any ongoing relationship with a man:

I think it's more acceptable to be with someone for a one-night stand than it was (Project manager, 25, rural area).

If that's what you want to do, if you just want to have sex, then it's got to be between two people who know that's all they want. It can't be public knowledge, or as many people call them now, shag buddies. Like, it could be one person that you'd only have sex with, and it could go on for as long as you want it to go on for, but that's basically what the relationship comes down to, and nothing else (Office worker, 25, suburban area).

It's just that we're learning now that we can do it too, without feeling ashamed about it. There's no shame about a man doing that, and nobody talks about it. Nobody cares. But now that we're doing it, among your friends like, they kind of get the gist of it now. But the fellas still don't. They just don't understand that if they can do it, we can do it too. But that's what's come about, we've realised that we can do it too (Invoicing clerk, 24, Dublin).

However, there is still a very strong discourse about women having sex outside relationships being labelled. There is a hidden warning for the Irish woman who carries condoms — she can be referred to as a “slag”, a “slut” or a “slapper”:

I think like, well, for young people, say around my age, I think the attitudes are still very backward like. Especially when it comes to men our age like, they'd still brand women 'slags' like, for sleeping around, and men studs, and that's still very much alive (Nurse, 26, small city).

If I had condoms in my bag, I would be like hiding them in my bag. Like even older friends would think I had condoms in my bag, because it looks like you're going out looking for it. You know that kind of way? (Restaurant worker, 29, small city).

And I think women still feel, well in my experience anyway, obviously I'm generalising here, but women still feel carrying condoms at times will make them be perceived as kind of easy, or expecting to have sex or something (Community worker, 29, small town).

Several women argued however that women are beginning to mind this labelling less and less and are getting better at confronting men on their double standards:

You'd be offended but not as you would have been a couple of years ago. I just go 'Yeah whatever.' (Financial services, 26, small city)

I remember I decided one day, I put one in my wallet. And it was sitting there for ages. And my wallet was taken by one of the lads, like going through it, and he saw it, and he was like 'What are you at? What, are you expecting something from someone soon?' and I was like 'Would you shut up?' (Project manager, 29, Dublin).

There may be an age dimension to this, however, that as women grow older, they can cope readily. The issue is why they should have to cope at all with this labelling, which must be especially difficult for very young women.

### 5.5 Emergency contraception

As already seen above, women have incorporated emergency contraception into their practice to prevent a crisis pregnancy. The circumstances of using emergency contraception are diverse, but women saw themselves as acting responsibly in seeking it out:

Because we don't have fail-safe contraception. And people are contracepting responsibly in going to get the morning-after pill, for whatever reason (Catering manager, 30, small city).

Most of our respondents have used emergency contraception. These were the reasons they cited for its use:

- broken condom or condom slipped off
- forgotten pill
- using antibiotics and not sure about pill's effectiveness
- using no contraception at all.

However, four significant problems were cited about accessing emergency contraception:

- limited availability of services over holiday periods
- limited availability in areas of the country
- judgmental attitudes on the part of health care providers
- expense.

Here are some accounts of how women have experienced these difficulties.

#### *Limited availability of time:*

I think the services should be open on a Sunday as well because the weekend, that's when a lot of those things do happen and they don't allow for those kind of days. Not that I found (Project manager, 29, Dublin).

You ring up and 'Oh we're booked out' and OK you lose the morning-after pill after seventy-two hours. I've been there like, I'm telling you! (Computer programmer, 30, Dublin).

It is difficult. I mean, if you find yourself in a situation where you need it, you have to go to a doctor. The only time I ever did need it was a New Year's morning. And nothing was open until the following Monday. So I had serious problems, if I hadn't had my sister [who helped her with emergency contraception] I don't know what would have happened (Customer services, 24, Dublin).

One woman who eventually had a crisis pregnancy had been using condoms and in the wake of an accident, had gone to a clinic for emergency contraception. She was told that there were no appointments. Fortunately she was not pregnant on that occasion. When she did subsequently become pregnant, she did not return to the clinic:

Well to be honest with you, I would say that, obviously I'm not going to lay all the blame on them, but, if I hadn't have been treated in the way that I was treated when I

did go in first time, I probably would have went the time I did get pregnant. But I said to myself 'Oh no, sure they wouldn't have an appointment, I don't want to go through that embarrassment again of standing in a packed reception and this woman telling me that she couldn't help me.' It is, that would be one of the reasons I wouldn't have gone back alright (Bank clerk, 20 small city).

*Limited availability of services in rural areas:*

One woman recounted how she was working away from home in a rural area when she realised she would need emergency contraception because she had forgotten to take her contraceptive pill. There were no numbers in the local telephone directory. She did find a helpline. But it was Dublin-based and the nearest clinic the helpline could recommend was several hours' drive away. The helpline carried no telephone numbers of local GPs at all. The woman resorted to looking for "Protestant names" (Civil servant, 34, small town) in the immediate geographical vicinity and when she did call a doctor's surgery – where incidentally the named GP had died – there was no fuss at all. She was resourceful; the problem was a helpline with inadequate information for a part of the country where assistance is limited as there is no family-planning clinic at all.

*Judgmental attitudes on the part of health care providers:*

I remember going for the morning-after pill. I was dating someone, I'd say for about a year or two, and it [period] was late and the fear set in. And I went into one of the family-planning clinics. And I didn't know much about it, I didn't know how the morning-after pill worked, but I was at the door the first thing in the morning. The nurse was lovely, the doctor was horrible. Horrible. 'Did I think I was silly enough not to use a condom?' And I was trying to explain, and in the end I just shut up. Out the door, out past the nurse, last time I was ever going to enter into anything like that (Student, 24, small city).

I think it's a sense that you've done wrong, that you should have used something, that you should have had the guts or what not, you know, someone might look down on you and say 'tsk tsk tsk ... ' you know? (Student, 24, small city).

My first experience of the family-planning clinic was actually going down and requesting the morning-after pill. And I gave a false name, I gave my sister's name which was really silly! I remember thinking at the time, why did I do that? And it was actually a male doctor that was talking to me, he's from my home, and knew my sister and went 'Wait a minute! You're not [sisters name]!' it was really embarrassing. So I had to come clean. And he kind of gave me a stern talking to, and was quite patronising which I was a bit upset about. And it really put me off going back to the family-planning clinic when I should have a few times, when I was a bit worried about what had happened the night before because I had drink on me. So that was a really negative experience (Trainee solicitor, 30, rural area).

*Expense:*

I had to take it three times. One occasion just due to my own stupidity. I blame half a bottle of wine. And the other two times just due to an accident with the condom. And obviously it's preferable to the alternative, but still not the most fun experience. And also having to shell out, the last time I had to take it was last year, and it was something like €70! It was astronomically expensive! All for something that made

me feel sick and cranky. It was something in the region of that figure. I just remember staggering out of the surgery going 'I feel bad enough about my situation without having to spend ...' and obviously if I had to go to England, it would be considerably more expensive and more traumatic. But I was really appalled at how much it cost (Computer operative, 31, Dublin).

One respondent reflected on the position of women and their partners going to NGO clinic providers for contraceptive care and for counselling on abortion. She argued that several of her friends had reported clinic staff as being judgmental and unpleasant. She queried a possible conflict between the overall philosophy of providers and individual practitioners on the rota, which led to less than optimum support of male partners in such circumstances:

If they went with their partners, their male partners would be treated like shit. I've had one person I know who went for termination counselling with her partner, they had made the joint decision, they had been together a good few years, and her partner was also treated disastrously. Which is surprising, but it's there. And it seems to me that there's a conflict there. There's a very pro-choice thing, but then the individual doctors, you know, the organisation may have a certain philosophy, but that doesn't necessarily apply to the individual practitioners that come in on a rota system. This would have been happening to them in their late twenties, and they kind of feel 'Well look, I'm a mature person, I don't need to have this lecture at 27. I don't need to sit here in front of you and have you giving out to me. And if I bring my partner, it means that I have a very good relationship with a very good man, who should be respected as well, and that we're making a joint decision, and he didn't impregnate me, he's not some irresponsible boy of nineteen' (Teacher, 30, Dublin).

## 5.6 Cost of reproductive health services

Our respondents view the cost of contraceptive and health care services as an issue requiring attention. The financial circumstances of most respondents were not poor and a number of them had a good salary. But women cited the costs of paying for the following on an ongoing basis:

- the pill
- repeat prescriptions
- six-month check-ups with the doctor for blood pressure etc.
- the consultation and cost of emergency contraception.

They must also pay for additional screening tests, like that for cervical cancer.

This outlay, "Ah, it's a crime!" (Customer services, 24, Dublin), was seen as excessive and unsupportive of women's basic needs:

I started taking the pill when I was eighteen or nineteen, and I'm 30 now, and the price has just gone to the point when 'Ah this is getting to a joke.' It's €13 like. And you're just thinking, you hear in Spain oh, it's €4 and you don't need a prescription. We seem to be, as with everything in Ireland, with the price of the pill, plus seeing the doctor (Computer programmer, 30, Dublin).



I found every single time, you go to the doctor, you pay their €35, you pay for say six months of the pill which is another €40 or €50 or whatever it is. But then you need a smear test, so you have to go back the next day and pay for your smear test (Project manager, 29, Dublin).

A male job pays higher than the female, and women have to pay for it all, pay out for the pill, pay for your contraception, you're paying for it all like, you're paying for your sanity! (Local authority worker, 27, small city).

It was argued that those on a medical card must still pay for services such as cervical screening. Those women living on a very low income and not having a medical card would find it hard to pay for contraceptive services. The cost of emergency contraception for a very low-waged worker is a burden:

And like where is the money going to come from? You have to get into that agency within 48, well they say 72 hours, but the earliest you can get there would be like the next day. What if you don't have the money to go there? You're just going to have to suffer the consequences. Because it actually happens (Unemployed, Dublin, 28).

This respondent went on to recount how her sister had got emergency contraception from a chemist just before Christmas last year. But when she had need of it again recently, she was told she would need to go to a doctor for a prescription. She did not have the money "and she's hoping now that she's not pregnant, she only has a new seven-month-old baby" (Unemployed, Dublin, 28).

This account also begs the question of adequate follow-up support services and contraception needs in hospitals and clinics in the wake of childbirth.

Using injectible contraception is still expensive:

I get the Depo [Depo-provera] now, the injection ... That's €15 every twelve weeks. But it's €28 to get the nurse to give it to me. So that's where the expense comes in (Invoicing clerk, 24, Dublin).

For younger teenagers having sex, cost was thought to be a significant issue contributing to non-use of contraception. The cost of condoms at €3 to €5 was felt to be too much for younger teenagers, making decisions between say, drinks for the night and a taxi home. Two respondents, who have lived and worked abroad, compared free contraception elsewhere to charges here:

I can very well understand how a lot of people get pregnant at a teenage level here, because when it comes down to money, it's still €40 for the doctor. You still have to pay for your own pill here ... In \_\_\_\_ your doctor's fee costs you nothing, your pill costs you nothing, it's going to encourage you to use it (Health worker, 24, Dublin).

I worked in a school when I came back, and it was ... in a fairly deprived area of Dublin where we had to manage quite a number of teenage pregnancies. But I was appalled at how difficult it was to get the pill. Really, really difficult ... Really expensive. How do you expect a teenager, who doesn't really have a good relationship with their parents, and I don't know many teenagers who do, to go into a doctor's, and pay €40, or whatever it was, it was £32 I think at the time - where do you get £32 at sixteen?" (Civil servant, 28, small town).

The value of having a clinic nearby to attend rather than having to seek out a more expensive GP was raised by one student:

Like if a schoolkid, or even a college student wants to go and see, or have a consultation, they don't want a bill of €40 on top of the bill of whatever else, whatever they're going to get done or whatever, you know. I think the price of the GP would definitely come into play. It has with me anyway (Student, 20, suburban area).

The issue of cost for emergency contraception for teenagers was also raised:

Even trying to go to the doctor to get it [morning-after pill]. Like ... I went to the doctor and it was fifty quid ... Like for a lot of fifteen or sixteen year olds, its fifty quid to go to the doctor, without asking their mother? (Ban garda, 22, small town).

## 6.0 Safe and unsafe sex

Our respondents felt that the public discourse on safe sex focused on the issue of sexually transmitted infections (STIs). Yet for young women, safe sex is about not getting pregnant. To get pregnant provokes a life crisis, whereas an STI is thought of as an event that more likely than not will not happen to them.

### 6.1 Safe sex and STIs

In this section, we will set out data first on what our respondents think about safe sex and STIs.

The overwhelming majority of our respondents do not think of STIs as a serious issue. For them "safe sex" is not getting pregnant:

I think pregnancy is still the big number one for girls. Absolutely. I think STDs come second down the pile, 'it'll never happen to me' kind of attitude (Nurse, 27, small city)

I went through a stage in college of pills and condoms together. You really don't want to get pregnant (Occupational therapist, 27, small city).

Even when women know the realities of HIV, they still take chances:

There is a fear of HIV. But that hasn't stopped me. I've still put myself at risk, even though I have that fear. And I know the majority of my peers have as well. Repeatedly, not just like on one night (Community worker, 29, small town).

It's just not serious enough a topic. People don't take it seriously enough. We don't consider it a priority whereas as regards pregnancy, that's a huge priority because that is life-altering (Ban garda, 22, small town).

There is also an impression that STIs happen to "other" people:

Like you always hear the lads slagging about crabs and that kinda stuff, but I don't know any of them who know what it is unless they've actually had it. And as well they go 'That wouldn't happen to me, that's only sluts' that kinda thing. They don't get it that it can happen (Ban garda, 21, small town).

Condoms is what I think of as safe sex and I am as guilty as anyone of not being too conscious of STDs ... because I know somewhere out there, although I am kind of

aware that STDs are a factor, but I'm not very immediately aware of it. I'm not conscious of knowing anyone who has ever had one. I'm not conscious of anyone ever talking about them. I'm just not conscious of them in my surroundings (Health worker, 26, small town).

You look at the person you're with as well like and you think well, you know, he looks like a real good guy (Student, 25, small city).

There is also a problem around the portrayal of condoms as the only answer to combat STIs:

Well, I think that there is this ... condoms have been advertised and portrayed as this magic thing that will stop you getting anything. Put that on you, just, it's grand, away you go. Completely safe. I don't think people realise that a condom isn't a kind of, 100% barrier. Use a condom, you won't get STDs, you won't get pregnant, you'll be fine. If it's burst you worry. But you go and take the morning-after pill, you don't get concerned about getting Chlamydia like (Scientist, 28, small city).

Tellingly, the respondents who were acutely aware of STIs were women who have lived with the drugs crisis and the associated threat of HIV. One respondent, aware of her own experience, recounted how she takes condoms from her workplace to give out to her siblings and her nieces and nephews:

I mean, I had to learn this myself and I was the one who carried condoms with me to protect myself. Well, some people will call women slags. But it never bothered me. I'll actually show you what I have in my bag now, and you're going to laugh. See, I just leave them in the drawer down in my Ma's as well. Get them out of work and just leave them there, and if they're up in their rooms or whatever, and they come across them, well, they're there just to be taken (Voluntary drugs worker, 28, Dublin).

But this respondent was deeply critical of what she had seen several years ago with an older woman friend, a drug user, being given no choice about using long-term contraception before being accepted on to a methadone maintenance programme, "that choice was taken from her which was wrong as well" (Voluntary drugs worker, 28, Dublin).

## 6.2 Taking risks with unprotected sex

Fear of getting pregnant remains the overwhelming health concern of sexually active women. But it does not prevent them from taking risks. Sometimes they have become sexually active without any education or access to supportive services that could help them manage the risks:

It does take the scare to get you to do that [seek contraception]. It really does, and you just really do think that it's just not going to happen to you. I was an A-class student, loads of friends, I'd never done anything wrong in my life, never been in trouble, and I thought it just couldn't happen to me. You do though, you really do just think it's not going to happen. It's just really, I lecture all my younger cousins, all my younger friends, my little sister's just ten, saying 'Come to me, come to me, if this happens to you, you don't know how easy it can happen' (Invoicing clerk, 24, Dublin).

Sometimes, risk-taking is seen as related to drinking:

Like any time you were completely smashed. It was as if you could say 'OK I'm never going to get smashed drunk, and I'm never going to take drugs, and I'm never going to do this' but we're human (Project manager, 29, Dublin).

I think alcohol has an awful lot got to play with it as well. It's like the date rape drug (Occupational therapist, 27, small city).

Yeah, it's like the drink thing, you know. They're all drinking earlier than you and it's everyone trying to keep up with everyone else, 'Oh I got more drunker than you,' and you know, all this kind of lark (Ban garda, 22, small town).

There is also a form of risk-taking for its own sake:

There is, there's something sexy about the risk element as well. It kind of makes the whole thing a bit more exciting (Community worker, 29, small town).

Having other friends look out for you on a night out drinking is suggested as a safety net:

My sister said to me a long time ago 'If you're out drinking and you want to get completely blotto, just make sure you're around people that you know. Youse are going to make sure youse all get home safe, and you're not going to be left on your own and you're not going to be left in any situations' or, you know (Office worker, 25, suburban area).

I think when we go out, you know, I think girls should be more trying to look after each other. You know all that aspect of it. Looking out for the drinks, what you're drinking (Ban garda, 21, small town).

### **6.3 Choosing not to have sex outside marriage**

Two respondents were clear that they have chosen not to have sex. Both are engaged to be married. One, having had sex in the past, felt that this is not a direction she wanted to continue to pursue. By agreement, she has not had sex with her partner, now fiancé. The second woman is a virgin, by choice, something about which she feels she has been strongly influenced by her sense of family and Catholic identity. At 30 years of age, she is content with this decision for herself. She is also clear that this is a personal choice that each woman makes and strongly argued for support and information on contraception and reproductive health services for women.

### **6.4 When unsafe sex results in a crisis pregnancy**

We can see from what has already been presented that almost all respondents have had unsafe sex at some point, where they left themselves at risk of becoming pregnant. It has the feel of a lottery for many respondents. It is also clear that unsafe sex takes place in many different contexts: it may be casual sex; it may be sex in a short-term relationship where the woman is unsure whether she wants to commit herself to using the pill; it may be inexperience of younger women; a sudden letting go of any sense of caution; it may be forgetting to take precautions. Some women may be lucky, some women use emergency contraception successfully and some women end up experiencing a crisis pregnancy.

Many respondents have experiences of either family members or close friends who have had a crisis pregnancy, outside the context of an established co-habiting or married relationship. In some ways, a change in the general social climate is seen to have made things easier, because marriage in such circumstances is no longer forced upon women who become pregnant:

I had a very good friend that fell pregnant unexpectedly when we were at college. Now I don't think there would have been anybody looking twice at it, but at that time, it was a huge issue, and again a rural background and completely unexpected ... I think it's a good thing, the attitude now, because I think a lot in the past people were rushing into marriage, and really, and they weren't ready for it to be quite honest with you, and it was always seen as the answer, and it was wrong because nine times out of ten you were dealing with two very young people that would change a lot in ten years. So I think the attitude now is a lot more positive (Health worker, 30, rural area).

And even where the pregnancy is a shock to traditionally-minded parents, they work at being supportive:

But like say, my mam and dad would be big into religion or whatever or Catholic or whatever. But they'd be still not liberal now, but understanding. Like my sister had her baby when she was 23 but she wasn't married. And when she came over to tell Mam and Dad she was pregnant, we were like all going 'Shit, this is going to be terrible.' but Dad just shook his head and said 'Sure what can we do about it?' And Mam cried of course, but apart from that, Mam was the ultimate support. The way she saw it, it wasn't that you know, she was Catholic and this was wrong, you know. Mam saw it as like 'I'm a Catholic and I'm a Christian and it's up to me to do my best to help and make the best of the situation' (Ban garda, 22, small town).

But for many women a crisis pregnancy remains extremely difficult for family relationships, because of the family trauma and because the individual involved may feel obliged to conceal the pregnancy as long as possible. If she decides on a termination, the secrecy may be extended over a very long period of time:

My friend got pregnant. She hid it from her family till she was six months pregnant. And I don't know how she managed it. Nearly the whole pregnancy behind their back. And she was terrified to go to the doctor, she was terrified to go to the clinic, she was five months pregnant before she went to see a doctor (Student, 19, Dublin).

My sister had an abortion about two or three years ago, but she waited nearly a year until she could tell me. And she's still, I mean, she was destroyed at the time, she even contemplated killing herself when she came back from [abortion clinic] and it was just awful. And she couldn't tell any of us because she felt she'd done such a wrong thing. And she still hasn't got over it, I mean she never will, I don't think. It's a huge loss (Civil servant, 28, small town).

Younger female family members will feel the burden of a crisis pregnancy:

Like we got an awful lot of hassle, I think as well because my older sister had gotten pregnant when she was young. We were like, you know, every time you were going anywhere, it was 'don't you get yourself in trouble! Don't drink because you never know what'll happen' (Student, 26, small city).

One respondent had the realities of the negative weight of a crisis pregnancy brought home to her when she accompanied her friend to a clinic in Britain:

I remember sitting in an abortion clinic with my friend in [UK location], and I think for me that was a big realisation of what that experience is like, and of what becoming pregnant is like. And I think especially, if you're from a more rural background as well, it's just such a 'Oh my God she's pregnant!' (Occupational therapist, 27, small city).

In our group of respondents, six women disclosed that they have had to deal with a crisis pregnancy.

One woman became pregnant recently because she had been using the withdrawal method, due to extremely adverse physical reactions to the contraceptive pill. Since her abortion she has been fitted with the new coil, which she finds comfortable and workable. She feels that both her partner and her family gave her tremendous support and she found the services sympathetic and supportive also.

Two women in this group experienced crisis pregnancies several times. The first woman decided to keep her baby – she was a teenager when she became pregnant – but recently had an abortion after she was raped. She described the journey to Britain and the experience of abortion as “harrowing”. She found out where to go for the abortion from the back pages of Cosmopolitan magazine:

It was like travelling down the longest darkest tunnel. I found out where to go for the abortion from an ad on the back page of Cosmo. I remember all that stuff about it being illegal for women to travel [the X case]. I really argued against abortion. It was going against all my principles before when I went for the abortion. I ended up with one set of beliefs and being pulled the other way. I flew to [UK location] and I'll never forget the taxi ride from the airport to the clinic. The taxi driver knew why I was going there, he said 'So many come over from Ireland. Everything will be alright.' What did he know? You had no privacy and they were cold there in the clinic. I told very few people when I came back. The whole taboo, you just can't talk (Unemployed, 31, small town).

The second woman had an abortion after unsafe sex at twenty years of age:

I was really afraid, really afraid. So my mother went with me to the abortion clinic (Self-employed, 33, rural area).

She subsequently had a “one-night stand”, became pregnant, and decided to have the baby and has “absolutely no regrets” about her decision, even though the father of the child has never been involved, at her request.

None of these women had post-abortion counselling.

Three other women talked about crisis pregnancies and their decision to keep the baby. For two of these women, denial and isolation were features when they first discovered they were pregnant:

I was four months pregnant before I went to anyone (Office worker, 24, Dublin).

I would say for about six months I was in denial (Bank clerk, 20, small city).

One of these women spoke about her immediate reactions which she had to handle on her own:

I think anybody who says they don't think about abortion is ... they're fooling themselves, because you do. You do. What it is is because of all the emotions you're going through, it's because of the worry of what other people are going to say and it's because ... well I mean the major worry is what way is your life going to go? I mean still today, my baby is thirteen months old and still today I have worries of where my life is going to go. So you have to, you have to think about it. It's not something that you want to think about or you don't want to think about. You have to think about (Bank clerk, 20 small city).

Both women experienced a complete lack of parental support:

It was very, very hard. I mean my mother wouldn't talk to me for about two months (Bank clerk, 20, small city).

She [mother] went absolutely ballistic. Because I was always told not to come home pregnant and that was that. And I was very innocent 'till I was seventeen years of age. I didn't even have a proper boyfriend 'till I was seventeen. And it was just one of those things. Literally just one of those things. It was like the second time or something that I wasn't careful, I got pregnant. And just like that. And she just said 'Don't come home. Don't come home pregnant. Don't come home and tell me you're pregnant' (Office worker, 24, Dublin).

This woman recounted further the unsupportive response when she went to a Dublin maternity hospital to have the pregnancy confirmed:

My friend persuaded me to go into [Dublin maternity] hospital. So not knowing where to go I went in, and my friend went up to the desk and she said 'My friend would like to take a pregnancy test.' And the girl behind the counter said 'OK take a seat.' And the next thing this woman comes out, a nurse or a midwife or whatever, and ate the head off me. 'Who did I think I was, walking in off the street, asking for a pregnancy test? Did I not know what chemists and doctors were for?' and '[they weren't] here to provide that kind of facility.' So I've never been back in there since. So I just cried all the way home. And then my friend went to the chemist and got me a pregnancy test. So that was it like. You don't, there wasn't support there at all (Office worker, 24, Dublin).

The third woman, a teenager when she became pregnant, did consider abortion, although her family wanted her to have and keep the baby. Her isolation arose from not being able to discuss abortion as an option. She was also faced with the issue of paying for the abortion: She simply could not find the money:

And then I was trying to get the money up then to go [for the abortion], and I couldn't get it anywhere anyway. Like, he's thirteen now, thank God I didn't do it. But like even the family then wouldn't let me go. They said no. I really had nobody to talk to about it (Voluntary drugs worker, 28, Dublin).

The overall issue here is the lack of truly coherent support for women.

In the case of the young woman using the withdrawal method, what stands out is that an abortion might have been avoided with far better contraceptive advice and support. Fortunately for her, she found the experience difficult but not insurmountable. For the two women who spoke of having abortions, support and counselling were paramount and remained unmet needs. For two of the women who chose to keep their babies, the lack of family support was tied to the shame of becoming pregnant. For one of them, unsympathetic professional responses made it harder on her still. The third woman faced the impossibility of her raising the money for an abortion and also the lack of a supportive context for her to make that decision.

Just as with finding out about contraception, you must pick up what you need to know as you go along, with no clear support and information structures and this is woefully inadequate for such a major life decision.

## 7.0 Motherhood becomes a foreign country

There is no denying that becoming a mother changes a woman's life. What is changing radically in Ireland is the context of that event. Cook (2004) has explored the economic rationale of the Northern European model of marriage and sex. In past centuries, a woman required the economic framework that marriage provided for her own survival and that of her children. That equation of economic dependence within marriage legitimated sex and children but left women struggling to exercise their agency.

Cook (2004) and Shorter (1982) argue that women increasingly sought to use self-help contraception methods in the nineteenth century such as withdrawal, instrumental abortion and abortifacients (e.g. quinine), as they tried to gain greater agency and control over their bodies. This was despite the public emphasis in national and religious discourses emphasising the importance of motherhood. Cook's argument is that effective contraception, notably the oral contraceptive pill, released women in mainstream European cultures from the equation of marriage/sex/children. This enabled women to begin to explore their sexuality on their own terms, and, of course, to make decisions about having children. As this sexual revolution finally became widespread in the demographic "outlier" of Ireland in the mid- to late 1990s, the key decision that women now needed to make was whether to have children at all.

We have explored in Sections 5 and 6 the very real problems that young Irish women still face in accessing contraception and dealing with crisis pregnancy. As we have seen, those women in less fortunate and more marginalised class positions and very young teenage women continue to face a considerable struggle in achieving reproductive control. Quite simply, although the public discourses currently highlight women's "choices", women in lower socio-economic class positions have limited agency and limited scope to make these "choices".

Nevertheless it can be argued that if a young woman is in a reasonably well-resourced social and economic position, she can make a decision about children. She is now free to decide:

- if she wants children
- when she wants children
- how many children she wants
- whether she wants to do so in or outside marriage.



The economic dependence that once dictated that a woman should marry and then have children has evaporated. The fact that the state makes possible financial support, however limited, for a single woman who becomes pregnant, has lessened the impact of that form of patriarchal control (Hyde 1996).

Certainly, many of our respondents are very optimistic about women's greater freedom:

Women of this generation have a lot more confidence, and a lot more independence and a lot more options regarding work and earning money and we know that we can do that as well as the men, and we know that now ... I think that's where it could have happened. Just broke the line, got more and more equal rights (Invoicing clerk, 24, Dublin).

But different economic and social constraints have emerged, which strongly influence how women are thinking about childbearing, even when they are in more secure socio-economic positions. Women thinking about planning a pregnancy are having to consider:

- time constraints
- money constraints
- lost or delayed career opportunities
- cost of housing
- cost of childcare.

There is also the issue of a lifestyle choice when weighing up these constraints against a menu of other "choices". We will explore the extent of these constraints in this section.

### 7.1 Notions of motherhood

Notions of motherhood are changing fast. Like our respondent in Section I, who speaks of the multiple dimensions that women now aspire to retain in their lives, our other respondents are thinking about how to balance these many dimensions with being a mother. At one level, the chance to plan entry into motherhood enables women to become more discerning about what they want and do not want:

The whole romantic notion of having a little kid that you can dress up, when you've younger brothers and sisters, has been swept out the window a long time ago. And you realise from a young age the very hard work involved. And not so much what it stops you doing, what you perceive it stops you doing at such a young age. Or you see different people's opportunities, who had a kid at eighteen or who had a kid at 28. You're very much trying to picture what your life would be like with a child. I think [there's] more concern actually for the child, because trying to manage my own life for the moment is hard enough, rather than having to be responsible for somebody else's as well (Occupational therapist, 27, small city).

I think there's a real dichotomy going on. There's the home and work aspect of things. I'm conscious that you know, to stay at home is seen in a kind of negative and scornful way, that you're not achieving your full potential, that you should be out there working. And then when you are working, you realise that 'God, maybe, maybe I just want to be at home with my kids.' And there's nearly a pressure to stay at work now, it's nearly come full circle (Trainee solicitor, 30, rural area).

Even the very few respondents who are thinking along more traditional lines in terms of marriage and a larger family, are conscious of a need for balance in their own lives before embarking on that path:

I definitely want to have children. I want to have three or four. I definitely want to be married. And I definitely will be married if I have children. And I definitely want to spend some time, just as a married couple, just to, well, children do end certain things as well. Your aloneness even with somebody. After that you're a family. But I think two or three years of singleness. Not singleness, coupleness! (Voluntary worker, 24, suburban area).

## 7.2 Careers and lifestyle vs. babies

Almost all of our respondents are working. Many of them see themselves with a career to manage and clear directions in which they want to go. So in this respect, what is now spoken of as choice becomes curiously challenging, precisely because you do have to make decisions:

You must make all your life choices and it's hard. You really do have the chance to fit in everything, to travel and so on. How children get fitted into this is difficult. How do you know you are making the 'right choices' as you plan? (Social worker, 25, small town).

The time to do "everything" is another dimension in this complex decision-making process:

I've barely time now. My work entails a lot of overtime, I'm studying, I have to see my boyfriend, get washing done and personal chores, be with other friends. If I added in a child at this point, I'd collapse (Financial services, 30, suburban area).

Of course the overriding dimension of time in relation to childbearing is the "biological clock" and respondents in a career are acutely aware of this and of how a baby might impact on their career, especially where women experience acute work pressure as part of their career:

As a woman, I know that I would only have another few years to, you know, to decide when to have children. I'm progressing my career all the time at the moment, and since I left college it's been a steep enough curve and it will continue for another few years. But in another few years if I was to have a baby, it'll just change. It's different, it's unequal between the guys and the women, I just feel anyway, I know, because the way I would want to see it working out as well if I had a baby, I know I probably wouldn't be as interested and would have different priorities (Financial adviser, 26, small town).

I don't have that sense of wanting to have children, and so I just don't think about it. But I do know that it's something I will have to think about. But I'm still so, I dunno, the kind of work I'm doing at the minute and the kind of way that I'm living is not, kind of, kid friendly, you know (Teacher, 30, Dublin).

One respondent was trying to reflect not just on her own decision making but on when motherhood still presents a version of a "career opportunity". Her comments were framed by the fact that she is working with teenage pregnancies, often very young women from deeply disadvantaged areas:

Having a baby is a career, maybe the only trajectory possible for very young disadvantaged women. Through having children, it does give them a sense of self-esteem they are getting from nowhere else (Social worker, 25, small town).

### 7.3 Pressure to have children

There remains a general expectation that once a woman is in a stable long-term partnership she will marry, and if she marries there are queries about when she will have children. This expectation is expressed by family and friends and is seen as a source of pressure:

I'm on probation in a new job, and I don't think we're in a financial position to have a kid either. So there's that. But yeah there are definitely pressures, and more so, I have this aunt who's a midwife, who sits me down every time she sees me and tells me the statistics of getting pregnant at my age ... So the last time she said this, and it was in front of my Dad which was very bad, and I just said to her 'Well that means I can have thirty times more sex!' But I was just so annoyed with this constant harping ... So yeah, yes there's pressure! I don't let it get to me (Scientist, 28, small city).

I have actually arguments with my mother. If she had her chance, if she had her way, if there was arranged marriages, I'm serious! She would have me married off. I get slack the whole time, 'when are you getting married?' well, not when am I getting married ... 'when are you going to settle down and start coping on to yourself?' (Nurse, 26, small city).

Well I'm not really getting that pressure from my parents ... But I find there's a big pressure around friends (Nurse, 27, small city).

### 7.4 Priorities in deciding to have a baby

When women now think of having a baby, they are setting out a list of priorities. Tellingly, this does not necessarily need to include a partner, although this might be ideal. What is vital however are secure economic circumstances and social support in order to rear a child:

For me it's not essential to have a partner in my life. But definitely, to be secure would be the main thing, financially, emotionally, because it's a huge thing to go through. And definitely with good support systems in place, be it friends, family (Shop manager, 22, Dublin).

What is most vital of all, and cited by most respondents, is affordable housing. However, given the size of mortgages necessary to purchase property, especially in the greater Dublin area, although a house is the very condition seen as essential to have a baby it then jeopardises one's chance to have a baby. For this respondent, the crisis provoked a move from Dublin to the countryside:

In Dublin I think that house prices for young couples is a major issue. I think that when you're starting out, you're getting married, obviously your house is the priority. And then you eventually move on to children. And that's when it's a big crisis of life. Particularly for women ... So that's more pressure. Like for me, that's one of the reasons we left Dublin (Rural tourism, 33, rural area).

The range of requirements for having a child are practical but formidable:

If you can't financially afford it, you can't buy a new car, you know, if you can't pay for childcare, if you don't have a house, or can you have an extra child ... you know, I think there are very real problems. If you can't afford to give up your job, and if you don't have a partner to support you, they're all very kind of practical things as well (Nurse, 27, small city).

For those who live in rural areas, there is still the more traditional framework of an extended family which helps to take the strain off some of these decisions.

One of the respondents, now married into a farming family, considers herself very fortunate by comparison with her urban sisters. She knows that she will have the support of her parents-in-law and her parents in rearing her family:

We're very lucky, we live with my mother-in-law, and she's great. Most of the time! And then my parents are the other side of me, moved down from [Irish location] to live down this side of the country (Farmer, 28, rural area).

The importance of this family network in rural areas was commented on by other respondents also:

But I think the family network is so important. And people don't have it, their grandparents are nowhere near them. And if you want them sometimes, they'll take them if it's an emergency or whatever, other than that they're just not interested ... And so they're relying on schools, crèches, and stray mothers, to take the children (Self-employed, 32, rural area).

### 7.5 Making the choice not to have children

The growth in well-paid career opportunities, combined with sexual freedom, means that some Irish women are now in a position to openly declare that motherhood is not a preferred option. In one group interview of seven women, three said they preferred to remain childless. Despite a growing body of literature that talks about "baby hunger" (Hewlett 2002) among older women in countries like the United States and Britain, perhaps for the first time in Irish society women are feeling able to say clearly when they do not want to have children:

I'm 29 now and I don't feel a bit maternal, to be honest. Maybe in my mid-thirties I will think about it (Restaurant worker, 29, small city).

I'd be like 'when do I fit it in!' And would I really want to do it? You know? Because I really want, I really like travelling, I could happily spend my days travelling round the world, and it would be a lot easier too, without a baby in tow (Student, 26, small city).

And now I'm kind of thinking 'Do I really want to have children? Like really?' It's very interesting how I've changed in the space of a few years. And I don't know is it that whole selfish reason. Is it because they're very expensive? Is it because I want to go on and further my career? Is it because I want to have like ten holidays a year? I don't know why. I still haven't put my finger on why am I starting to think this way. Or is it because of all those horrible ER programmes, where they show it in such a horrible and painful way that is so off-putting? (Trainee solicitor, 30, rural area).

### 7.6 Ideal age at which to become pregnant and ideal number of children

Whereas almost all respondents who favoured having children were in agreement about the need for secure economic circumstances before deciding to become pregnant, opinions about the ideal age at which to do so varied. The discussion produced differences related to career opportunities, as well as to the number and range of lifestyle choices that better-paid careers make possible. This can prove compromising – when do you decide to give up those options for a way of life that will be more constrained, at least when measured by popular consumer culture?:

I'd say about, like, 26, 27. I mean, my mum was 21 when she had me, when I was born and, I think it's great, I can go to her now, and she's still young enough that I can talk to her, and she's my best friend ... And Mum's now 40 and I mean, she's out and she's enjoying her life now and she now has this part of her life to herself. I think that's important too. You know, you give up so much to have a child (Shop manager, 22, Dublin).

This was an atypical answer in respect of age. Most women who expressed an interest in having children said they would consider having children in their early thirties. As to the number of children, only one respondent aspired to a large family of four children. Others indicated two children at most, but one child was the most common.

This respondent argues that expectations around having children are circumstance- and age-dependent anyhow:

I think there's also expectations on women and what they should be doing, particularly at different ages. I think if you ask someone in their mid-twenties or in their mid-thirties what their perception of motherhood and their needs are, it's very different. Because at 30 it's much more a real issue, and there is a biological clock (Occupational therapist, 27, small city).

Despite that biological clock, there is a strong sense of wanting time to enjoy being in a relationship before introducing children, especially where both partners have a career:

I would prefer to enjoy the whole set-up of marriage for a few years before I settle down so to speak. And I think spending some time together yourselves. And I suppose, we certainly wouldn't be planning a big family. Two children probably, if we're lucky enough that it works out that way (Health board worker, 30, rural area).

Women who are considering their options in this light come close to the kind of weighting that women who are choosing not to have children make. The potential of a child is a good on the same level as all other potential positive choices in one's life. It is part of a menu.

### 7.7 The strain of becoming a mother

Women are realistic enough to observe from family and friends how the conditions of contemporary Irish society create strain around being a mother:

Big stress. Yeah, and you see it in them [new mothers] when you meet them like. Because it's not all about you any more, you lose everything about yourself, it's all about what the baby needs (Student, 25, small city).

It's a struggle like, it's just such a struggle. And especially like, even people who are renting, they just have no chance of getting a house, it's just not going to happen (Student, 24, small city).

My brother's in \_\_\_\_\_, and he says it's €800 a month for childcare in a crèche. I mean, both do work and the child is in the crèche, and they've had the second baby now ... So you're looking at €1600 Euro a month, just to have your children minded so that you can go out to work (Community worker, 31, rural area).

The circumstances of single parents are often even more strained, with loneliness and deep personal isolation:

I think it's more of a case of, maybe loneliness because that would be the worst thing. Because I'm in a completely different situation now, to what I was. And the people that I was with are ... I mean they do, they are still there, but ... they have a different life. You know I'm twenty. Take New Years Eve. I sat in and watched Winning Streak, while they were out partying. That's the difference. And it's at times like, major events, even New Years Eve, when you're sitting on your own and you're saying 'This is my life.' That's when you say like 'Am I going to be like this in ten, fifteen, twenty years time, like.' And the other thing is that I'm young, and I haven't experienced the world, so how can I teach my daughter about the world, when I haven't been there? (Bank clerk, 20, small city).

## 8.0 Reforming reproductive health services

Respondents were asked about what they would see as necessary changes to existing reproductive health services. This section presents this data.

### 8.1 Cultural changes around sex and relationships

There was a strong sentiment expressed in Section 3.1 that Irish society still has a distance to travel in being more open about emerging patterns of sex and relationships. So there is a need to change what remains of the older, more repressive culture in the first instance:

It's like everything. We all know what goes on, but we'd rather it didn't. We'd rather it went on within wedlock. My mum always called it wedlock, and I hate that term so much! (Scientist, 28, small city).

I think what you're seeing in your clinics and that is just a reflection of what's going on in society at large. You know, it needs to change at a much more basic level. Because the condoms or the pill or whatever are just the tiny piece in a much bigger picture that's still very much muddled in Ireland. (Occupational therapist, 27, small city).

For women like, you were in the house, you done what you done, you made your bed and you lie in it. And that's whether the man had the right over what he done. Do you know what I mean? And even my Ma today would not have a clue about sex. And yet she had twelve kids. And that still continues, that the man has the upper hand in society. Yeah it's changing when people and women are beginning to get stronger. Because they're going to women's groups and they have more confidence in their

personal development. And it has to start in the family. At a very young, very, very young age [Community worker, 30, Dublin].

## 8.2 Levels of service provision in clinics

There was a sense that clinics needed to become more user-friendly. A number of younger women had never attended the clinics because the name itself, 'family planning clinic', does not suggest to them anything that connects with where they are at this point in their lives:

I think they need to change their image if you like, more user friendly, more approachable [Shop manager, 22, Dublin].

But family planning. I'm not planning a family, so why would I bother? By family planning you're thinking planning the family and not not planning the family if you know what I mean [Ban garda, 22 small town].

Clinics also need to begin to publicise and provide Levonelle.

The morning-after pill isn't even the proper morning-after pill, it's just a high dosage of contraceptive. That's bad as well [Student, 20, Dublin].

## 8.3 Information and public health campaigns

Our respondents argued that more needed to be done in disseminating:

- effective information on contraception
- advertising campaigns on STIs – public billboard campaigns and campaigns in clubs and pubs
- condoms in packets stamped "Free", to give out in clubs to help remove the stigma of women carrying condoms.

The following extracts give a feel of what respondents said:

Maybe the information has been produced without consulting with the people who are actually reading the information. It's only when you actually need something that you go and look for the information. Maybe there's something around that information not being appealing to the women using it, because they haven't been involved in its design or planning, or how it looks, or how it reads or whatever, you know? And if it's just, maybe written information isn't enough, maybe there's more to do around that [Project manager, 25, rural area].

It's when you're out and when you're drinking and all those other factors that influence those kind of things that are taking place, then that's when people will see it, you know? [Ban garda, 22, small town].

## 8.4 Building information and access for young teenage women

The needs of younger teenage women were cited as requiring a special approach:

So it's not even so much educating people, but making people realise that its OK to want to protect yourself. That that's a valid way to be. I mean, I'm thinking of groups of girls in the areas that suffer the most [from teenage pregnancy]. And it's not just a question of getting the leaflets out there or getting the information out there. They

still go, 'My friends aren't doing it, I couldn't do that, my boyfriend wouldn't have that.' You know. So we need something else, something more than that, to make these people stronger. And turn peer pressure on its head. Peer power (Catering manager, 30, Dublin).

One suggestion that arose early on from a respondent who had seen the Crisis Pregnancy Agency's Positive Options advertising campaign was to extend considerably its range in respect of text messaging. If a list of frequently-asked questions (FAQs) could be included, it would be a way of getting accurate information to more vulnerable younger women about their sexual health needs. It was also suggested that young men could access that service and begin to find out vital information from a male perspective:

You've got to tie in with what young people are using as well. And text-based is it. But the idea of text messages in general, first of all it's because they don't have any money and texts are cheap. And second of all, people are using them a lot, and they don't want conversation, they want to say something, but not have to deal with what's said back. They want to be able to say what they say, and leave it at that. And then there's also the non face-to-face type conversation. They'll go looking for this information if they can get it on a text message, they won't ask somebody face-to-face. Because all the young ones, they won't go near any of the services. Because all you get is a 40-year-old receptionist on the other side of a closed window going 'Heh? What do you want?' But definitely frequently asked questions, get people to submit. Like, a jokey FAQ, put people at their ease, and realise 'Oh look at all the stupid things that people actually thought.' And then have the correct answer underneath. That kind of idea (Catering manager, 30, Dublin).

### 8.5 Contraceptive services for those under the age of consent

Another concern was to deal with more effective ways of providing contraception for those very young women who are sexually active and under the age of consent:

I worked in a garage, and they did sell condoms in there. And there on the wall in the staff room, and they said under sixteen they cannot be allowed [*unclear*] but they said nothing about condoms (Student, 19, Dublin).

Because, perchance you are having sex at twelve, you can't exactly go into your local chemist and go 'Sorry, can I have a packet of condoms please?' You're not going to be in a pub to use the vending machine. And your doctor's just going to tell you not to do it (Invoicing clerk, 24, Dublin).

### 8.6 Abortion support services

Their own experiences and those of family members and friends made respondents clear on the support needs for women confronting crisis pregnancy. They discussed how there needs to be public movement on it:

When Mary Robinson became president, there was an opening of doors, and people in the media, and in certain establishments, like political and healthcare, suddenly felt freer to speak up ... It's like we took a giant leap forward, and we've been kind of pushing against an invisible wall now. And certainly in terms of termination, because there's been resounding silence since the X case, that women do not feel safe speaking up (Teacher, 30, Dublin).



When I was pregnant with [my child], there was a girl who worked with my friend, and she was pregnant as well, and she had an abortion. And she does say to me, I say like, [my child]'s the best thing that ever happened to me, and she says the same. She says '[your child] is brilliant, but I'm so glad I made the decision I did.' And our kids would be the same age. Because she had an abortion and I didn't. It's choice like, what you feel is best for yourself (Invoicing clerk, 24, Dublin).

I suppose it was far more traumatic than I would have ever thought. D'ye know it's very easy to take a moral stand, and I think in this country that's what people do. We take a judgement, but when you see the trauma that somebody goes through. And the thing is with crisis pregnancy it's the first option that I suppose every woman thinks about is termination, abortion because you think there's no way out (Civil servant, 28, small town).

### 8.7 Maternity services

Some respondents expressed views about our maternity services and the effects of cutbacks on women giving birth in understaffed and heavily medicalised facilities:

There are issues around the caesarean sections, and the numbers of them that are happening, and around home births not being actually, that's not an option for a women, and the cutbacks mean that some hospitals are losing their maternity services, and what that means for women living three hours from a hospital, from a maternity service, people living in rural areas where the closest hospital is one that's, you know, hours away (Project manager, 25, rural area).

I can't believe that you go home after a day or something, or they just say 'yeah, grand, off you go' after having a baby (Student, 24, small city).

The lack of support for new mothers in the face of these cutbacks is what is critical. Given the pressures on the hospital systems, the dearth of community midwifery and the shortage of public health nurses, there is a diminished chance of picking up on postnatal depression, which itself is bound to be a greater risk with less support:

Like for postnatal depression. Like you could be going around for months not knowing what's wrong with you, and it's not picked up in the hospital. There's no follow-on treatment, how the mother's doing, how the baby's doing. I think that now today, it's different. I mean, they're getting out of hospital after 24 hours. If someone is in a real crisis, and it can happen, three days down the line after a baby, and a young girl is sent home on her own (Community worker, 30, Dublin).

### 9.0 Other policy measures

There was again a sense of a broad agenda that is waiting to be government-led:

I think the government has had to grudgingly bring in this façade of supporting women, but if you look at the Dáil, how many women are there? And how many family women are there? (Trainee solicitor, 30, rural area).

This same respondent cited the following as areas for action:

- grass-roots-level support groups for women on sexual health

- advertising campaigns
- funding of crèche facilities
- enforcement of the maternity legislation on SMEs so women in small firms get their full entitlements.

### 9.1 Sex education

Virtually all respondents discussed the need for a comprehensive wide-ranging programme of sex education that would be part of core developmental skills and be delivered in an ongoing way from primary school through secondary school. Here are a few of those responses:

I think the education system, around sexuality, if they were taught emotional development. Particularly for young women, I think nowadays they're under so much pressure about their sexuality and everything, from a very very young age, before their teen years now, eight, nine and ten (Farmer, 28, rural area).

This is the problem with secondary school, it's needed. My sixth-year class, I'd say there was five of us that didn't have babies in sixth year. It was unbelievable. (Student, 24, small city).

I think they're having sex too young, and they don't realise really what it is. Like I was seventeen, and I felt even at the time, or maybe later, that maybe that was too young, that maybe I should have waited longer. Because then you really understand what you're doing, and you know, you enjoy it, it's not just this quick thing behind the bike sheds or something ... And I've talked to my younger sister, and she was fourteen, and she says she does regret it, and would have preferred to have waited longer. So I think helping people to understand that, and to maybe delay sex a bit longer (Student, 24, small city).

If there was a programme for the parents ... If you had a night with the parents to discuss what you're going to discuss, why they're going to discuss it, you know, to prevent this, that and the other happening, get the children to understand. And it's — sex education — not going to make children go out and have sex ... But if the parents knew that it was just, that they're just going to learn, they're just learning about life really. Instead of picking it up off the streets or out of magazines (Student, 19, Dublin).

### 9.2 Maternity leave

A more wide-ranging and supportive system of maternity leave was suggested to deal with the growing reality of women's self-employment and contract work:

The way things are going as well at the moment in Ireland, people are employed but you're not employed on a permanent contract, like. You don't, it's almost a thing of the past. And you don't, you may not even have a temporary contract, you're just kind of, you're brought in to do a piece of work like, and you have no real rights. You just do your piece of work and you go, and we don't have to, we don't owe you anything, you pay your own taxes, you sort out your own PRSI like. And it's becoming more and more like that, that you sell your services as an individual, and you're not really part of anything, you're nobody's responsibility. If you're self-employed and you're out for X, however many months, six months maternity leave, well it's up to you to fund your own (Health board worker, 30, rural area).

### 9.3 Affordable childcare, flexi-time and other family-friendly initiatives

The problem over women's need and desire to work and the lack of a supportive structure to help them is strongly colouring women's perceptions. They feel that it is difficult to consider having children. Affordable childcare has been on the public agenda for the last decade with no substantive government action. Yet again respondents raised this issue:

I think women don't have a choice really, either give up work or stay. I think it's appalling actually. I think even if childcare was affordable, but at the minute it is just exorbitant. You aren't given any enticement to stay in full-time work really (Health board worker, 30, rural area).

But the government should try to do something about that. The workplace for women should be much more child friendly. I mean, my sister has to get up at the crack of dawn to get the children to the crèche, I mean, she has to leave two hours before she's due to get there (Teacher, 30, rural area).

But with flexi-time as well, like you could work from half-seven till half-three, and work it out that way. Or you can take off in the summer. They do cater where I work with that. That's not so bad (Local authority worker, 26, small city).

One respondent, who had gone through a crisis pregnancy and kept her baby, spoke of the childcare issue with special poignancy. She would want to have a wonderful standard of childcare, as would any mother, but she is on low wages:

It's finding childcare that I can afford. And to me that's a terrible thing to say because it should be finding childcare that I want, that is right for my child and right for me. Not that I can afford. But that is not the case because . . . I mean I pay €700 a month, childcare, I mean that's half my wages (Bank clerk, 20 small city).

Some people I know who have babies they have been dying to go back to work. Because it's a case of 'I need some interaction again,' that type of thing. Obviously I think a lot of people do take maternal leave and decide not to go back to work. So the option should be there for job-sharing. Ideally, you'd like to be able to have the choices (Marketing worker, 29, Dublin).

As regards breast-feeding facilities in the workplace, well where I work, out in the ... nobody's breast-feeding! But I don't think there'd be that many breast-feeding facilities around the workplace in different parts (Nurse, 27, small city).

### 9.4 Community-based health clinics and outreach groups for women

Community-based clinics delivering free reproductive health care and contraception were seen as vital in more disadvantaged areas. Similarly, grass roots or outreach groups were seen as a way of building women's confidence in caring for their reproductive health:

The woman is, I think, is looked on as superwoman. Like, a man can walk away, but a woman is left with her six kids. Whether she has a fridge full of food or not, she has to go, and get survival. So it's a lot worse. I feel there should be a lot more resources in communities. And people know where the communities are, and where

people are being deprived. There should be a clinic that a woman can walk in in her own community, and have an STD scan done. People feel vulnerable, and they won't go outside to other clinics, because it's a very sensitive issue (Community worker, 30, Dublin).

Just say this is Dublin [area code], right? There's no clinic here for me to go in Dublin [area code]. I'm going to have to go and ring up, and make an appointment, and if I don't have a medical card, I'm going to have to pay, right, for the contraceptive after 72 hours, I'm going to have to pay. Sometimes people don't have the money so they'd rather go through the pregnancy because they haven't got the money to pay. Whereas if in Dublin, there was the clinic ... They do need outreach workers for women's issues alone. They need outreach workers for women's issues (Voluntary drugs worker, 28, Dublin).

We've just moved out from home where they're building a housing estate. And they're putting in no community facilities ... They don't have a community centre. The area where they're building where we were living, it's going to have a railway station when they have enough people to use it. So you have more cars on the road. But you have people leaving children to child-minders who may be in the housing estate, there won't be a central crèche or a crèche that leads on to a school. And I think that has to be addressed by the government (Rural tourism, 34, rural area).

## 9.5 Support for men

A number of respondents argued that men are more 'in tune' with women's needs in today's society. Men have become involved in issues, such as childcare, that would previously have been considered female domains. Women in this study felt, therefore, that policies should be developed that support men's increased involvement in relationships, sexual health issues and the responsibilities of parenting.

I think when a guy really is in a relationship with a female, its, wants to know what's happening now. And they definitely do. And I think they're way more, I think you'll be surprised at how in tune they are (Computer programmer, 30, Dublin).

I think if men could understand that, that its OK for them to be there taking care of children, like half and half, and share responsibility, down the middle, to work in the house (Restaurant worker, 29, small city).

But I'm sure they feel pressure that it's not a macho thing to do and, I'm the breadwinner and all that (Local authority worker, 26, small city).

It was also thought important to work with younger teenage men:

We also have to educate the boys that they have to help take care of the children. That they have responsibilities. Maybe during transition year there should be a project for them and they could go to mother and toddler groups. As well, girls as well (Family business, 30, rural area).

It was noted amongst those women who have observed it with their siblings and friends that men are changing their roles when children are born:

Looking at my friends who are my age who have become Daddies, planned or not planned, they have been really involved with the rearing of their children. And quite proud of it all, and like to talk about it, and like to be seen looking after it. Yeah, it's just consumed their life, it's amazing (Occupational therapist, 27, small city).

Men need to be targeted to join childcare courses, it can't be a thing where it's, you can't join, it's women only. I think, you get women to enter into areas that are male dominated, the same has to happen the other way round (Health board worker, 30, rural area).

My friend now, he's, the way it works is he's entitled to paternal leave. And his wife had the first baby. And he had certain days off like from the work, like a day every week, flexi-time like. And he had that, plus his paternal leave, and he kind of divides his holidays so he has every single Monday off (Financial services, 26, small city).

Yet it must also be observed that, under present legislation, men have no paid paternity leave in Ireland. Realistically, for more men to become involved with their very young families will require a commitment to change current policy in this area.

## 10.0 Women's reproductive decisions: what the literature says about these dilemmas

Kaufert and Lock (1998), amongst others, have observed that women have always had to make pragmatic decisions about fertility and reproduction, most frequently in settings where they had extremely limited control over their lives. But in this era, women in advanced post-industrial societies continue to negotiate around constraints in their decision making about having families. Perhaps the signal difference now is the capacity of women to link these personal decisions with political mobilisation in order to achieve change on the context of reproductive decisions.

In the data presented above, we can see how young Irish women are currently negotiating a range of dilemmas and possibilities for themselves. But the data also pinpoints huge gaps that need to be dealt with by decisive new policies. In this section, we will comment on the data in relation to perceived and reported policy and service gaps. We will draw on the international literature to do this.

Probably the single most important concept that came out of the second wave of feminism in the latter half of the twentieth century was that of agency. By agency, we mean the capacity of women to be able to:

- reflect on their circumstances and lives
- make decisions about those circumstances
- take actions to create change in their lives.

What feminism has done is to identify the critical tools of analysis whereby women could begin to exercise agency and thus to challenge and confront at personal, social and political levels those conditions that have deprived them of agency historically. We could also describe this as empowerment or enablement.

The broad themes identified in the data that continue to require attention and change in the Irish context can be viewed through the recent scholarship on this issue of women's agency and the following themes:

- contraception and sexual freedom
- reproductive rights vs. “choice” in accessing services
- what constitutes safe sex for women
- combating double standards about sexual practice that confront younger women
- the cost of motherhood

### 10.1 Contraception and sexual freedom

Nowhere is the necessity for women’s agency clearer than in relation to fertility, sex and motherhood. Cook (2004), amongst many other theorists, details the extent to which women’s bodies as sexual objects have historically jeopardised women. Physically women have borne the massive impact of unregulated fertility. At the same time they have been penalised for structurally-embedded levels of social and economic dependence and injustice. Cook argues that effective oral contraception (the contraceptive pill was released for public use in 1961), backed up by safe legal abortion, was a key development in finally enabling heterosexual women to take control of their own sexuality and sexual relations.

Interestingly from an Irish perspective, Cook emphasises the extent to which punitive constraints condemned women in Britain, into the decades of the mid-twentieth century, to have unsafe sex and become pregnant. The socially sanctioned cruelties of mother and baby institutions and the impact of life-threatening illegal abortion were gradually discarded from the 1960s onwards in Britain. This was not done without struggle. What needed to happen between the 1960s through the 1980s was to bring forward Marie Stopes’ pioneering work in the 1920s. She had tried to secure contraceptive protection for married women and to extend that to women outside marriage. Cook’s analysis reminds us of the ferocity of the arguments that raged against opening up contraception to all women, regardless of marital status. Women “had never possessed the right to say no — or yes — to sex” (Cook 2004:3). By the 1980s, the women who were coming of age could see this as a right.

Despite the disturbing grip of a post-Famine ideology in Ireland about sex and pregnancy, which proved so disabling and crippling for many thousands of women over the generations, it can be argued that we have taken huge steps to secure a similar level of agency in relation to sexual expression here. We have accomplished this in a relatively short timeframe, undoubtedly aided by our proximity to these cultural changes in Britain. Although this movement is as yet incomplete, we have reached what Berge and Ve (2000) describe as a “moment of equity”, where we can identify that measurable progress has been achieved for women.

Thus our respondents identified that they could:

- decide to become sexually active
- become familiar with contraception choices
- contracept effectively in many of their sexual encounters.

However there are many difficulties and drawbacks in what is a long process of personal and social negotiation:

- a residual and still-strong public discourse that young Irish women should not be practising sex outside marriage

- a very poor response to dealing with issues of sex, sexuality, and sex education.

These two aspects, exemplified and reflected through parents and schools, lead to women having to learn how to become sexually active largely without informed guidance and support.

This is a critical issue because it exposes women to the risks of unsafe sex, crisis pregnancy and transmission of STIs. There are additional personal and emotional adverse impacts such as younger women feeling unnecessarily insecure and even feeling panic over potential adverse outcomes of unsafe sex. There are also issues about women who do not want to feel pressured to have sex.

We urgently need to reframe public discourses and policy initiatives in a positive light. A substantive framework should be put in place that enables each young Irish woman to decide for herself whether and how she wishes to act in relation to her sexuality and that she does so in safety, physically and psychologically.

This puts the focus on sex education material that is mainly schools-based and that takes on the challenge of avoiding the “public health” model. Landry (2003) has observed that school-based sex education in the United States has been oriented towards the public health concerns of preventing teenage pregnancies and preventing the transmission of STIs. The effectiveness of this approach has been limited by a number of factors, including:

- poor teaching (poor coverage of topics, poor delivery by teachers)
- too little time devoted to the teaching
- teaching that takes place too late chronologically in the lives of adolescents (ibid.).

These are all issues that our respondents have observed during their experiences of the continuing poor, irrelevant approaches to sex education in Irish schools.

Blake and Jolly (2003) observe that one of the most harmful arguments that is frequently put forward by opponents of comprehensive sex education is that such teaching encourages young people to have sex earlier than they otherwise might do. This thesis has a number of adverse effects including:

- preventing young people from getting best-quality sex and relationship education
- undermining the confidence of teachers to deliver good education.

It also ignores the evidence-based data that good quality education, delivered on an age-appropriate basis, can give young people the confidence to delay having sex until they genuinely feel ready to engage. Blake and Jolly argue that young people themselves continually report that what they receive is too late, too narrow and too biological. The authors ask “When are we going to genuinely listen to young people and ensure that we offer them what they need?” (2003:18).

The same question can be asked here in Ireland. We need to deal with our sex education in the schools. But we also need to explore innovative ways to deliver positive messages on learning about sex and sexuality in the wider community.

## 10.2 Rights, “choice” and access to health services

Health policy activists campaigning for women’s reproductive health services in other economically advanced countries have been subject to institutional and political compromises. For example, Cook (2004) points out how the use of the term “family planning” was itself a compromise to protect clinics in the UK from the charge of abetting sexual licence. The title “family planning” implied that only women within marriage, intent on regulating family size, were the target client group of reproductive health clinics.

Solinger (2001) analyses how in the United States, reformers used the word “choice” to replace “rights” as a more acceptable term to describe access to reproductive health services, including access to legal abortion. In 1980s America, the notion of “rights” and a rights-based approach came to be seen as a threat to a conservative social order taking shape under Reaganism, and the switch to the concept of “choice” appeared to be a way of making access to reproductive health facilities less threatening.

However it has proved a Trojan horse for reformers. As the United States has evolved into an increasingly privatised and individualist consumer culture, “choice” has come to be equated with being responsible as a woman: women can make a “choice” not to get pregnant or to deal with a crisis pregnancy. This conflation hides the reality that “choices” are open to women who have reasonable levels of social and economic resources. Women with very few or no economic resources are not less responsible; they simply cannot make the “choice” of dealing with their sexual health needs, or responding to a crisis pregnancy, if they cannot afford to pay for health care services.

We have much to learn from these analyses of other contexts because there are echoes of the Irish context here. Our respondents indicated that:

- successful access to health care services did rely on personal confidence, ability to pay and, to an extent, on geographical location
- it could be more difficult at a younger age to access clinics and GPs for a variety of reasons, primarily lack of confidence about the right to be there, and cost
- clinics and clinic staff could be off-putting and were perceived to be judgemental at times
- the cost of contraception and reproductive health care was an issue for all women but a major constraint for very young women and women from disadvantaged backgrounds.

We need to be careful about our language and to emphasise rights rather than choice. Women too easily perceive themselves as having no choice, especially when they have very limited financial resources.

This is a special problem for very young women and for women from disadvantaged backgrounds. The suspension of family planning services for medical card holders at the IFPA clinic in Dublin’s north inner-city last year, due to lack of funding, flags up how critical an issue this is. We need to speak about women’s rights to reproductive health care in terms of cost. Women urgently need reproductive health care that at best is free and at worst requires a very moderate sum of money only.



### 10.3 What constitutes safe sex for women

E.J. Sobo (1995) in her study of low-income African-American women in the United States challenges how policy-makers frame the term “choice” in respect of what they deem as safe sexual practices. Her findings throw into doubt the assumption that individuals who do not practice “safe sex” are “in denial” about the risks involved. She shows how women who have certain expectations about their heterosexual relationships actually need to practice unsafe sex so that they can judge their relationships as being successful. What can be seen as denial in a public health model, is actually linked to “psychosocial well-being”, the attainment of which necessitates unsafe sex.

All but one of our respondents (one had decided not to have sex until she was married) reported having unsafe sex at some point, yet they were aware of and had successfully used contraception for many of their sexual interactions. The status of their relationship with a man, as well as a woman’s age, experience and class location seemed to be especially important in relation to consistent use of contraception. Being older, personally and socially secure and in a long-term relationship augured best for consistent usage. However, even then, exiting from such a relationship and subsequently engaging in very short-term sexual encounters increased the likelihood of a woman having unsafe sex.

These findings point to the conclusion that policies on women’s health and safe sex urgently need to be based not on the ideal scenarios of public health, but on the realities of women’s lives. If women are socially (and emotionally) dependent on men for their well-being, they are compromised in their capacity to care for themselves safely.

Most studies on the relationship between factual understanding of AIDS and other STIs and the practice of safer sex conclude that the two do not have a significant positive correlation (Sobo 1995). We see this with our respondents. Not only did they have unsafe sex, virtually all of them equated unsafe sex with pregnancy rather than with STIs. Only two respondents spoke of regularly insisting on condom use in their sexual encounters on the grounds of avoiding HIV and other STIs. For the most part, although they had varying amounts of knowledge about STIs, diseases were something that happened to “other” people.

Agency is once more the critical term of reference; Sobo’s work highlights how policies that support women’s agency must go beyond immediate public health policies on the containment of STIs and unwanted pregnancies. Policies need to counter what remains an overwhelming pressure for women to be sexually open to men, on men’s terms of reference. What is also required is an overarching framework initiative that endeavours to secure women’s socio-economic independence and self-determination.

### 10.4 Combating double standards about sexual practice that confront younger women

The still-existing discourse of double standards affects very young women, who are easily labelled as “sluts”. Tannenbaum’s work (Tannenbaum 2000) on this issue demonstrates how teenage women are victimised for not being virgins while teenage men engage in wide sexual activity.

Our respondents spoke of this labelling of “sluts” and “slags” as an ongoing problem that they needed to deal with; if they decided to carry condoms for their own sexual protection,

they faced the almost certain outcome of being condemned as sexually licentious by men. As some of our respondents got older they were better able to dismiss this harassment or deal with it, but they should not have to be exposed to it in the first instance.

Tannenbaum (2000) restates urgently the need for adequate sexual education that responsibly addresses the needs and sexual desires of younger women, while encouraging younger men to understand how sexual harassment of young women disguises double standards in sexual behaviour.

### **10.5 Women as mothers: supported or unsupported?**

There have been a number of recent critiques of the pressures that being a mother in contemporary society entails.

Melissa Benn (1997) has called for a "new politics of motherhood" because, she argues, women do not want to choose to become mothers as a sort of adjunct to their working lives. She writes:

I do not think our society/culture possesses a genuine understanding – or more to the point, a care – for what it means to raise a child, the quality of that experience, the quantity of effort involved (Benn 1997:18).

In the British context, Benn offers a lucid description of how the state has largely abandoned women on the issue of childrearing and the value of this work. For her, if we are to get serious about women's needs and the needs of their children, there must be a significant redistribution of wealth in favour of parents. This is most important for mothers and very especially poor mothers, who are increasingly single parents, living on marginal levels of income, many of whom have been forced out of the labour market because of the additional cost of childcare (1997:186-7).

In similar vein Buxton (1998), Walter (1998), Franks (1999), Freely (2000), Solinger (2001), Hewlett (2002), and Shrage (2003) question the lack of public policy response to women as mothers at the same time that the post-industrial economy has pushed women into the workplace with far fewer supports. Of the group in the United States corporate sector that Hewlett (2002:255) characterises as "high-achievers", 42% do not have children. Franks (1999) asks "Choice, what choice?":

The choice allegedly open to women between children or childlessness, work or home, full-time or part-time employment is often just an illusion of real choice (1999:174).

She and other writers critically analyse the incorporation of the majority of women into the workforce over the last two decades as a pressing economic necessity, not a "choice". Lacking adequate public policies on pressing needs like childcare, many women must move through a working day with great difficulty. From uncertain situations of short-term, low-paid childminders, to low-paid workplace settings, to family chores, they hope to bridge all the gaps. Women may be doing this without a partner, increasing the strain on them.

Solinger concludes that what gets identified and approved of as "responsible motherhood" becomes a class privilege in an unequal society. Shrage (2003) has taken a similar approach, arguing that advocates of reproductive rights must examine how the

conditions of women's lives lead to or constrain what has been so unfortunately termed "choice". This challenging scenario is why Franks cautions us to remember that one-fifth of all women of child-bearing age in Europe are now choosing not to give birth at all (Franks 1999). The stress, expense and the lost opportunity costs appear not to be worth it for these women.

Some of our respondents express either serious doubts about taking on this compromised role of motherhood, or have already determined not to have children because the personal costs are too high.

Several respondents who had gone through a crisis pregnancy reported the strains on them in dealing with their and their child's needs, while working to pay basic upkeep and childcare. Other respondents observed friends and family members dealing with new motherhood. They could see for themselves the unsupported conditions of new motherhood and the personal loneliness that accompanies it. It was also implicit in respondents' concerns that being a full-time "stay-at-home" mother is too isolating.

This isolation of the work of mothering is central to works by Cusk (2003) and Figs (2002). The latter has written that older generations of women have dissembled with younger generations about the burden of motherhood. This idea is also implicit in the work of Kendall-Tackett (2001). She quotes the American Psychological Association which states that the phenomenon of depression is so common in mothers of new babies that they consider new motherhood a risk factor for depression. Of course the context is once more central to understanding this "risk factor": personal isolation is not a sensible condition in which to undertake mothering. This is especially so for single parenthood.

Being able to "choose" motherhood, to plan it, is immensely important in respect of women's agency. But there is a hidden burden here. One of our respondents referred to "choice" as a burden: how do you know you are making the right choices?

Nancy Folbre (1994), the feminist economist, argues that the state has to be at the centre of the solution. Only the state can respond adequately to the steep increase in the real costs of having children and the extreme tensions these escalating costs have produced for parents, whether in the context of marriage or never-married mothers. Folbre, whose book is aptly titled *Who Pays for the Kids?* makes exactly that point – the costs do not vanish, whether individuals struggle to pay them or whether the state intervenes. But if the state does not intervene and women falter in the face of overwhelming burdens, then society as a whole pays dearly in the future for this lack of investment at the critical points in a young child's development.

Women economists compiled a special issue of the journal *Feminist Economics*, on children and family policy in 2001. Nancy Folbre and Susan Himmelweit (2000:1-3), in their editorial, express this deep concern that as women move into what has traditionally been a male labour market, the "importance" and the "vulnerability of the traditionally female sphere of family care" becomes ever more apparent. In strict economic terms, the problem is that market work is remunerated in terms that have some relationship to productivity; non-market work is not. The opportunity cost of time devoted to family care is going up, intensifying a long-standing distributional struggle over who should pay the costs of rearing and maintaining the next generation of workers and citizens (ibid.).

Franks (1999) and Folbre (1994) argue that there are three central issues up for debate here:

- the lost opportunity costs for women if they do not have paid employment vs. the dual burden if they engage in paid work and have children
- the problem of reconciling what are deemed non-market principles of family life in a market which often sees costs and competition in far too narrow a focus
- the problem of whether parenting is meant to be a central part of our lives as women.

This is an urgent debate that needs to come much more to the fore in Ireland.

A survey carried out by the Economic and Social Research Institute for the National Centre for Partnership and Performance in 2003 on attitudes and experiences in the workplace, found that:

- 51% work under great pressure
- 38% never have sufficient time to get all their work-related tasks completed
- 47% often work extra time in order to finish their work
- 31% come home exhausted
- 18% are too tired to enjoy things outside work
- work stress peaks for those in the age groups, 25-39 years
- parents with pre-school children have the highest reported stress levels.

(National Centre for Partnership and Performance, Press release, 24 October, 2003).

The complete gender breakdown of these figures is not yet available but these outline findings capture the very real pressures in the peak years for family formation.

In the meanwhile, the Maternity Protection (Amendment) Bill 2003 seeks to make the following provisions:

- adjusting the requirement for women to take four weeks of their maternity leave before a baby is due to two weeks
- entitlement for women to attend one to two sessions of antenatal childbirth classes without loss of pay
- entitlement for partners to attend one session of antenatal childbirth classes without loss of pay
- entitlement of adjustment to working hours without prejudice to their job status for women breastfeeding until the baby is six months old.

Cutting down the requirement to begin leave only two weeks before the baby's birth is actually only trying to match the reality of women's "choices" at present, where they lie about their due date in order to maximise their statutory eighteen weeks leave time with the baby after birth. This pressure to continue working as long as possible, above all else, is related to housing costs and the need to work as long as possible because of mortgage repayments. What is needed is to improve the conditions, not to legitimate a bad situation, especially given the findings on workplace stress, detailed above, and the fact that problems over entitlements to maternity leave as it now stands continue to form a large portion (over 50%) of the enquiries to the Employment Equality Authority. What women (and their partners, if they are in a relationship) require is a more generous package of maternity leave, that does permit heavily pregnant women to have adequate time and

rest before they give birth, without worrying that this will compromise their time with the baby once it is born. By contrast with Ireland, the latest regulations in the UK give entitlements of:

- six months' paid maternity leave
- two weeks' paid paternity leave
- leeway to employers as to when they claim back these statutory payments to help ease the burden on SME employers.

These reflect official concerns about the very low fertility rate in the UK and the need to "repackage" motherhood to make it more attractive to women.

This is an area of public policy in Ireland that needs sustained, serious and scrupulous attention to available options if we are to address the concerns of our respondents about taking on motherhood.

## 11 Conclusions and recommendations

The data presented in this research indicates that the multiple meanings of their bodies' potential for childbearing present as complex a picture as ever for women in Irish society. Gail Kligman (1998) and Faye Ginsburg and Rayna Rapp (1995) have been clear that the phrase "reproduction" is a "slippery" concept having multiple meanings around birth itself, sustaining the family household, and how the labour force gets constituted. This 'slipperiness' is part of the problematic framework that women attempt to negotiate.

What we know of this process of negotiation in Ireland now, as it emerges from its Celtic Tiger phase, is that wider availability of contraception alone does not "solve" the problem or the complexity of handling fertility. If anything, it extends the issues with which women must learn to deal.

The women we interviewed were extraordinarily generous with their time, experiences and perspectives. They were working hard to be optimistic despite these new challenges they face. Our demographic profile in respect of childbearing has changed so radically in such a short period of time that they are pioneers in a country new to all of us. They have come from larger families and yet are heading into, or are now part of, an era where they and their siblings may be deciding not to have children, or to have only one or two. They are negotiating uncharted waters, with no guide and with very little public and institutional support.

A recent report in the Irish Times highlighted the feedback from the family forums organised by the Minister for Social and Family Affairs in 2003 (Brennock 2004). That feedback criticised government approaches which appear to prioritise economic needs over those of the family in traditional and non-traditional forms.

One of the 700 participants was reported as commenting:

Family support is not reducible to questions about childcare or getting women back to work. It's about giving adults and children the choice and the chance to have the best life they can (Brennock 2004).

As a society, we now face the complex task of supporting women, no matter what they decide, while at the same time working to provide a far more equitable distribution of life chances, so that the scope for decision making is evened out across the strata for all women. We need to take on the challenge of becoming neither pro-natalist nor anti-natalist, but pro-women and pro-diversity of all the ways women decide to live.

The following recommendations are based on our findings from the 66 women who participated in this research:

- Re-branding family planning clinics to meet the needs of a broader range of women and girls
- Training protocols for GPs, chemists, and family-planning clinic staff to reduce client perceptions of stigma experienced through interactions upon requests for contraceptives
- Developing protocols for incorporating partners in consultations, where women request this, while being careful to protect women's decision making
- Renewed public health campaigns and information on
  - STIs
  - contraception
- Provision of condoms in packets stamped "Free" in clubs to help increase condom usage
- Mobilising text messaging and similar technologies to extend the information base available to young women and young men
- Development of strategies for making contraceptives available for sexually active women under the age of consent
- Examining the current cost and provision structures of contraception and emergency contraception to bring down the individual cost for women
- Greatly improved maternity services and support services in the community to meet the support needs of new mothers and their babies
- The issue of support services for women seeking terminations should be revisited, along with examining how counselling and support for women who leave the state for terminations can be made more accessible
- In public-education campaigns and literature, emphasise the role of decision making for women and decrease the emphasis on "choice", as many women do not experience their decisions as "choices"
- More government-sponsored services of grass-roots-level support groups for women on sexual health
- Comprehensive wide-ranging programme of sex education, which would be part of core developmental skills and be delivered in an ongoing way from primary school through secondary school
- A more wide-ranging and supportive system of maternity leave to deal with SMEs and the growing reality of women's self-employment and contract work
- Action to create affordable childcare
- Action on extending flexi-time and other family-friendly policies
- Promotion of messages that encourage greater respect for the broad range of women's decisions around motherhood in line with the vast diversity of

women's experiences

- Promotion of messages that combat double standards about young women's sexuality and the meaning of women who are prepared with contraception to use if they require it
- Community-based clinics delivering free reproductive health care and contraception are vital initiatives in disadvantaged areas
- Policies to support men in respect of their information needs on reproductive and sexual health needs.

## References

- Benn, M. (1998) *Madonna and Child: Toward a New Politics of Motherhood*. London: Jonathan Cape.
- Berge, B-M and Ve, H. (2000) *Action Research for Gender Equity*. Buckingham: Open University Press.
- Blake, S. and Jolly, J. (2003) *Evidence and Entitlement: Teaching about Sex and Relationships in Schools*. In Institute of Ideas, *Teenage Sex: What Should Schools Teach Children?* Hodder and Stoughton: London.
- Brennock, M. (2003)
- One in four 15 to 17 year-olds have had sex – poll. In the Irish Times, 19 September, 2003.
- (2004) Government policy on family criticised at public meetings. In the Irish Times, 2 February, 2004.
- Buxton, J. (1998) *Ending the Mother War: Starting the Workplace Revolution*. London: Macmillan.
- Central Statistics Office
- (2003a) *Vital Statistics, Fourth Quarter and Yearly Summary 2002*. Dublin: Government Publications Office.
- (2003b) *The Statistical Yearbook of Ireland 2003*. Dublin: CSO.
- (2003c) Size of labour force jumps by 11% in five years. CSO press release, 11 August, 2003.
- Cook, H. (2004) *The Long Sexual Revolution: English Women, Sex, and Contraception 1800-1975*. Oxford: Oxford University Press.
- Cusk, R. (2003) *A life's work: on becoming a mother*. London: Fourth Estate.
- Devers, K. and Frankel, R. (2000) Study Design in Qualitative Research –2: Sampling and Data Collection Strategies. In *Education for Health*, Vol. 13, no. 2, 2000, pp. 263-271.
- Douglass, C. (in press) Introduction. In C. Douglass (ed.) *Barren States: The Population Implosion in Europe*. Oxford: Berg.
- Eurostat (2003) *Statistics in Focus: Population and Social Conditions, Theme 3-20/2003*, <http://europa.eu.int/comm/eurostat/Public/datashop/print-product/>, 7 May.
- Figes, K. (2000) *Life after Birth: What Even Your Friends Won't Tell You about Motherhood*. London: Penguin.
- FitzGerald, G. (2003) Traditional family forced to undergo many changes. In the Irish Times, 6 September, 2003.
- Folbre, N. (1994) *Who Pays for the Kids? Gender and the structures of constraint*. New York: Routledge.



- Folbre, N. and Himmelweit, S. (2000) Children and Family Policy: a Feminist Issue. In *Feminist Economics*, Vol. 6, no. 1, March, 2000, pp. 1-4.
- Franks, S. (1999) *Having None of It: Women, Men and the Future of Work*. London: Granta.
- Freely, M. (2000) *The Parent Trap: Children, Families and the New Morality*. London: Virago.
- Ginsburg, F. and Rapp, R. (1995) *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press.
- Hammersley, M. and Atkinson, P. (1983) *Ethnography: Principles in Practice*. London: Routledge and Kegan Paul.
- Hewlett, S-A. (2002) *Baby Hunger: The New Battle for Motherhood*. Grove Atlantic: New York.
- Holden, L. (2003) Are 'geriatric' mothers presenting a medical challenge? In the *Irish Times*, 20 January, 2004.
- Hyde, A. (1996) *Unmarried Women's Experiences of Pregnancy and the Early Weeks of Motherhood in an Irish context: a Qualitative Analysis*. Unpublished PhD. Thesis, Trinity College Dublin.
- Inglis, T. (2003) *Truth, Power and Lies: Irish Society and the Case of the Kerry Babies*. Dublin: UCD Press.
- Health Promotion Unit, Department of Health and Children/Centre for Health Promotion Studies, National University of Ireland, Galway (2002) *National Health and Lifestyles Surveys*.
- Kaufert, P. and Lock, M. (1998) Introduction. In P. Kaufert and M. Lock (eds.) *Pragmatic Women and Body Politics*. New York: Cambridge University Press.
- Kendall-Tackett, K. (2001) *The Hidden Feelings of Motherhood: Coping with Stress, Depression, and Burnout*. New York: New Harbinger Publications.
- Kligman, G. (1995) *The Politics of Duplicity: Controlling Reproduction in Ceausescu's Romania*. Berkeley: University of California Press.
- Landry, S. (2003) *Sex Education: A View from The United States*. In *Institute of Ideas, Teenage Sex: What Should Schools Teach Children?* Hodder and Stoughton: London.
- Lehane, M. (2003) Women 'leaving jobs to save on childcare costs'. In *Irish Examiner*, 7 July, 2003.
- Mahon, E., Conlon, C. and Dillon, L. (1998) *Women and Crisis Pregnancy*. Dublin: Stationery Office.
- Murphy-Lawless, J. and McCarthy, J. (1999) Social Policy and Fertility Change in Ireland: the Push to Legislate in Favour of Women's Personal Agency (1999) *European Journal of Women's Studies* Vol. 6, No.1, pp. 69-96.

- National Centre for Partnership and Performance, Press release, 24 October, 2003.
- O'Connor, P. (1998) *Emerging Voices: Women in Contemporary Irish Society*. Dublin: IPA.
- Phelan, S. (2003) *Baby Left in Bag*. In *Irish Daily Star*, 14 October, 2003.
- Reid, L. (2003) *IFPA says numbers down for UK abortion*. In *the Irish Times*, 31 October, 2003.
- Ruane, M. (2003) *The word Ahern is the best contraceptive*. In *Evening Herald*, 4 December, 2003.
- Shrage, L. (2003) *Abortion and Social Responsibility: Depolarizing the Debate*. Oxford: Oxford University Press.
- Shorter, E. (1982) *A History of Women's Bodies*. London: Allen Lane.
- Sobo, E.J. (1995) *Choosing Unsafe Sex: AIDS-Risk Denial Among Disadvantaged Women*. Philadelphia: University of Pennsylvania Press.
- Solinger, R. (2001) *Beggars and Choosers: How the Politics of Choice Shapes Adoption, Abortion, and Welfare*. New York: Hill and Wang.
- Tannenbaum, L. (2000) *Slut! Growing Up Female with a Bad Reputation*. New York: Perennial Books.
- Walter, N. (1998) *The New Feminism*. London: Little, Brown and Company.







Crisis Pregnancy Agency  
4th Floor  
89 - 94 Capel Street  
Dublin 1

tel: 353 1 814 6292  
fax: 353 1 814 6282  
email: [info@crisispregnancy.ie](mailto:info@crisispregnancy.ie)  
web: [www.crisispregnancy.ie](http://www.crisispregnancy.ie)

ISBN: 0-9548669-2-4