Negotiating the reproduction imperative in late modernity:
How do young women make decisions about if and when to have children?

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BA (Hons)

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Statement of originality

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Abstract

At the beginning of the twenty-first century, the reproduction imperative has taken centre stage in Australia in response to declining and delayed childbearing and the resulting below replacement fertility levels. The personal and political costs associated with these demographic trends, including unintended childlessness and the economic repercussions of a ‘greying’ population, have situated the discussion within a social framework that questions the degree of agency involved in reproductive decision-making.

This thesis examines the extent to which young women (aged 18-32) are experiencing reproductive choice in Australia in late modernity. An interpretivist and broadly feminist approach investigates if and when women would like to have children and whether these desires are being achieved. The mixed method three-component research design was qualitatively driven and comprised: seven hundred and eighty existing qualitative written comments from the 1973-78 cohort of the Australian Longitudinal Study on Women’s Health (ALSWH); seven focus group discussions with a community sample; and fifty semi-structured telephone interviews with a sub-sample of the ALSWH. Quantitative survey data provided a detailed demographic profile for each sample.

The findings draw predominantly on the experiences of educated, urban, partnered, childless women who were around the age of 30 years old, and emphasise the complexity of reproductive decision-making for this group. Issues of identity and timing frequently compromised the women’s desired childbearing plan. Motherhood was felt to be undervalued, at odds with a society that privileges individual success, and in conflict with aspirations for, and the practical accomplishment of, paid work and other life goals. These perceptions created significant uncertainty toward the role and a strong belief in the need to achieve certain criteria prior to having children. The women described attempting to align their ideal childbearing circumstances with their views about ideal childbearing age in a delicate balance between attaining “security”, “stability” and “readiness” on the one hand, and fears of age-related infertility and the need for youthful energy to mother on the other. The research highlights the normative use of reproductive technology in an effort to achieve this balancing act and manage biological “chance”, such as unplanned pregnancy and infertility.
The trend toward delayed childbearing that resulted for many of these women is, therefore, usually a side-effect of their reproductive decision-making as opposed to a desired goal, with the technologies of contraception and assisted reproductive technology found to support as opposed to direct childbearing plans. In a culture of individualism and risk the women described an ambivalent relationship with the multitude of choices facing them. Many feared that motherhood could be continually delayed in an attempt to find the “right time”.
Chapter 1: Introduction

It baffles me why [having children] is such a hard decision and it didn’t seem to be previously for other generations… I’m not quite sure what those reasons are but it’s something that my friends and I talk about regularly: “Should we?” “Shouldn’t we?” And “when is the right time?” Tara, age 32, wants kids in 5+yrs

The difficulties contemporary women have getting to motherhood are not personal but political, and it’s going to take political action to ameliorate the devastating impact they are having on women's freedom to have the number of children they want, or any children at all (Cannold 2005: 20).

1.1 The research question and context

“Where have all the babies gone?” (Totaro 2005). This plaintive cry exemplifies the tone of the Australian fertility debate at the beginning of the twenty-first century. The debate has focussed on the decline and delay of childbearing (ABS 2010), a demographic issue that has commonly been located within a social framework, with discussion of “the baby gamble” (Briscoe 2004) and “the baby bust” (Summers 2003a) placing the question in the hands of women of childbearing age. The research for this thesis explores the reproduction imperative through an examination of how young women in Australia in the first decade of the twenty-first century make decisions about if and when to have children. These questions are investigated from the perspective of the tension between agency and structure that is present across the fertility debate, from the personal concern of “missing that baby moment” (Das 2004) to the political focus of “a nation of empty playgrounds” (Marriner 2005).

The public, political, face of the fertility debate is an economic perspective that stems from the potential implications for Australia of a ‘greying’ population; the age-ratio shift caused by the fertility decline. In 2002, the then liberal (conservative) Federal Government outlined these concerns in their budget paper the Intergenerational Report (Costello 2002a). This highlighted the economic repercussions of an ageing society, including higher taxes for new generations as they support the growing proportion of people aged over 65 years. Reduced spending on children was not expected to compensate for the increased costs for health and aged care, as historically, the former
are mostly supported by private money, while the latter are largely supported by government funds (Costello 2002a: 29).

Finding a way to reverse the trend toward smaller families and increased childlessness among Australian women (ABS 2010) would potentially assist Australia’s national and international economic position, and survival, by providing more tax payers to reduce financial pressure. This perspective resulted in what has been described as a “pro-natalist” approach by the last Federal liberal (conservative) Government (Heard 2006), with the introduction of a lump sum maternity payment in 2004, changes to child related tax benefits, and a message from the then Treasurer, Peter Costello, to have three children, including “one for the country” (Summers 2004). The personal as political as it can be: the political as personal as it can be.

Support for increased fertility continued under the Australian Labour Party (ALP) when it came to power in 2007. Prime Minister Kevin Rudd promoted his goal of a “big Australia” (ABC News 2009) and appointed a minister for population. The ALP approach, however, looked to immigration as well as births to supplement the population. One of the first messages of the new Prime Minister, Julia Gillard, was to emphasise her support for a “sustainable” population as opposed to a “big Australia”, going so far as to add the term to the population minister’s portfolio (Gordon 2010). Her stance is reflected in the 2010 ALP Federal Government Intergenerational report, Australia to 2050 (Swan 2010), which continued to focus on the economic implications of an ageing population, while also discussing the climate and sustainability implications of a growing population. This dual approach was used to justify the ALP policies for health care reform and increased investment in infrastructure and education. The “pro-natalist” maternity payment has continued under the ALP. In 2011, this payment will remain for those women who have children while out of the paid workforce, with a government-funded paid maternity leave scheme available to those women having children while in paid work. This split shifts the focus away from a fertility-for-all approach, to policies that identify specific groups within the population: “stay-at-home” mothers and (paid) “working” mothers. Each policy, however, rewards childbearing.

The basis of the political perspective is one of national survival. This echoes a similar debate that arose at the turn of the twentieth century when declining fertility rates resulted in a Royal Commission (Mackinnon 1998). Then, as now, the official government perspective viewed women as making active choices about their fertility
which resulted in demographic change. Crucially, however, this assumption has been criticised for not including the voices of women (Mackinnon 1998; Bryson 2001). This perspective gives rise to the major question underpinning this thesis: what are the factors which influence women’s decision-making for or against motherhood?

The complexity of fertility decision-making as experienced by individual women in Australia centres on the indecision they describe in regard to having children and a society that is often seen to be unsupportive of motherhood (Cannold 2005; Macken 2005; Summers 2003b), as illustrated by the quotes at the start of this chapter. Media, social commentary and academic research frequently suggest that the demographic trends of decline and delay in childbearing are commonly grounded in circumstance, including the political climate, as opposed to being a clear representation of choice (Cannold 2005; Haussegger 2005; Summers 2003a). Despite, or possibly because of, the increased emancipation of women in Australia and a culture of choice in late modernity (Giddens 1991), the “problem” of motherhood, emphasised by second wave feminism (Everingham 1994; 1998), remains unsolved (Bryson 2001; Summers 2003b). The extent to which young women are experiencing reproductive choice in Australia, therefore, should be investigated.

A background in social and medical anthropology and feminism, combined with an academic and personal fascination with childbirth, have brought me on a roundabout route to the question of reproductive decision-making. Anecdotal and academic literature on childbirth frequently highlights the relationship between social circumstances, demography, choice, knowledge, reproductive technology, and birth experiences (Davis-Floyd and Sargent 1997; Davis-Floyd and Dumit 1998; Wajcman 1991; Wolf 2001). Therefore, when I arrived in Australia from Scotland in 2002 to a climate of national concern over falling fertility rates and questions over who was and was not having children and how to encourage women to have children, my focus of enquiry followed the decision-making process back from birth itself to the choices that women face in their lives pre-conception. In the course of the research I did in fact undergo this process myself and now have a three year old son and a young baby. This gives me particular insight into the experiences of women of my generation who are struggling with this decision.
1.2 Research method
The research endeavours to connect a demographic problem, a below replacement level fertility rate, with its social context by grounding it in the lives and circumstances of individual women. It follows a mixed method three-component design, incorporating both qualitative and quantitative methods with priority given to the qualitative approach. A decision was made to focus the enquiry by studying the reproductive decision-making of women only.

The research is nested within the *Australian Longitudinal Study on Women’s Health* (ALSWH), a longitudinal survey designed to track the changes in health and well-being of the same 40,000 Australian women over a twenty-year time period. The ALSWH has a multi-disciplinary focus and gathers both quantitative and qualitative data via postal survey. Quantitative self-report data, often in response to multiple choice questions, are collected on a number of socio-demographic, health and lifestyle areas. An open question at the end of each survey invites participants to add any comments they wish; thus constituting the qualitative data (Brown et al. 1998). The ALSWH provided both sampling opportunities and access to existing quantitative and qualitative data from a large nationally representative group of women living in Australia. The three age cohorts in the ALSWH, who were born in 1973-78, 1946-51 and 1921-26, were recruited via the Medicare (national health insurance system) database and are surveyed every three years on a rolling basis [see Appendix 1.1: ALSWH survey schedule]. The research for this thesis focussed on the 1973-78 cohort. The method for the thesis thus canvassed the perspective of women of childbearing age as to their intentions about whether and when to have children, exploring the factors that were important to their decision-making processes.

1.3 Thesis outline
Following this introductory chapter, chapters two and three discuss the literature associated with the fertility debate. Chapter two focuses on the demographic changes, and the varying perspectives that have arisen in response to the potential implications of these shifts. Research on women’s aspirations and expectations for children is examined here, with particular attention paid to variations during the life course, and between generations, and geographic and demographic boundaries. The impacts of unplanned biological events and technological interventions are also outlined. Chapter
three considers the different explanations given for the transitions in the fertility rate, and discusses the social context in which they have occurred. The political and social changes emphasised in the literature as having the potential to alter the fertility rate are discussed. Chapters two and three highlight a call for further exploration of women’s reproductive decision-making. The thesis addresses a gap identified in the literature in regard to the age women aspire to be when they become mothers and perceptions of technologies that can assist with conception, key areas of investigation in Australia’s climate of delayed childbearing.

Methodological considerations for the research are described in Chapter four. This includes a detailed outline of the mixed method research design and the processes of data collection and analysis that were undertaken for each of the three research components. Reflections on the methodological approach for the research take into account theoretical perspective, and priority of method, implementation and integration.

The empirical findings from the research are presented in the following five chapters. Chapter five explores women’s preconceptions of motherhood. Their perspective on the fertility rate and the ideology of the mother-role are examined, with particular emphasis on the question of identity.

Chapter six investigates whether women want to have children. The childbearing and paid work aspirations of the women in the study are presented, along with a detailed examination of the level of conviction they applied to these intentions.

Chapter seven outlines when the women in the study would like to have children, including a description of their ideal circumstances and ideal age for motherhood. The contradictions found within their narratives are considered in relation to how women negotiate a “right time” to have children.

Chapter eight illustrates how the timing of childbearing is managed, focusing on the myriad of reproductive technologies in contemporary society. The ability and expectation women have to control their fertility, usually through the use of contraception, is examined. This is followed by a discussion of the potential for unexpected reproductive events, such as unplanned pregnancy and infertility, and the technological tools that the women in the study have used or would consider using in these circumstances.
**Chapter nine** questions how women move from planning to having children to making the active decision to start trying to conceive. This decision is examined in relation to perceptions of choice and the social and political landscape in which these choices are made. The influence of government policy on women’s reproductive behaviour is examined, along with a discussion of what the participants themselves felt should or could be done to enable women to have children if and when they want them.

**Chapter ten** concludes the thesis, providing a summary of the research findings and a discussion of their implications and future directions research in this area could take.
Chapter 2: The Australian fertility rate: demography and decision-making

2.1 Introduction

In common with other advanced industrialised countries, Australia has experienced a fall in its fertility rate over the past forty years. This has resulted in a national focus on childbearing intentions, expectations and outcomes. Statistics on the trends and repercussions associated with this decline, and the more recent plateau or stabilisation of fertility rates, form the background to the research for this thesis and are discussed first. These quantitative data present what could be termed reproductive events; how many children are being born, when and to whom. Decreasing family size and older first-time motherhood, two developments that contribute significantly to the declining fertility rate, are explored here.

The consequences of the fertility changes are outlined from both an Australian and a global perspective, detailing the range of stakeholders involved and the potential implications they foresee. The different perspectives within the fertility debate each have a specific focus of concern, including the ageing population; delayed motherhood; a ‘child-free’ society; overpopulation; and reproductive autonomy. In order to understand the demographic changes, each approach explores whether women are having the number of children they would like and whether, therefore, their reproductive lives are primarily a consequence of their own choice or agency or whether they are constrained by circumstances.

The second half of the chapter is devoted to research on women’s reproductive decision-making. This research attempts to establish reproductive aspirations from varying depths of enquiry, with the aim of identifying explanations for reproductive actions. Qualitative and quantitative data are discussed, examining intended and expected family size and timing of childbearing, both cross-sectionally and over the life course. Particular attention is paid to the potential impact of both demographic variables and reproductive chance on childbearing plans and outcomes.
2.2 Perspectives on declining fertility

2.2.1 The demographic context: fertility rate changes

It is important to begin this discussion of the literature by outlining the major catalyst for the fertility debate: the demographic evidence that the Australian total fertility rate (TFR) has been on a downward trajectory since the 1960s and has been below the current “replacement” level of 2.1 births per woman since 1976 (ABS 2010: 10), see Appendix 2.1. In 2004, when research for this thesis began, the TFR stood at 1.77 births per woman (ABS 2005a), slightly higher than the all time low of 1.73 which was recorded in 2001. More recently a rise placed the TFR at 1.97 births per woman in 2008. While remaining below replacement level this was the highest recorded rate since 1977 (ABS 2009a: 8 & 10). Current statistics show a slight decline in the TFR in 2009 to 1.90 births per woman (ABS 2010: 9).

For the purpose of this thesis, it is more helpful and relevant to discuss Australia’s total fertility rate (TFR) as opposed to the annual birth rate.

*The total fertility rate (TFR) represents the average number of babies that a woman could expect to bear during her reproductive lifetime, assuming current age-specific fertility rates apply (ABS 2009a: 10).*

As a statistical tool the TFR enables clear comparisons both over time and in relation to the national population replacement level of 2.1 births per woman, a figure that, if reached, would stem population ageing. The annual birth rate, on the other hand, needs to be considered within the context of an ever changing population size, requiring a more complex analysis than TFR. Consequently, the discussion in this thesis focuses on fertility rates not birth rates. The TFR level of “replacement” is not constant and has declined over time, influenced by declines in the female mortality rate. However, even if the mortality rate reached zero, in order to “replace” both mother and father, the TFR could not fall below 2.05 (ABS 2009a: 10).
Changes to the structure of childbearing, namely trends towards having smaller families and delaying first-time motherhood, along with an increase in the number of women who remain childless (Kippen 2004), have been identified as the demographic factors behind the TFR fall in Australia (Costello 2002a). The literature has found that smaller family size and childlessness can impact the TFR independently or as a consequence of delaying having children, and that the timing of childbearing can affect the number of children a woman has (Kippen 2004; 2006), see Figure 2.1.

Women aged 40-44 years are seen to be a good indicator of “completed” family size as they are considered to be at or near the end of their fertility. Over time this age group has shown an increase in those with no children or only one or two children, while the number who have given birth to three or four children has decreased (ABS 2007: 44). Between 1981 and 2006, the two-child family was consistently the most common “completed” family size for women aged 40-44 (ABS 2007: 44), with no cohort’s average “completed fertility” ever falling below this number (Kippen 2004: 34).
This trend is set to continue with a “completed fertility” projection of two children on average for those women currently of childbearing age (ABS 2009a: 11). The recent rise in the TFR has, however, been linked to an increase in the number of women of current childbearing age who are having a second, third, fourth or higher order child, with those having four or more children increasing for the first time in twenty years (ABS 2007: 16). The two child family remains the projected average family size as a result of the number of women who are now having larger families being countered by the increase among those having only one or no children. Discussion of “completed” family size is problematic as it cannot be truly known until a woman is past her reproductive years. Known “completed fertility” is limited to the family size of previous generations, who were having children at a different historical, social and cultural time to those women of childbearing age today, for whom “completed fertility” must be estimated (ABS 2009a: 10).

Women who have no children have been the subject of particular attention in the literature. The number of women who were childless at the age of 40-44 increased from 9% in 1981 to 16% in 2006 (ABS 2007: 45). This upward trend in childlessness supports McDonald’s (1998) projection of 22% childlessness among women born around 1970, and Kippen’s (2004) argument that the TFR was impacted more by those women who were not having children, or having only one child, than by a decline in larger families. However, Kippen (2006) has since revised her conclusions in light of more recent analyses which found that the move towards smaller families was more influential of fertility rates than the rise in childlessness. Indeed she states that childlessness among women is probably not going to be as high as originally thought, estimating that around 16% of women born in 1971 would remain childless. This figure corresponds to actual childlessness among women born between 1962 and 1966, suggesting that the number of women having no children could stabilise. The literature highlights the close relationship between changes to family size, the prevalence of childlessness and the TFR.

There are marked differences in the TFR between “more developed” and “less developed” countries. The former, of which Australia is one, generally have lower fertility rates, collectively projected to be 1.6 births per woman for the years 2005-2010 (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2009; see also ABS 2010: 24; Bryson 2001; PRB 2009). The question of declining fertility is not unique to Australia, which has a projected rate of 1.8 births for the same time period, and is in fact more pressing for some other “developed”
countries, particularly in Europe and Asia. Greece is projected to have a TFR of 1.4 and Hong Kong of 1.0 for 2005-2010. In contrast, “less developed” countries often have higher fertility rates. This results in above replacement level fertility, with “less developed” countries predicted to have a collective TFR of 2.9 for 2005-2010 (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2009). In comparison to other “developed” countries, therefore, Australia is in a relatively strong demographic position, although its TFR remains below replacement level.

One established explanation for these trends is demographic transition theory, the premise of which is an inverse relationship between fertility rates and infant mortality rates, whereby the more likely children are to survive to adulthood, the fewer children people have (Cleland 2001; Bulatao 2001). These trends, along with rising life expectancy and an increased ability to regulate fertility combine to create an ageing population and a declining fertility rate (Casterline 2001; see also Mason 1997; Newson et al. 2005; 1998). This is illustrated by the above comparison between more and less “developed” countries, with the former tending to have lower infant mortality, higher life expectancy and a correspondingly low fertility rate, and the latter experiencing the opposite. The underlying suggestion is that as a society modernises people choose to have fewer children because they do not need to have more.

Mackinnon (1998) has criticised demographic transition theory as an over simplification of the situation, one that focuses on populations alone and not people, and ignores social change. She argues that it is necessary to go behind the statistics to explore the reasons why women are not having children, rather than using scientific language to dislocate women from their fertility (Mackinnon 1998: 158). The uneven pattern of fertility decline in Australia over the past century, illustrated in Appendix 2.1, and the variation between different countries of similar “development” (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2009), certainly suggests that other or additional factors have negatively influenced reproductive decision-making in Australia, along with rates of infant mortality and life expectancy.

Whether the fertility rate has stabilised or has in fact begun to rise, the continuing trends of a below replacement level TFR, delayed childbearing, and smaller family sizes all contribute to an ageing population and have pushed fertility onto the agenda of government, and into academic and societal debate in Australia (Bryson 2001; Cannold
Demographers refer to these trends as the second demographic transition (Bean 2005). As a result of this concern, Australia has joined an international forum on reproductive decision-making (Berrington 2004; Caldwell 2001; Hakim 2003; Hewlett 2002; Macura et al. 2005; Quesnel-Vallée and Morgan 2003).

2.2.2 The social, economic, and medical context: fertility rate changes

The basic approach of this research thesis is sociological, with the goal of examining the question of fertility rates through women’s lived experiences, focusing on the impact of their socio-cultural circumstances on their reproductive decision-making. As the literature demonstrates, however, the topic of fertility can be situated across a broad multidisciplinary landscape that draws on demography, history, politics, economics, medicine and feminist theory, accompanied by media and social commentary. Indeed it is often considered beneficial to take a combined approach to investigating declining fertility rates in order to understand the phenomenon as a whole (Mackinnon 1998).

There are a number of different topics raised within the literature stemming from concern about the TFR decline. These include: the ageing population and its implications for the nation; the ageing would-be/mother-to-be; the possibility of a child-free society; and the question of reproductive autonomy. World population rates as a whole are the source of an associated, if contradictory, concern that focuses on overpopulation. These different perspectives converge under a banner of fertility research: each incorporate both old and new enquiries, often overlap and are the subject of a multitude of disciplines and stakeholders. For example, the relatively recent trend towards delayed first-time motherhood creates new perspectives on the more established concepts of childbearing ‘for the nation’ and reproductive choice (Mackinnon 1998; Bryson and Mackinnon 2000; Cannold 2005; Maher et al. 2004; Wajcman 1991). Which perspective is prioritised determines why these demographic changes could be considered problematic, and their possible implications and explanations. Ultimately it also influences which solution, should one be deemed necessary, is proposed.

In addition to the purely demographic concerns, issues associated with the declining fertility rate are discussed in several other contexts, including economics and health. As discussed in Chapter 1, the ageing population is seen as an economic problem and
has been the preoccupation of Australian governments both past (Costello 2002a) and present (Swan 2010; Gordon 2010).

Changes in women’s reproductive lives also present health challenges. Contributing to the urgency of fertility debates is the medical perspective on the declining fertility rate. This body of literature details research findings that older mothers, the ‘elderly prima gravida’, and babies born to older mothers and older fathers, have poorer health outcomes than their younger counterparts, and that the chance of conceiving falls with age for both women and men (Alonzo 2002; Bachrach 2006; Bewley et al. 2005; Bewley et al. 2009; Chapman et al. 2006; Dunson et al. 2002). The latter issue has a higher profile in the fertility debate.

Health and economic concerns intersect in the potential for older mothers and their babies to have higher medical costs than other mothers (Costello 2002a). This includes the controversial issue of who should pay for the fertility treatment of older women (and men), who are less likely to have successful results (Bryant et al. 2004; Wang et al. 2009) and who may have delayed childbearing. In addition to these financial costs are the emotional costs of health complications and unplanned childlessness due to older age.

Delayed first-time motherhood can impact the TFR of a country through a reduction in the fertile years in which a woman can ‘produce’ children (Dunson et al. 2002; Kippen 2004). A woman’s fertility is ‘bookended’ by the age she begins and ceases to be able to conceive. For the purposes of this thesis it is more relevant to investigate research discussing the ‘end’ of an individual’s capacity to conceive as opposed to the ‘start’, given the focus on declining fertility rates and its associated relationship with older motherhood. While this age varies from individual to individual, multinational European research has found that, in general, a woman’s chance of conceiving starts to decline when she is in her late 20s, and falls steeply from her late 30s (Dunson et al. 2002: 1399; see also Bewley et al. 2005). As a result, childlessness and smaller family size can become a byproduct of delaying childbearing (see Figure 2.1 above).

These findings are pertinent to the Australian context as the median age of mothers in Australia has been on an upward curve over the past thirty years, reaching 30.8 years in 2006 before plateauing at 30.7 years in 2007 and 2008, and experiencing a slight decline in 2009 to 30.6 years (ABS 2010: 14; 2009a: 13; see also Jain and McDonald 1997; Laws et al. 2010; McDonald 2000a) [see Appendix 2.2]. The majority of
Australian women have their children when they are aged between 25-39 years old. This is predicted to continue to be the case (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2009). The Australian age bracket is five years older than the world average, and older than most “developing” and many “developed” countries, where 20-34 years is the most common age range.

In Australia, rates of fertility have increased for women over the age of 30 and generally decreased for women under the age of 30 (Kippen 2006). Since the year 2000 women aged 30-34 years have achieved the highest fertility rate overall (ABS 2010: 11). This is followed by women aged 25-29, then women aged 35-39. Birth when the mother is in her early 20s was the next most common, and then the number of teenage mothers is narrowly ahead of the number of new mothers in their early 40s. Between 2006 and 2008 fertility rates increased for all age groups, apart from those aged over 45 years whose fertility remained the same (ABS 2009a: 6; Heard 2010). This provides a partial explanation for the stabilising of the median maternal age, and the recent rise in the fertility rate (Heard 2010). Likewise, however, the slight dip in the Australian TFR that was reported for 2009 could be accounted for by the decrease in fertility rates that was found in the same year for all groups aged less than 40 years (ABS 2010: 10).

Older motherhood is not a new phenomenon (Berryman 1991). Indeed, despite recent increases, the proportion of women aged 35 and over who are having children has not yet reached levels recorded at early points in Australian history, such as during the 1920s and the post World War two baby boom (ABS 2005a: 8; 2007: 11). It is first-time older motherhood which is on the rise (Kippen 2006). On average women are having their first child at increasingly older ages; rising from 27.0 years in 1998 to 28.2 years in 2008 (Laws et al. 2010: 17). It is not known yet if the shift towards later births will "replace" the loss of earlier births (Kippen 2006). While some are pessimistic (Costello 2002a) more recent research suggests that:

_Fertility recuperation appears to be strong in Australia. That is, cohorts who delayed having children through their twenties have higher fertility in their thirties to compensate_ (Kippen 2006: 6; see also Heard 2010).

The median age of fathers has also risen, reaching and stabilising at 33.1 years for 2006-2008, then falling fractionally to 33.0 years for 2009 (ABS 2010: 14; 2009a: 14;
see also Gray 2002). While men are generally fertile to older ages than women are, their fertility has been found to decrease after their late 30s (Dunson et al. 2002: 1399) making older men also at risk of age-related infertility. This is of significance as women tend to be younger than their male partners (ABS 2009b), thus a cascade age effect could be created in combination with female age-related fertility and delayed childbearing.

The medical literature offers scientific evidence that has been harnessed by the media (for example Hall 2005; Legge 2005) and social commentary (Macken 2005) to bring concerns about delayed childbearing and age-related infertility into the public arena. Internationally, some medical bodies have taken the direct approach of issuing public statements warning of the potential fertility implications of delaying motherhood (RCOG 2009; Bewley et al. 2009). This perspective on the changing demographic structure reinforces the place that biology, medicine and technology hold in the fertility debate, and the importance of informed consent in reproductive decision-making. As a result, questions regarding knowledge of fertility (Clarke 2008) and the technologies that can assist with conception, and the actual (Wang et al. 2009) and perceived (Weston and Qu 2005) success of these technologies in relation to the age of the mother (and father) are increasingly the subject of research.

Another issue which appears in the public discourse is the fear of, or in some cases a desire for, a child-free society. In her review of the fertility debate, journalist Deirdre Macken (2005) points out that the changing demographic structure of society is not only problematic politically and economically, but also socially, through her depiction of a society devoid of children. Macken argues that a society with fewer children gradually creates an environment that is not child-friendly, and that this can result in fewer people aspiring to have children. Research from Austria and Germany claim that long term low TFRs have reduced the desire for children among the current childbearing generation (Goldstein et al. 2003). The concern for Australia, therefore, is whether the association between a lower fertility rate and lower aspirations for children could also happen here (Martin 2001-2002).

In contrast to those who want to actively encourage people to have more children and raise the fertility rate, are those who desire and sometimes artificially create a child-free society. In some cases villages and restaurants have been designated as child-free spaces (Bindel 2006). This perspective views children as a private consumption choice
that should be the sole responsibility of the parents, financially and otherwise (Bittman and Pixley 1997). As with the German and Austrian example, child-free preferences are possibly a product of the fertility decline, along with the social shift in importance from the family unit to the individual (Bittman and Pixley 1997; Bryson 2001).

An alternative world perspective has also heralded falling population levels as a positive move, citing concerns about overpopulation (Curnow 1998). In contrast to the Liberal Party of Australia’s Intergenerational Report (Costello 2002a: 29), this sustainability approach argues that the decline in costs associated with raising young children will counterbalance the increased costs of an ageing population and the decrease in tax payers (Curnow 1998). It is maintained that smaller populations place less pressure on national resources and create a better quality of life overall. This position is unusual in the literature, although the argument has been reignited more recently in light of the apparent rise or stabilisation of the Australian fertility rate, with a call to abandon pro-natalist policies such as the maternity payment, in a bid to bring the fertility rate down (Thompson 2009). Bob Brown, the leader of the Australian Greens party, has introduced to parliament his party’s belief that the Federal Government’s desired population growth is untenable (The Australian Greens 2010). Most recently the Prime Minister, Julia Gillard, has emphasised her concerns over a “big Australia” (Gordon 2010). This approach has been criticised for enabling the potential for coercion should restrictive anti-natalist reproductive planning policies be enforced (Eberstadt 2007).

2.2.3 Reproductive choice and the fertility rate

An arguably overarching perspective in the literature questions the fertility rate in relation to the issue of reproductive choice, also termed reproductive rights. The concern with reproductive choice as a standpoint stems from the association between childbearing and human rights advocated by the United Nations in 1968 (Baker 2008) and the second wave feminist movement of the 1970s (Everingham 1994; 1998; Wajcman 1991). It is fundamentally feminist in nature, and often approached from a sociological perspective, focussing on issues of choice, agency, circumstance, identity, and equity. In the context of the fertility debate, reproductive choice as a concept originated at a time when fertility rates were higher, in response to the belief that women were having more children than they wanted (Albury 1999; Wajcman 1991). This concern remains for some groups of women, often those in developing countries or of minority races (Baker 2008; UNFPA 2005). The current literature, however,
suggests that other women have fewer children than they would like (Cannold 2005; Weston et al. 2004; Kippen 2006). The focus of concern is on whether the fertility rate changes represent agency or structure; asking whether more women are choosing to have fewer children, to have them later, or to remain childless, or if their reproductive plans are being constrained by external factors (Cannold 2005; Hakim 2003; Johnstone and Lee 2009). Historically, motherhood has had a difficult relationship with feminism, and this tension has continued in much of the recent literature and accompanying media and social commentary (Campo 2005; 2009; Cannold 2005; Ginn et al. 1996; Hakim 2003; Summers 2003b). The goal of gender equity is complicated by the biological process of reproduction in which women play the major role. The overall aim is for women to be free to choose motherhood or childlessness in combination with any other life goals (Cannold 2005; Summers 2003b; 2003a).

The question of choice is central regardless of which perspective is taken in the fertility debate, in order to understand why the changes are happening, and whether they are intentional. What is problematised, however, and whether a ‘solution’ is sought are determined by why and how this question is explored. The goal of those who support reproductive choice is to facilitate a situation where women can have the number of children they choose, regardless of the fertility rate implications. The medical message of age-related infertility builds on this premise, supporting reproductive decision-making that is informed by knowledge of fertility potential and limitations. If women want children they need to be enabled to have them at an age when they are still fertile. In contrast, for those whose main concern is the economic implications of the ‘greying’ of the population, the knowledge of whether the demographic shift is due to choice or circumstance is required to work out whether women’s aspirations need to be altered or enabled in order to change the pattern and ‘improve’ the fertility rate. Consequently, from the perspective of reproductive choice, research that includes women’s thoughts, beliefs, and aspirations, is needed to establish whether there actually is a problem with the fertility rate from the point of view of the women themselves. It could be the result of free choice, which in a society which privileges individual self-identity would end the debate (Giddens 1991).

Kippen (2006) bridges the divide between demography, medical knowledge and reproductive choice by acknowledging the possibility that age-related infertility could impact those women who delay childbearing, whether through structure or agency, stating that:
From an individual perspective, the general consensus is that if circumstances are conducive, women should have children before age 35. The fact that half the population is still able to bear children at age 40 is good news for Australia’s demography but a tragedy for women wanting a child who are in the wrong 50 per cent (Kippen 2006: 9).

From the perspective of reproductive choice, therefore, the impact of the demographic changes falls on women themselves, dependent on whether they achieve their desired reproductive outcomes, and for what reasons.

2.3 Research on women’s reproductive decision-making

2.3.1 Do women want to have children?
At the centre of each of the different perspectives on the fertility debate is the question of reproductive desire. This is the focus of much recent Australian and international research and social commentary, which typically explores one or more of the following questions: whether women want to have children; how many children they would like to have; and at what age they would like to have children (Berrington 2004; Bryson 2001; Caldwell 2001; Cannold 2005; de Vaus 2002a; Hakim 2003; Hewlett 2002; Johnstone and Lee 2009; Lee and Gramotnev 2006a; Macken 2005; Macura et al. 2005; Manne 2005; Quesnel-Vallée and Morgan 2003; Summers 2003a; Wicks and Mishra 1998). This research is largely employed to determine whether choice or circumstances prevail in childbearing decisions; asking if women (and men) expect to and actually do have the number of children they want when they want them.

Ascertaining something hypothetical like aspirations for a particular family size is methodologically difficult. Research investigating reproductive decision-making is often accompanied by a discussion of how questions about aspirations for children are phrased and the varying interpretations and meanings behind different wording possibilities (Berrington 2004; Weston et al. 2004). The main issue is the attempt to differentiate between the number of children people would “ideally” like to have, a “free” choice unconstrained by factors such as age and financial situation, and the number of children people “expect” to have, having taken their personal circumstances into consideration when determining their likely childbearing outcome. The latter is usually lower than the former (Weston et al. 2004: 17). While the terms “ideal” and
“expectation” appear to fulfil these roles, the respondent’s interpretation of the question and their realism about what certain circumstances could mean for their reproductive plans can influence their response.

The literature therefore highlights the importance of both careful question wording and careful interpretation of the data. The discussion suggests that both “ideal” and “expected” reproductive plans are necessary if all perspectives of the fertility debate are to be explored. On the one hand, without individuals’ reproductive “expectations” it is difficult to predict future fertility (Berrington 2004: 11); on the other, asking about “expectations” for children without also discovering the individual’s personal “ideal” makes answering questions about fulfilment of reproductive choice problematic.

2.3.1.1 Aspired family size

The consensus in the literature is that, in general, women want to have children. This has been the overwhelming finding of both recent Australian (Johnstone and Lee 2009; Maher et al. 2004; Lee and Gramotnev 2006a; Weston et al. 2004), and international (Berrington 2004; Goldstein et al. 2003) research on reproductive plans. Most of these studies found that the two-child family was the most popular aspiration.

The Australian Longitudinal Study on Women’s Health (ALSWH) is a large national research survey (Lee et al. 2005) whose data provide both cross-sectional and longitudinal findings on women’s aspirations for children (see Table 6.1, Chapter 6). Cross-sectionally, the first three of the triennial surveys illustrate unequivocally that the majority (92%) of the cohort born between 1973-78 “would like to have children by the age of 35 years” (ALSWH 1997; 2002; 2005). These data support the two-child family ideal, with over half the sample aspiring to have two children by age 35 at both Surveys 2 and 3, 57% and 55% respectively. The response options of one and two children were combined for Survey 1: 65% (ALSWH 2002; 2005; 1997). The next most popular aspiration was for three children, followed by one child, then none, the latter being 8% at each survey (Johnstone and Lee 2009; Lee and Gramotnev 2006a; see also Wicks and Mishra 1998). It should be noted that as these are cross-sectional findings it is not necessarily the same 8% of women opting for childlessness at each survey. In addition, the number of women who had already had children increased over time, 8%, 15% and 29% respectively, which meant that their aspirations for children could have been influenced by the number of children they already had.
These findings are supported by the *Fertility Decision-Making Project* (Weston et al. 2004), a national Australian cross-sectional random telephone survey of both women (n=1,951) and men (n=1,250) aged 20-39, that included parents (57% and 32%) and non-parents (43% and 68%). When asked: “Ideally, how many [children] would you like to have in total (including the ones you already have)?” around half of the women (46%) and men (53%) stated their “ideal” was two children, while a further quarter of women (26%) and a fifth of men (21%) felt three would be ideal, followed by those whose ideal was four or more. Less than 10% of women and men believed one child would be ideal, with a similar number aspiring to remain childless. These data were gathered in late 2003 and early 2004 when the national TFR was 1.75-1.77 (ABS 2005a); if the participants actually went on to have their ideal number of children their TFR would be 2.4 for men, and 2.5 for women, above the then and current TFRs and above replacement level. It appears clear therefore that a lack of desire for children is not the cause of demographic changes to the fertility rate.

### 2.3.1.2 Expected family size

Research has found that positive aspirations for children will not necessarily equate to actual births or a rise in the TFR. The evidence takes several forms: discrepancies between the number of children women “aspire” to have and the number they “expect” to have (Weston et al. 2004); differences between individual aspirations for family size and demographic projections for family size, including childlessness (Kippen 2006; McDonald 1998; 2000a); and retrospective dissatisfaction with the actual number of children they have had (de Vaus 2002a; Quesnel-Vallée and Morgan 2003; Read et al. 2007).

The *Fertility Decision-Making Project* (Weston et al. 2004) found that a third of their respondents (male and female n = 3,201) expected to have *fewer* children than they wanted to, while only 4% of women and 6% of men expected to have *more* children than they wanted to. This comparative approach to unpacking reproductive decision-making examined both “ideal” and “expected” family size, and is uncommon in the literature. The findings suggest that factors external to desire may impact an individual’s reproductive intentions, while also acknowledging that women (and men) themselves may realise this process is happening. Overall “expected” family size was lower than “ideal” family size.
The disparity between “ideal” and “expectation” was most poignant in the number of people who did not expect to achieve their ideal of parenthood at all. A quarter of men and 12-16% of women expected to remain childless, compared with 5-8% of men and 3-4% of women for whom childlessness was their ideal (Weston et al. 2004). Despite these differences, the majority of women and men did “expect” to become parents and the two-child family “ideal” continued to be the most common “expectation” (Weston et al. 2004; see also ABS 2008). Furthermore, following the two-child expectation, more women “expected” three children than childlessness or one child. The opposite was true for men. As discussed above, achievement of the participants’ “ideal” family size would have created an above replacement level TFR for both men and women, with women wanting slightly larger families than men. Achievement of “expected” family size, on the other hand, would result in a TFR at (for women) or just below (for men) replacement level, similar to that in Australia at the time of the research (Weston et al. 2004: 103-4). This finding suggests that “expectations” for children, plans that arguably consider external factors (Berrington 2004; Weston et al. 2004), are more predictive measures of actual fertility rates than women’s “ideals”.

In order to explicate these data further, reproductive aspirations and expectations are often situated and compared across a number of variables in the literature, including transitionally over time, for both individuals and different generations (Bryson 2001; Goldstein et al. 2003; Johnstone and Lee 2009; Weston et al. 2004), and between specific demographic (Johnstone and Lee 2009; Weston et al. 2004; Berrington 2004) and geographic (Goldstein et al. 2003) groups.

2.3.1.3 Tracking aspirations and projecting outcomes over the life course

The consistency of individual aspirations for children has been measured over the life course. These investigations took the form of longitudinal analyses (Johnstone and Lee 2009) and retrospective comparisons (Weston et al. 2004). In both cases, the research found that the majority of women (and men) expressed a continuing desire for children, while their desired family size fell over time.

Cross-sectionally the ALSWH 1973-78 cohort indicated a consistent desire for children by age 35 (92%), while also reporting a downsizing in their family size ideals as they got older (ALSWH 1997; 2002; 2005; Johnstone and Lee 2009). When these data were analysed longitudinally, over half of the sample, 51.4% of the 7,790 women who responded to the question at each of the three surveys, were found to have varied their
aspirations for children over time (Johnstone and Lee 2009). Seventeen percent ‘upsized’ their desired family size, 25% ‘downsized’, while 5% dipped and then rose and 5% rose and then fell. Of those who were consistent in their aspirations, 31.8% wanted two children by the age of 35 years; 10% wanted three or more children; 4.4% wanted one child. These findings support the two-child ideal and indicate that while it was more common for desired family size to fall over time, in keeping with the national trend toward declining TFRs, many women showed an increased aspiration for children. Of particular note is the fact that only 2.4% of women in the study consistently aspired to childlessness by the time they were 35 years old, despite the cross-sectional figure at each survey being around 8% for those not wanting any children (Johnstone and Lee 2009).

Less certain conclusions can be drawn from retrospective data such as that presented by the Fertility Decision-Making Project (Weston et al. 2004), which asked participants aged 22-39 to compare the number of children they aspired to now with the number they had aspired to at the age of 20. They found that the majority of their participants believed they had consistently aspired to have children: two-thirds of men and three-quarters of women. A fifth of each gender had changed from not wanting to wanting children, with most of this group already being parents at the time of the study, suggesting that their ‘change of mind’ could have occurred as a result of actually having, perhaps unplanned, children as opposed to making a conscious decision. The study found that only 6% of men and 5% of women reported that they had consistently aspired to remain childless, while a small percentage of each (3% of men, 2% of women) said that although they had previously wanted a family, they did not now.

These findings suggest that, while people often expect to have fewer children than they desire to have, few women actively identify childlessness as a long term lifestyle choice. At most 12-16% of women “expect” to remain childless, while considerably fewer actually “aspire” to this status. In contrast, demographic projections for childlessness among these age cohorts in society are, at their most conservative, around 16% (Kippen 2006; see also McDonald 1998; Kippen 2004). Indeed, given the trend toward older first-time motherhood (Laws et al. 2010), and that the ALSWH data refer to aspirations by the age of 35, aspirations for lifetime childlessness among this cohort could be even lower than 2.4% longitudinally (Johnstone and Lee 2009). This research highlights the potential discrepancy between women’s desire for and actual rate of childlessness.
2.3.1.4 Transitions in desire between generations

The decline in the fertility rate over the past forty years (ABS 2010: 9) indicates that, in general, women in successive generations have had fewer children than their mothers and grandmothers had. The question is whether this demographic change represents a change in desire for children between the generations. Research has found that women of current childbearing age aspire to have smaller families than their mother’s and grandmothers’ generations actually had (Bryson 2001). In the ALSWH, at Survey 1, women born in 1921-26 and women born in 1946-51 were more likely to have actually had three or more children than the number of women born in 1973-78 who aspired to that family size, 58%, 42% and 27% respectively (ALSWH 1997; Bryson 2001). Indeed data from later ALSWH surveys indicated a further decline in the 1973-78 cohort’s aspiration for a three or more child family as they aged, 23% and 21% respectively (ALSWH 2002; 2005; Johnstone and Lee 2009). In contrast, a similar percentage of women born in 1973-78 aspired to childlessness as those women born in the 1921-26 and 1946-51 cohorts who have remained childless (8%, 9%, 8% respectively).

These findings do not, however, necessarily indicate a decline in aspired family size across generations nor a consistent desire to remain childless. Previous generations may not have chosen to have the number of children they did or did not have (Bryson 2001). This point is exemplified by de Vaus’ (2002a) analysis of retrospective data from the World Values Survey of 1995-97, which found that almost a quarter of women aged 45-54 (23% of n=130) had had fewer children than they wanted to have and 11% had had more children than they wanted to. Two-thirds (66%) of these women, on the other hand, stated they had had their desired number of children. A larger discrepancy was found in a US study with almost two-thirds (62%) of women aged 40-44 having failed to have the family size they intended to (Quesnel-Vallée and Morgan 2003).

European research found that younger generations (aged 20-34 years) did hold smaller family size ideals than older generations (aged 35-49 years) (Goldstein et al. 2003). Austria and Germany represented extreme examples of this trend, with over 30% of women aged 20-34 aspiring to have only one or no children, and very few women wanting to have more than two children. These below TFR replacement level aspirations have potentially serious implications for the population in question given that the fertility outcomes are usually lower than fertility ideals, as indicated by the disparity between aspirations and expectations for children and the TFR in Australia.
(Weston et al. 2004). Although, in the case of Austria and Germany “aspired” and “expected” family size were found to be closer than for other European countries.

Goldstein et al. (2003) viewed the low family size aspirations in Austria and Germany as evidence of a societal shift in ideals towards having fewer children. They hypothesised that because the surveyed women had only known below replacement level TFRs this had changed social norms and therefore what was ultimately aspired to. Discussion on the influence of social change on the fertility rate is common in the literature (Bittman and Pixley 1997; Bryson et al. 1999; Bryson 2001; Costello 2002a; Lee and Gramotnev 2006a; Mackinnon 1997; McDonald 2000b; 2006; Weston et al. 2004). For example, access to contraception and a rise in the social acceptance of having fewer or no children are argued to have enabled younger generations to choose to have the smaller families they want, in contrast to earlier generations (Bryson 2001; Hakim 2003). Comparing different generations’ reproductive aspirations and outcomes is complex. Older generations’ aspirations data are frequently retrospective, and therefore tentative, while younger generations may well not continue on to have the number of children they aspire to (Bryson 2001). These methodological issues are illustrated in the above research where the two European age cohorts were surveyed at different stages in the life course which could have impacted their reproductive ideals (see Johnstone and Lee 2009; Weston et al. 2004).

2.3.1.5 The geographic context: comparing fertility aspirations on a global and a local scale

The importance of the social environment on fertility aspirations and outcomes, emphasised in the generational differences above, can also be found in geographical comparisons. While there is a general division between the fertility rates of “more developed” and “less developed” countries, diversity also exists between the countries within each group (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2009). In late modernity most industrialised societies are experiencing a decline in fertility. Contrary to some public depictions of the issue, Australia is in a more favourable position than most, i.e. experiencing a smaller decline (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2009). The discrepancy between women’s ideal and expected family size, highlighted above, is not large enough, however, to suggest those women in “more developed” countries aspire to have the number of children many in “less developed” countries are having (Population Division of the Department
of Economic and Social Affairs of the United Nations Secretariat 2009). This suggests support for demographic transition theory.

In keeping with findings from Australia, European research has found that on average the two-child family ideal persists as the most common aspiration (Goldstein et al. 2003; Berrington 2004). There is evidence, however, that women in some European countries hold different aspirations for children than those found in Australia. A report on the Eurobarometer survey, which included fifteen western European countries and asked for participants’ ideal and expected number of children, found that women in Austria and Germany held far lower fertility ideals than those in both Australia and many of their European neighbours (Goldstein et al. 2003; see also Berrington 2004), as discussed above. Women in Finland and Ireland, on the other hand, were remarkable in being the only Eurobarometer surveyed countries where women felt having three or more children would be more ideal than two.

A comparison between childless women’s fertility plans from the ALSWH 1973-78 cohort and women of a similar age from the British Household Panel Study (BHPS) indicated a higher intention to remain childless among the British women (Berrington 2004; Johnstone and Lee 2009). In their late teens and early 20s the two cohorts held almost identical intentions, including 8.7% of the ALSWH and 6.7% of the BHPS who intended to remain childless. When the ALSWH cohort was resurveyed aged 25-30, however, childless women no longer held comparative aspirations with their British counterparts (in this case a different group of women); 11.2% of the ALSWH and 17% of the BHPS expressed their plan to remain childless. The diversity between different “developed” countries’ aspirations for children illustrated here suggests that socio-cultural circumstances impact on individuals’ reproductive intentions.

From a more localised perspective, geographic difference within Australia, in the form of rurality, was also found to be an influencing factor in both reproductive decision-making and outcomes. Among the 1973-78 cohort, small differences in aspirations for children between urban dwelling women and the whole national cohort suggest that rural and remote women were more likely to aspire to more than two children and to have them at younger ages than their urban counterparts (ALSWH 1997; 2002; 2005). This supposition is supported by Australian research on both rural and remote women’s aspirations for children (Johnstone and Lee 2009; Read et al. 2007) and their actual reproductive outcomes (Bryson 2001; de Vaus 2002a; Summers 2003a; Warner-Smith and Imbruglia 2001; Warner-Smith and Lee 2001). De Vaus found that the TFR
increased with women’s relative “remoteness”, ranging from under 1.2 for those whose region was “highly accessible” (major city) to over 2.2 for those whose residence was “very remote” (de Vaus 2002a). The focus of this thesis is on women living in urban parts of Australia in order to understand the factors underlying the below replacement fertility rate.

2.3.1.6 Demographic differentials for aspired, expected and actual childbearing
Along with life stage, generation and geography, the impact of demographic differentials on reproductive plans is often explored in the literature. Variables such as gender, partner-status, age, parity, education, paid employment and economic status have been investigated. The need for this approach is highlighted by the inconsistency between childbearing aspirations, expectations and outcomes, and the downsizing of aspirations over the life-course. It recognises the heterogeneity of the population, and tests theoretical arguments about the impact of circumstances on the choices people make, and the expectations they hold, about having children. This literature results in a demographic profile of the women behind the fertility rate statistics, often juxtaposing who is actually having children with those who are not.

Broadly, research has found that aspirations and expectations for children are positively associated with already having children, having a partner and/or being married, living in a rural area, and, to a small degree, being female; and negatively associated with age, being more educated, and being in full-time paid employment. Those women who had actually had children were more likely to be married or cohabiting, to have a partner who also wanted children, to be older, to have less education, to not be in the paid workforce, to be poorer, and to live in a rural area.

The impact of gender, partner-status, and partnerships
The few studies that included men as well as women found that gender was not an important differential in the desire for children (Berrington 2004; Weston et al. 2004). The majority of both sexes wanted to have two children, although women aspired to slightly larger families overall (Weston et al. 2004), and men reported more uncertainty than women in having either a first or subsequent child (Berrington 2004). In each case, however, the percentage differences were small. The remainder of the discussion in this section, therefore, will centre on women’s reproductive aspirations as they are the focus of the research for this thesis.
Research has found both a decrease and a delay in marriage in Australia, and a rise in cohabitation (ABS 2009b; de Vaus et al. 2003). These trends have been associated with declines in the fertility rate. However, the link between marriage and childbearing has also loosened both attitudinally and statistically (de Vaus 2002b; Qu et al. 2000). In regard to aspirations for children, partner-status produced mixed results in the literature. An Australian study found that married women were more likely to aspire to have children than those who were in a de facto relationship or single (Weston et al. 2004), while British research did not find an association between reproductive plans and having a partner (Berrington 2004). When it came to those women who were actually having children there was more agreement. The Australian research found that those who were married were more likely to be mothers (Weston et al. 2004), while British research found that having a partner, regardless of whether they were married or cohabiting, increased the likelihood of having children (Berrington 2004). The same study found that couples generally shared reproductive aspirations, although the authors hypothesised that this was due to not wanting to disagree in front of the researchers. If their plans for children did conflict, however, the couples were less likely to go on to have another child (Berrington 2004). These findings offer support for the arguments that lack of partner and lack of a willing partner can impact the fertility rate (Cannold 2005).

**Fertility aspirations and outcomes as women age and have children**

Age and parity were the most commonly discussed demographics in the fertility literature. Their importance is linked to medical findings of age-related infertility (Bewley et al. 2005; Bewley et al. 2009; Chapman et al. 2006; Dunson et al. 2002) and the increasing trends toward delayed first-time motherhood and increased childlessness (ABS 2010; Laws et al. 2010). All studies reported that women’s aspirations for children declined with age (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004). However, this was usually in relation to reduced ideal family size as opposed to whether or not they wanted to have any children. Having two children prevailed as the “ideal” family size regardless of age or parity (Weston et al. 2004). Men’s family size intentions were found to decline later than women’s did (Berrington 2004). This was possibly due to men generally being older than their female partners (ABS 2009b) and becoming fathers at older ages than women become mothers (ABS 2010; Gray 2002). Childless women were found to aspire to fewer children than women with children (Johnstone and Lee 2009; Berrington 2004). While aspirations for children
declined with age regardless of parity, childless women’s aspirations fell further (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004).

The ages of 30 and 35 proved to be pivotal time points, both in women’s reproductive aspirations and their expectations (ABS 2008; Berrington 2004; Weston et al. 2004). For childless women the popularity of having four or more children fell after age 30, while those viewing three children as ideal fell after age 35 (Weston et al. 2004). Similarly three-quarters (72%) of childless women in their early 20s “definitely” wanted children as compared with a third (33%) of childless women in their late 30s. However over half of those in this oldest age bracket still said they “definitely” or “sort of” wanted children, and just under a fifth of the women in their 30s now planned to have more children than when they were aged 20 (Weston et al. 2004). This finding is difficult to measure in regard to the ALSWH data due to the 35 year age cap in the aspirations for children question (Johnstone and Lee 2009; ALSWH 1997; 2002; 2005).

As with desire for children, the “expectation” of having a first or subsequent child also declined with age (ABS 2008; Weston et al. 2004). At age 30-34 over a quarter of mothers and two-thirds of non-mothers expected to have another child (ABS 2008: 13). For women aged 35-49 this expectation dropped dramatically to 5% of mothers and 14% of non mothers. Being “too old” was the most common reason given for not expecting to have any, or any more, children (ABS 2008; see also Weston and Qu 2001). Across all age groups those with one or no children were more likely to “expect” to have another child than those with two or more children (ABS 2008; Berrington 2004; Weston et al. 2004). This suggests that the majority of women expect to become parents and supports the two-child family “ideal” and outcome.

A British study found a sharper and more conservative response to ageing among the reproductive intentions of its participants, with marked declines again after age 30 and age 35 (Berrington 2004). The majority of childless women under the age of 30 “intended” to have two children, followed by those wanting three, then none, then one child. After the age of 30 the majority of childless women intended to have no children, followed by two children, then one, then three or more. Over a third of childless women aged 30-34, and more than 80% of those aged 35-39, reported intending to remain childless. This pattern did not occur among childless men until after age 35 years (Berrington 2004).
As might be expected, being older was found to increase the chance of being a parent (Johnstone and Lee 2009; Weston et al. 2004). Older childless women who aspired to have children, on the other hand, were less likely than their younger counterparts to become mothers (Berrington 2004). Those women who began to have children at older ages were found to have fewer than they had intended (Quesnel-Vallée and Morgan 2003). Few of the women who had two children in Maher et al.’s (2004) study planned to have more, supporting the two-child ideal, while almost half of those women with one child did not plan to have any more children, often downsizing their original intentions. Most women cited external factors such as work-life balance as having influenced the size of their family. The evidence that women often expect to have fewer children than they would like combined with the finding that women’s aspirations and expectations for children fall with age further compound the negative implications for the fertility rate of the trend toward delayed childbearing.

The impact of education, paid employment and economics on fertility aspirations and outcomes
At the same time as the fertility rate has fallen in Australia the number of women in higher education and the paid workforce has risen dramatically (Macken 2005; Mackinnon 1997; McDonald 2001; Summers 2003a; 2003b). The association between education, paid employment and fertility has been investigated in the literature to explore the relationship between these trends. There is evidence that higher educational attainment is associated with having fewer or no children, and delaying childbearing (de Vaus 2002a; Franklin and Tueno 2004; Martin 2000; Mackinnon 1997; Quesnel-Vallée and Morgan 2003; Romeu Gordo 2009; Warner-Smith and Imbruglia 2001; Weston et al. 2004). De Vaus (2002a) found that, for women aged in their 40s, having a tertiary qualification meant they were twice as likely to be childless and half as likely to have four or more children than their less well educated counterparts. He suggests the cause is two-fold: having children makes it difficult to attain educational qualifications, and not having qualifications reduces options and choices in paid work making unpaid work, such as motherhood, more likely. This is supported by findings from the ALSWH that women who have children earlier in life have lower levels of education than those women who have children later (Lee and Gramotnev 2006b).

In contrast, women’s desire for children and expectation that they would become mothers were not found to be negatively associated with having achieved higher levels of education. Indeed, a slight increase in desire was connected with being more
educated (Weston et al. 2004; see also Lee and Gramotnev 2006a). Childless women in their 30s who continued to expect to have children were found to be more educated and have higher earnings than those women who expected to remain childless (Berrington 2004). When combined, these findings suggest that the more education a woman has the less likely she will be to realise her desire for children.

Similarly, a German study found that women who spent more time in the paid workforce were more likely to have delayed motherhood than those women who had spent less time (Romeu Gordo 2009). This corresponds with Australian findings that women in full-time paid work had lower family size “ideals” than those in part-time paid work and unpaid work in the home (Weston et al. 2004). Mothers, on the other hand, were found to be less likely to be in the paid workforce (Lee and Gramotnev 2006b). While these findings suggest that women in paid employment are less interested in having children, the literature has found that the majority of women, up to 90% in some studies, aspire to combine paid work and motherhood (Johnstone and Lee 2009; Hakim 2003; Maher et al. 2004). This implies that women are limiting their childbearing in response to the question of how to combine motherhood with paid employment, as explicated by a number of women in Maher et al.’s (2004) empirical study who anticipated that they would only have one child for this reason.

The increased participation of women in paid employment has also influenced reproductive decision-making from an economic perspective, in regard to the potential loss of earnings a woman will suffer while she is out of the workforce having children (Gray and Chapman 2001). This compounds the already high cost involved in bringing up a child (Percival et al. 2007). These findings are important given that a perception of financial security, namely an assessment of whether they felt they would be able to support and provide for a child, was found to be the most influential factor in reproductive decision-making for women both with and without children (Weston et al. 2004; see also Maher et al. 2004). Childless women under the age of 26 were particularly concerned about the cost of raising a child (Maher et al. 2004). This suggests that a woman’s economic position could be a determining factor both in her decision to have children and in her decision to delay childbearing until such time as she feels financially secure. This concern appears well founded given research findings that motherhood is associated with being less well off financially (Birrell 2000).

The above findings indicate that while intended family size was often impacted by perspective, aspiration versus expectation, and demographic circumstances, women’s
overall desire or expectation to have a child and become a mother did not fall to the same degree. Furthermore actually having children was found to be more strongly associated with women’s demographic circumstances than their intention to do so. The research suggests that some groups of women are more at risk of not achieving their aspiration for motherhood than others, namely older, more educated, urban dwelling women who do not have a partner.

2.3.2 Chance: the unplanned and the technological response

There may be as many reproductive occurrences as there are clear choices, with a high degree of chance and circumstance being crucial to reproductive outcomes for women with and without children (Maher et al. 2004: 31).

Comparison between women’s reproductive aspirations and expectations and the national total fertility rate is complicated by the possibility of reproductive chance. Unplanned pregnancy has the potential to increase the fertility rate, while miscarriage, stillbirth and infertility have a negative impact. The possibility of these events has diminished in late modernity due to the existence and increasing availability and acceptability of reproductive technologies, which have the potential to reduce or rectify the incidence of reproductive chance but not to eliminate it altogether.

The ability to prevent pregnancy is noted in most of the literature as being directly linked to changes in the fertility rate (ABS 2010; Costello 2002a; Bryson 2001; Hakim 2003; Lee and Gramotnev 2006a; Mackinnon 1997; Weston et al. 2004). Specific reference is made to the Oral Contraceptive Pill (‘the pill’) which was seen to transform contraceptive use through its control by women (ABS 2010; McDonald 2000b), and the fact that its introduction in Australia in the 1960s and 70s coincided with the start of the most recent fertility rate decline (Weston et al. 2004). Since this time ‘the pill’ and contraception more generally have become normalized, resulting in high and widespread usage (Bryson et al. 1999). To a lesser extent, the option of pregnancy termination is also mentioned in the literature for its capacity to reduce the fertility rate (ABS 2010: 10 & 14; Bryson 2001). While this reproductive technology is viewed as being an increasingly socially acceptable “fall back”, it is also perceived to be a potentially “traumatic” decision, and is still to be decriminalised in a number of Australian states and territories (Bryson 2001: 16; see also Albury 1999; Baker 2008; Betts 2004; 2009).
While the option of pregnancy termination exists for most women in Australia, unplanned pregnancy can and has impacted the fertility rate. Two Australian studies found a high incidence of unplanned children. Of the participants with children, almost one third of the men (n=394) and women (n=1101) in Weston et al.’s (2004) study, and almost half of the fifty-eight mothers in Maher et al.’s (2004) study, described having had at least one child from an unplanned pregnancy. A British study also reported the presence of either unplanned children or a change of mind, with between a fifth and a third of women in their 20s who had stated their plan to remain childless going on to have a child in the following six years (Berrington 2004: 14). The fertility rate, therefore, has been in decline and remains below replacement level despite the evidence of a high incidence of unplanned children in Australia. If women are having children that they have not aspired to, this suggests that there is a larger discrepancy than first appears between the number of children women desire or expect to have, and the actual number they do have.

The unplanned reproductive events of infertility, miscarriage and stillbirth have the potential to reduce the fertility rate by preventing desired, expected and planned children. Given the below replacement level TFR, the question of infertility and unplanned childlessness is more significant to this thesis than unplanned children. People are usually described as infertile if they have been unsuccessful in conceiving after one or more years of trying (Wang et al. 2009). It is difficult to discuss the prevalence of infertility as people do not necessarily report their inability to conceive in the same way that the number of babies born each year is recorded. It is also difficult to discuss the occurrence of miscarriage, particularly early miscarriage which could go unnoticed. The number of stillborn children, a baby of twenty weeks or more gestation who dies before or during birth, are recorded and account for less than 1% of the babies born in Australia each year (Laws and Sullivan 2009). Of the ALSWH 1973-78 cohort at Survey 3 when they were aged 25-30 years old, 6% reported having tried unsuccessfully to conceive for 12 months or more, 11% reported having experienced one or more miscarriages, and 0.5% reported having experienced a stillbirth (ALSWH 2005). The technical definition of infertility (Wang et al. 2009) meant that those women who reported problems conceiving were all trying to have children, while it is unknown if the pregnancies that resulted in miscarriage or stillbirth were planned. Consequently, for the purpose of this thesis, only infertility will be explored in relation to its impact on the Australian fertility rate, and not miscarriage or stillbirth.
Assisted reproductive technology (ART) offers the potential to rectify infertility through the possibility of enabling conception, thus facilitating reproductive desires and supporting the fertility rate. ARTs are continually being developed, with newer technologies such as freezing embryos until they are needed and tests that claim to predict the age of menopause (Wallace and Kelsey 2004). These technologies in particular potentially provide additional options and safety nets for older motherhood, a consideration in the current climate of delayed childbearing. Technologies that ‘create’ a pregnancy have less certain outcomes than those which prevent pregnancy. ‘The pill’ has a success rate of between 97-99% (Foran 2003), while, in 2007, only 17% of initiated ART treatment cycles (n=56,817) resulted in a live birth (Wang et al. 2009). This figure included a number of different techniques which each have their own success rates. Findings show that in 2008 around 3.2% of births in Australia were as a result of ART (Laws et al. 2010: vii). This means that while ART has the capacity to raise the TFR, its actual impact has, to date, been small.

While there are many reasons behind the inability to conceive, age-related infertility (Bewley et al. 2005; Dunson et al. 2002) is of particular concern with respect to the fertility rate given the trend toward delayed childbearing (ABS 2010; Laws et al. 2010). Central to the issue of older first-time motherhood is the question of whether the existence of ART impacts on an individual’s reproductive behavior, perhaps making them think that they can delay childbearing because of a belief that they can conceive at any age with the help of technology. Relevant beliefs include women’s confidence in and perspectives on the different assisting technologies, knowledge of age-related fertility, and desired age at motherhood. While the literature recognises delayed childbearing as an important factor in demographic trends (Costello 2002a), less research exists for these particular questions.

In regard to the question of whether the existence of ART could encourage delayed childbearing, openness to using the technology and belief in its potential success are key. An Australian study (Weston and Qu 2005) has found that childless women were more likely to consider using ART should they need to than women with children, with those who already had two children least likely to consider ART. This supports the two-child family ideal found across the literature. Among childless women who “definitely” wanted children, those who were in their 20s were more likely to consider using ART in the future should they need to than those women in their 30s. These findings are important as it is generally women in their 20s who are in the process of postponing having children, two-thirds of whom (66%) are open to using ART thus potentially
encouraging their delay. Women in their 30s, the age group most likely to be having children (ABS 2010), were found to be less likely to consider using the technology to conceive (52%). The authors of the study hypothesise that this hesitance was related to the increased reality of actually needing ART for women in their 30s, with ambivalence linked to their concerns about using the technology.

Overall around 60% of men and women felt that ART would be successful for them should they need to use it (Weston and Qu 2005). An unsurprising correlation was found between belief in ART success and positive views on potential use. While childless women were more likely than those with children to state they would use ART should they need to, they were less certain that ART would be successful for them, possibly because their ability to conceive was an unknown for them. Participant age was not found to influence views on the potential success of ART (Weston and Qu 2005). This finding is significant as research has found that ART success rates support the fecundity curve of age, being strongly associated with maternal age (Wang et al. 2009). In 2007, the average age of women having ART treatment using their own eggs was 35.5 years (Wang et al. 2009), a time at which women’s ability to conceive “substantially decreases” (Dunson et al. 2002: 1399; see also Bewley et al. 2005). Consequently, as Kippen (2006) points out, despite medical research suggesting that 50% of women at age 40 will be able to conceive, this says little for the choices of the other half who are not able to conceive.

Fertility knowledge is therefore an important factor in making informed reproductive decisions. An Australian survey conducted by the Fertility Society (Clarke 2008) found that half of women aged 30-49 thought that they would be able to conceive if they tried. This was despite the finding that 95% of this same group believed that their fertility declined with age. This research suggests that few women are concerned that their own delayed childbearing could result in unplanned childlessness. It also provides support for the direct approach a British medical body has taken in making public statements on the best age to have children (RCOG 2009; Bewley et al. 2009), as discussed above.

2.3.3 Aspirations and older motherhood
Australian research has found that women do not aspire to be older first-time mothers (Weston et al. 2004). The question of desired timing is pertinent to the fertility rate given that more women are delaying childbearing (ABS 2010; Laws et al. 2010) and
their aspirations and expectations for number of children, and ultimate reproductive outcomes, have been found to decline with age (Johnstone and Lee 2009; Berrington 2004; Weston et al. 2004). Research has found that only half of childless women in their 30s who intend to start a family will manage to do so in a six year period (Berrington 2004; see also Kippen 2006). Furthermore, it was established that women were confident in both the ability to conceive at older ages (Clarke 2008) and the success of ART (Weston and Qu 2005), despite medical evidence to the contrary (Bewley et al. 2005; Dunson et al. 2002; Wang et al. 2009).

The combined outcome of these findings suggests that more women are starting to become mothers at later ages when they are more likely to aspire to, expect to, and actually be able to have fewer children. Discovering whether they are actively choosing older motherhood is therefore important. Research exploring when women would like to have children is, however, uncommon in the literature. Discussions of older motherhood tend to focus on trends towards, and the possible reasons behind, delayed childbearing (Cannold 2005; Kippen 2006) as opposed to women’s desired age at motherhood.

The Fertility Decision-Making Project (Weston et al. 2004) reported that women, and men, generally wanted to start having a family before the age of 30 years old. For women, on average, the age they felt was “ideal” to have children was 26.8 years old. This is below the median age of mothers in Australia, both at the time the research was conducted, when it was 30.5 years (ABS 2004a), and more recently, 30.6 years (ABS 2010). Nor does this finding correspond with data showing that births after the age of 30 are increasing, while those before 30 are decreasing (Kippen 2006).

Beliefs about the ideal age to have a first child were found to be impacted by gender, parity and age. Ideal age was found to be higher for men than women, and for those without children than those with children (Weston et al. 2004). It also increased with current age, as you might expect. For those who were already mothers, their ideal age bracket ranged from 22.2 years, for those in their early 20s, to 27.2 years, for those in their late 30s. The ideal age range for women without children began at 26.8 years, for women in their early 20s, and ended at 29 years for women in their late 30s. Men had higher ideal ages than women, both in their early 20s (fathers: 23.7 years, non fathers: 27.5 years), and late 30s (fathers: 28.9 years, non fathers: 29.8 years). These findings suggest that childless women and men in their 30s had either been unable to fulfil their
desired plan to have children at a younger age, or had specified their preferred, younger, age at parenthood with the benefit of hindsight.

Weston et al. (2004) also compared parents' ideal age to have children with the age they actually were when they had their first child. For parents in their late 30s, the ideal age to start a family was comparable to when they actually had had their first child, while parents in their early 20s had generally had children before the age they perceived to be ideal. This suggests a general belief that late 20s or early 30s was more "ideal" for childbearing than early 20s. The Fertility Decision-Making Project (2004: 77) hypothesises that as women (and men) are increasingly older when they have their first child, this could become the social norm and encourage a shift in the perceived "ideal" age to have children. This belief echoes Goldstein et al.'s (2003) argument regarding the impact of social change on declines in aspired family size in Austria and Germany.

2.4 Conclusion

The research examined in this chapter highlights the fact that, while Australia’s TFR remains below replacement level, women and men continue to aspire and expect to have children. Most people aim for a two-child family, and are therefore not far off "replacing" themselves and their partner. Indeed the two-child family continues to be the most common actual family size, although intergenerational comparisons indicate a fall in family size over time. Internationally, Australia is in fact in a favourable position demographically, in comparison to other “developed” countries.

The key influence on the demographic structure has been found to be the age of mothers, specifically the increasing prevalence of older first-time motherhood. Childless women aspire and expect to have fewer children as they get older. Research suggests they are also more likely to remain childless or have fewer children than their younger counterparts, although confirmation of this requires the current childbearing cohort to “complete” their reproductive years. Desire for delayed motherhood (after age 30), on the other hand, has not been found.

The concerns expressed in the different perspectives on the fertility debate, including economic and environmental sustainability for the nation, the potential for age-related infertility and unplanned childlessness, and, crucially, uncertainty over whether women are actively choosing their reproductive lives, appear, therefore, to be well founded.
The impact demographic differentials were found to have on reproductive plans and outcomes suggests that although the context of the fertility debate is grounded in demography, showing how the TFR has fallen, these data provide a spring board for a number of different, often more empirical, enquiries that ask: Why are women having fewer children? Why are they delaying childbearing? Why are more women remaining childless? These are the issues which will be addressed by this thesis. The next chapter examines the context in which young women are making reproductive decisions and provides the key concepts for the study.
Chapter 3: The lives and choices of young women in modernity

Many arguments about a ‘birth strike’ miss a key point: wombs are connected to brains. Women are not fools, and neither are their partners. Nor are they selfish, self-interested and absconding from a responsibility to nation. As the ones who, in the main, end up with main care of children and other dependants, women - having achieved control of their fertility - are thoughtful about their decisions (Pocock 2003: 260).

3.1 Introduction

This chapter focuses on the varying explanations given for the changes in the fertility rate which Australia has experienced over the past forty years. It outlines key social, cultural and political factors that have been identified in the literature as having impacted fertility aspirations, choices and actions. This builds on the demographic influences discussed in the previous chapter. The main theoretical standpoints in the fertility debate are introduced. These variously include an emphasis on preference, materialism, rational choice, risk aversion, and gender equity. The extent to which the theories emphasise a balance between structure and agency is discussed, that is, the extent to which women are free to make reproductive choices as opposed to their choices being constrained by social and cultural factors.

The need for an investigation into the possible causes behind the demographic changes has been stressed from an economic, social, feminist, health and environmental perspective, as discussed in the previous chapter. Of importance to each perspective is the question of whether individual women’s reproductive decision-making is being compromised (McDonald 2000a). This question arises because of the discrepancy which research has found between women’s childbearing aspirations, expectations, projections and actions (Berrington 2004; Cannold 2005; Kippen 2006; Weston et al. 2004). These inconsistencies have led to a consideration of research into motherhood itself, as a choice and an identity (Maher 2005; Maher and Saugeres 2007), reigniting feminist debate from the 1970s. The rhetoric of choice is central to discussions of fertility, motherhood and reproductive decision-making, and crucial to the feminist perspective.
In this chapter, a discussion of reproductive decision-making in the context of late modernity is followed by descriptions of the main theoretical perspectives in the debate. How these perspectives are applied in the literature is then outlined along with the recommendations for political and social change that could improve both the fertility rate and women’s reproductive choice. The evidence base provided by the literature is assessed to identify areas of enquiry that merit further investigation to enhance the breadth and depth of understanding of young women’s reproductive decision-making.

3.2 Fertility in late modernity

In order to understand fertility choices it is important to look at the social, cultural and political context in which Australian women make decisions about if and when to have children. Over the past forty years Australian society has undergone enormous social change due to the availability of contraception, the cultural changes following the second wave feminist movement and the rise of a culture dominated by individualism. The term late or high modernity has been applied to societies, such as Australia, that are deemed to be “post-traditional” and have undergone industrialisation, capitalism, increased surveillance, secularisation, and the creation of a nation-state (Giddens 1991: 2-3; see also Baker 2008). These transitions have been viewed as negatively influencing the fertility rate through an increase in women’s participation in the workforce and the importance of material wealth in society (Hamilton and Denniss 2005; McDonald 2006). During this time there have also been significant changes in the gender order, social roles, careers, and variations in family formation that are also perceived to have had an effect on reproductive decision-making (Macken 2005).

Late modernity is characterised by an emphasis on the individual. Individualism has been identified as inhibiting the fertility rate as a consequence of its goals of independence and autonomy, and an increase in risk awareness, and personal responsibility (McDonald 2006: 489; Beck 1992; Giddens 1991) producing caution as opposed to ‘action’ in fertility. This is compounded by the “disembedding” of the individual from society (Giddens 1991: 2), the decreased influence of the church and an increase in mobility which have resulted in a move away from both community and “the family” as the primary organising structures in society (Bryson 2001: 18; Bittman and Pixley 1997). Choosing to have children in modernity, therefore, places a strong emphasis on the need for self-sufficiency (Bittman and Pixley 1997).
It could also be argued that decisions about having children are influenced by what Giddens terms the modern “pure relationship”.

* A pure relationship is one in which external criteria have become dissolved: the relationship exists solely for whatever rewards that relationship as such can deliver (Giddens 1991: 6).

This has implications both for partnering and for having children as the emphasis moves from tradition and obligation to one of “intimacy” and choice. Significantly, this places a value on that relationship beyond its reproductive potential; such pure relationships require time and resources which compete with the desire to reproduce.

Late modernity and, more specifically, individualism, have created a choice culture in society (Giddens 1991). Central to this choice culture is the concept of the “reflexive project of the self” in which “reflexively organised life-planning…becomes a central feature of the structuring of self-identity” (Giddens 1991: 5). Giddens argues that people reflexively decide who they want to be based on a chosen lifestyle and create a “biographical narrative” to underpin this. The self-analysis involved in this process takes surveillance to a more personal level and, in the context of the pure relationship, offers the potential for fertility choices to take a cost-benefit approach. Giddens notes that reflexivity does not occur in a vacuum, and that his use of the term “lifestyle” does not denote free choice, and recognises that modernity is both oppressive and emancipatory. Consequently, individuals structure their identity and lifestyle from their relative circumstances and position of (in)equity of class, gender, ethnicity and material wealth (Giddens 1991: 6).

Along with an emphasis on choice, modernity has created a focus on risk (Beck 1992; Giddens 1991). Perception of risk is heightened as a consequence of increased awareness of the world, largely through the media, and the introspective nature of the reflexive project of the self. It has been argued that the combined cultures of choice and risk create a “tyranny” of choice and make decision-making and life planning more complex and potentially more stressful (Schwartz 2000; Giddens 1991). Other features of modernity can compound this, such as the disembedding of individuals from tradition. These factors particularly conspire against making choices about ‘unknown’ factors such as having children. Consequently, a balance of risk and trust can determine whether life plans are realised (Giddens 1991: 3).
3.2.1 A gendered experience

The conditions of late modernity have impacted the life choices of both men and women; however, in the context of the fertility debate a specific set of circumstances are particularly applicable to how women experience these choices. For women, the culture of choice in reproductive decision-making is facilitated practically by the availability of contraception, and culturally by the feminist ideology of gender equity.

It is impossible to discuss fertility choices without mentioning the influence of contraception. The benefit of pregnancy prevention that contraception offers is generally felt to have increased women’s ability to choose and take an active part in shaping their life course (Bryson et al. 1999). Consequently, in combination with the rise of individualism, contraception has created a situation where people usually make *decisions* about reproduction, as opposed to simply having reproductive *experiences*. As Giddens explains:

*In the spheres of biological reproduction, genetic engineering and medical intervention of many sorts, the body is becoming a phenomenon of choices and options* (1991: 8).

From this perspective, “human action” overrides “nature” in the pursuit of a particular identity.

As discussed in the previous chapter, an immediate fall in the fertility rate followed the introduction of ‘the pill’ to Australia and women’s increased ability to control their fertility (ABS 2010; Bryson 2001; Costello 2002a; Hakim 2003; Lee and Gramotnev 2006a; Mackinnon 1997; McDonald 2000b; Weston et al. 2004). This has been interpreted by some theorists to indicate that reproductive technology has enabled women’s preference for smaller families (Hakim 2003). Issues of access and the control of contraceptive, and other reproductive, technologies, have however resulted in an ongoing debate, particularly among those influenced by second wave feminism. The extent of the empowerment the technology offers women and their status as promoters of choice is questioned in relation to who is controlling their use (Davis-Floyd and Dumit 1998; Wajcman 1991; 2004). Moreover, while the existence and usage of contraception have clearly influenced fertility patterns, researchers argue that the decision to limit fertility must be examined in its social, cultural and political context to understand the reasons behind its enthusiastic uptake (McDonald 2000b: 11; Bryson 2001).
Part of the investigation into this choice needs to consider the potential for age-related infertility for women who continue to postpone childbearing (Bewley et al. 2005; Chapman et al. 2006; Bachrach 2006), usually facilitated by contraceptive use. In late modernity’s culture of choice, reproductive technologies that can assist with conception, such as IVF, are tied to the issue of individual women’s knowledge both about these technologies and their own fertility potential. As discussed in the previous chapter, these questions are in their infancy in the literature. Research has found unrealistically high expectations of the ability to conceive at older ages (Clarke 2008) and the success of assisted reproductive technology (Weston and Qu 2005). While use of the term “choice” in childbearing implies making an informed decision, in reality the actors may not have all the knowledge they need to make informed reproductive decisions, particularly in regard to when they have children.

A key element of the context in which reproductive choices are made is the feminist ideology of gender equity. The issues of self and identity that are central to individualism in late modernity are also at the heart of feminism. In the feminist context “life politics” (Giddens 1991) remain emancipatory and the personal is political (Cannold 2005). Placed within a feminist framework women’s choices about having children can be complex and conflicted, and are politically situated. Feminism celebrates the ability to have reproductive choice, while recognising that the difficulty of those choices needs to be respected (Albury 1999: 21).

Feminism has a long and ambivalent history with motherhood (Bryson 2001; Everingham 1994; 1998; Summers 2003b). One goal of second wave feminism was to separate women from motherhood in an attempt to right the gender imbalance (Albury 1999; Everingham 1994). This approach arose from the continuing belief that women who do not have children are more likely to achieve gender equity that those women who do (Bryson 2001). One perspective viewed reproductive technology, particularly contraception and pregnancy termination, as offering women freedom from motherhood (Wajcman 1991). This belief was taken to an extreme by some second wave feminists who suggested that reproductive technology be harnessed to “bring an end to biological motherhood” through, for example, the invention of an “artificial womb” (Wajcman 1991: 56; see also Piercy 1976). The aim of this stance was to create gender equity by making women and men essentially the ‘same’. In contrast, other second wave feminists emphasised the importance of recognising women’s ‘difference’, both from one another and from men, when exploring the issues of
motherhood and reproductive choice (Everingham 1994; 1998). It was argued that motherhood needed to be reclaimed as a core part of being a woman (Everingham 1994). This often involved rejecting reproductive technology which was seen to have originated from, and to continue to be controlled by, the patriarchal world of medicine (Wajcman 1991). These feminist dilemmas of equity and biology complicate women’s reproductive decisions. Those prioritising difference were seen to create excuses for continuing gender discrimination, while those who focussed on sameness were seen to be disloyal to motherhood (Everingham 1994). Furthermore, while the choices reproductive technology provides women with have generally been embraced in late modernity (Bryson et al. 1999), motherhood as a valued and equal role in society has been slower to be achieve (Bryson 2001; Hakim 2003; Maher et al. 2004; Maher 2005; McDonald 2006). This situation creates questions about the real choices available to women today in regard to motherhood (Cannold 2005).

In recent years, there has been an improvement, though not an equilibrium, in the gender order in Australia, with an influx of women into the paid workforce and more cultural acceptance of women in ‘non-traditional’ roles (McDonald 2006). To a certain extent having children is no longer an assumed part of life, although it is possibly more accurate to say that the path to having children has become more varied. While childlessness is more socially acceptable than in previous generations (Merlo and Rowland 2000; Weston and Parker 2002), parenthood at some stage in life remains the social norm and, as discussed in the previous chapter, is also the aspiration of most people (Johnstone and Lee 2009; Weston et al. 2004; Maher et al. 2004). A stigma remains for those who are voluntarily childless, with particular questions asked of those who choose to be sterilised (Campbell 2003).

While social change has increased gender equity, especially in the areas of education and paid work, it is not possible to include this as an unmitigated positive provider of choice. The choices women make about work and family do not have the same outcomes as men’s choices, and, therefore, women’s choices about work and family are not made in an equal context (Summers 2003a; 2003b). More women are going to university and more women are in the paid work force (Macken 2005; Mackinnon 1997; Summers 2003a; 2003b). However, women in the same job and of the same calibre as their male counterparts, are still often paid less (Summers 2003b; Watson 2010). While gender on its own can be a limiting factor, women who are married and those with children are even worse off (McDonald 2000b). These findings do not enhance the choice of motherhood for the majority of women of current childbearing age who aspire
to combine motherhood and paid employment (Hakim 2003; Johnstone and Lee 2009; Maher et al. 2004). This is compounded by the fact that women continue to undertake the bulk of domestic chores, regardless of paid work involvement (Baxter 2002; Bittman and Pixley 1997; Pocock 2003; Summers 2003b).

Catherine Hakim (1995; 2000; 2003) argues that gender inequity in the paid workforce exists as a consequence of women prioritising family over career, and that it is not primarily due to discrimination. This stance has been disputed in the literature, with the belief that the choices women face in relation to having children are not equal to those of men, that workplace inequity shapes the type of work women do, that women are not supported in an endeavour to have both children and career, and after being placed in this position women often prioritise career over motherhood (Summers 2003a; Wicks and Mishra 1998; Campo 2009; Ginn et al. 1996; McRae 2003b; 2003a). The combination of increasing equity for women and continuing inequity for mothers in the workforce has, therefore, been identified as negatively impacting the fertility rate (McDonald 2000b).

While the stereotypes of the childless career woman and the stay-at-home mother persist in contemporary Australian culture (Maher and Saugeres 2007; Pocock 2003), a newer "have it all" ideology has developed (Campo 2005). Combining paid work with motherhood is not a new concept and is often a financial necessity as well as being the aspiration of the majority of women (Johnstone and Lee 2009; Maher et al. 2004). However, this choice is now presented as one of lifestyle (Arthur and Lee 2008). A discussion has ensued in the literature about whether women do indeed want to have it all and whether it is a tenable position. Anti-feminist backlash blames feminism for the “having it all” philosophy and claims that it is an impossible and unachievable aspiration that creates an expectation of perfectionism and thus makes women’s lives more difficult as opposed to easier (Haussegger 2005; see also Campo 2005; Campo 2009). Hakim’s premise that the majority of women lack commitment to paid work suggests they do not in fact want to do it all (Hakim 1995). Others argue that while women do want it all they do not want it all at once (Mackay 1997; Manne 2005). Those advocating gender equity in society, however, state that women should be able to have it all and need to be enabled to do so (Cannold 2005: 289; Campo 2005; 2009; Ginn et al. 1996).
3.2.2 Why do women choose to have children?
While individualism, feminism and contraception are all generally presented as promoters of motherhood as a *choice*, more often these choices appear to be associated with factors that enable women to have *fewer or no* children as opposed to more. In this context, while the Liberal Party’s *Intergenerational Report* (Costello 2002a) asked why women were not having *more* children, the literature points to a more poignant question of why so many women still want to have children, and how to enable women’s desire to have children. This emphasises the issues of women’s perceptions of motherhood as an identity, and of the existence of the ideology of motherhood. If motherhood is viewed as a choice, information about perceptions of motherhood is essential to assess how this decision is made. The literature suggests that in late modernity motherhood is valued less than other roles, particularly that of the paid worker, thus impeding many women’s decision to mother (Bryson 2001; Hakim 2003; Maher et al. 2004; Maher 2005; McDonald 2006).

3.3 Theorising fertility trends
A number of theoretical explanations have been developed to understand the changes in the fertility rate, each requiring the debate to be embedded in its cultural and social landscape. These include explanations based on preference, post materialist values, rational choice, gender equity, and risk aversion (Coleman 2000; Hakim 2003; McDonald 2000b). The principles of these approaches are outlined below, followed by an exploration of their application in the literature.

If one takes seriously the decision-making which underpins statistical trends, one encounters two broadly different hypotheses as to the level of intent behind childbearing outcomes; whether these reproductive trends are predominantly the result of personal choice or of the circumstances in which these choices are made (Cannold 2005; Hakim 2003; Johnstone and Lee 2009; McDonald 2000a; Summers 2003b). The theoretical approaches mentioned above divide loosely between these two standpoints. Those who believe choice dominates present motherhood as an option to be chosen or not, and consider Australia’s current demographic position to be a consequence of these choices. On the other hand, those who believe circumstance prevails explore how motherhood is chosen and the different contexts in which reproductive choices are made, and question whether in fact women make reproductive *choices* or whether the fertility rate is the result of external factors. An investigation of the literature has found...
more support for the latter viewpoint (Bryson 2001; Cannold 2005; Maher 2005; Maher and Saugeres 2007; McDonald 2000b; 2006; Summers 2003a).

The issue of choice has resulted in increasing scrutiny of individual and particularly women’s, childbearing aspirations, expectations, and ‘actions’, as discussed in the previous chapter. Consequently, while the fertility debate unfolds on a platform of national population statistics, women’s voices, views and experiences are increasingly being heard in the literature. Many researchers have taken a more empirical and “person-centered” (Hakim 2003: 351; Maher et al. 2004; Weston et al. 2004) approach to their explorations and explanations of the fertility question, regardless of whether their perspective prioritises the interests of the nation or the individual. The goal is “getting inside people’s heads” (Weston et al. 2004: xiv) in an attempt to unpack the processes involved in reproductive decision-making. As a result the theories that are currently debated in the literature usually place women (and men) as individuals, and active agents, at the centre of the discussion on fertility rates.

3.3.1 Privileging individual action
Those who espouse “preference” as a decisive factor in women’s decision-making argue that given the societal transitions that have occurred, namely the contraceptive and equal opportunities revolutions, along with specific workplace changes that have increased the participation of women, and an emphasis on “lifestyle”, women can have “genuine choices” about their reproductive lives (Hakim 2003: 355-7 & 369). While the potential impact of varying social and economic environments on these choices is acknowledged, supporting claims that this approach takes into account the heterogeneous nature of women, preference is viewed as “the primary determinant of women’s behaviour” (Hakim 2003: 361).

The theoretical approach of British sociologist Catherine Hakim (2003) divided women into three groups: home-centred, adaptive and work-centred. The categories were based on women’s work and family preferences, and the priority they applied to each. Home-centred and adaptive women both prioritised family over work, the former to the exclusion of paid work unless a financial necessity, the latter in combination with paid work, usually resulting in the ideal of part-time work. Depending on the country in question, between 10-30% of women were found to be home-centred, while 40-80% were adaptive. Work-centred women were the only group not found to prioritise having a family, and only constituted between 10-30% of women. Hakim argues that while
social circumstances can influence the proportion of women in each group, they usually only effect “adaptive” women and the three categories of women remain.

Preference theory (Hakim 2003) represents a modern, person-centred approach in the belief that motherhood has become a choice and changes to the total fertility rate are the prerogative of the women who are making choices about whether or not to have children. The premise that the majority of women prioritise having a family over having a career means that gender inequity in the workplace is viewed as the product of women’s choices as opposed to structural discrimination. It is argued, therefore, that women are disadvantaged by pro-employment policy. As a result, preference theory was adopted by the Australian Federal Liberal Government under Prime Minister John Howard to support policies that favoured women as mothers as opposed to workers (Heard 2006). The stance that reproductive outcomes largely represent reproductive choices rests on the belief that preferences about having children are unchanging and are sustained over time.

A focus on post materialist values associates the decline in fertility rates with the growth in value of the individual and the resulting increase of autonomy and freedom in society, along with changes to family formation (McDonald 2000b), maintaining an emphasis on choice in reproductive decision-making. This stance has been largely discounted in the literature (McDonald 2000b; Gray et al. 2008). It has been criticised on several grounds, including the emphasis on women as selfishly not choosing to have children, when evidence shows they do desire children, and often would like more than they have.

Most writers in the field, however, emphasise the impact of external social and cultural factors over agency, and question whether it is accurate to use the word “choice”, or indeed “preference”, in describing reproductive decisions that have been limited in some way (Bryson 2001; Cannold 2005; Johnstone and Lee 2009; Maher and Saugeres 2007; Weston and Qu 2004). In contrast to the theoretical approach which privileges individual preference and post materialist values, explanations which emphasise rational choice, risk aversion, and gender equity maintain that circumstance often outweighs personal choice in an individual’s decision of whether or not to have (more) children (Coleman 2000; McDonald 2000b).
The standpoints that counter preference do not, however, replace “genuine choice” with “circumstance” in their explanation of the fertility rate changes. Women are still viewed as making choices about having children but these choices are believed to be dependent on the social and cultural circumstances within which they are made (Summers 2003a; McDonald 2006; Cannold 2005). The perception that the choices women make about having children impact what other choices they have available to them is also viewed as a limiting factor in reproductive decision-making (Albury 1999: 21; Bittman and Pixley 1997: xiv).

3.3.2 Recognising the effects of structural constraints

Proponents of the rational choice explanation hold that people make a logical assessment of the known costs and benefits of motherhood before deciding whether or not to have children (McDonald 2000b). From a perspective based on economics, the field from which rational choice theory originated, having children would be calculated as an irrational choice in late modernity. Research has found that the economic cost of having children, in terms of both actual outlay and loss of earnings, is substantial (Gray and Chapman 2001; Percival et al. 2007). When these costs are combined with the social transition away from child labour that occurred in “developed” countries in the twentieth century there is also no return on the investment (Macken 2005).

It is necessary, therefore, to take a broader sociological approach to rational choice theory (Hedström and Stern 2008) before applying it to reproductive decision-making. From this perspective the costs of having children, which are often focussed on direct and indirect economic losses but can include any change perceived to be negative, are weighed against the benefits, which are frequently perceived to be psychological but can be anything positive (Coleman 2000; McDonald 2000b). Women are viewed as active agents in their childbearing decisions, however, their choices are constrained and influenced by the impact they believe their actions will have on their lives (Hedström and Stern 2008).

In order to make childbearing a more rational decision, and thus encourage people to have (more) children, it needs to become more economically viable, reducing the costs possibly through additional financial incentives and supports. In addition, the psychological benefits need to be emphasised, such as increasing the value society places on children (McDonald 2000b).
A perspective on risk aversion postulates that motherhood is viewed as an unknown risk (McDonald 2000b). The emphasis on the unknown makes this theory particularly relevant to those people who are yet to have any children, as opposed to those having a subsequent child, as they do not yet know what the impact of motherhood will be for them personally. Any uncertainty about having children has the potential to cause women to go for the safer known option of continuing their current childless state (McDonald 2000b; Maher et al. 2004).

McDonald (2006) has refined this argument more recently, pointing to social liberalism of the 1960s and 70s, and the rise of the individual, and personal responsibility, as the origins of a risk culture where caution often prevails over action, thus creating a fall in fertility rates. This perspective fits with Giddens’ (1991) general premise of the ethos of late modernity and Schwartz’ (2000) discussion of the tyranny of choice. Perceived risk can include any negative outcome. As with rational choice theory, the literature often cites risks as financial (Weston and Qu 2001), along with factors such as repercussions for career (McDonald 2006) and uncertainty about the ability to mother (Cannold 2005; Maher and Saugeres 2007; Weston et al. 2004). Risk aversion theory thus highlights the potential for personal choice to be overridden by the perception of risk shaped by the individual’s current circumstances. Perceived risks must be reduced in order to facilitate motherhood as a safe choice.

While women have increased emancipation in late modernity, associated with the prioritising of the individual, feminist analysis shows that inequity still exists in both the public and private spheres and is especially pronounced for mothers (Bittman and Pixley 1997; Bryson 2001; Coleman 2000; Mackinnon 1998; McDonald 2000b; 2000a; Summers 2003a). A belief in gender equity is associated with the goal of providing women with real reproductive choices and the question of how to reconcile gender equity with the biological reality of motherhood. In a social context where it is believed that "women come closest to equality with men when they do not have children" (Bryson 2001: 21; see also Mackinnon 1998), motherhood is not presented as a straightforward unencumbered choice for women.

Women are viewed as making active choices about having children, but these choices are made in a social and cultural environment in which women are conscious that their reproductive decisions could have negative implications for their equity (McDonald 2000b; 2000a; Summers 2003a). It is argued that these circumstances result in the tendency for women to delay and limit the number of children they have (McDonald
Evidence of gender inequity in society also contributes to the rational choice approach, highlighting the potential costs, for example in terms of loss of income (Gray and Chapman 2001) and, occasionally, the benefits of motherhood.

From this perspective gender inequity in society must be overcome in order for women to be able to make “genuine choices” about motherhood. Comprehensive and “enabling” government policies (Cannold 2005: 15; Mackinnon 1998), that allow women to choose motherhood, or not, without negative repercussions for their equity in both the public and private sphere, are believed to provide a solution to the issue of lower than desired fertility rates. This is evidenced by Scandinavian examples of successful gender equalising policies in the workplace (Coleman 2000: 2; see also Bryson 2001). Improving the value society attributes to motherhood and female roles and traits in general is also argued to be necessary before equity can happen (Bryson, 2001: 19).

3.4 Reproductive decision-making as a situated choice

In expressing higher ‘ideal preferences’ on average, women are effectively commenting upon the nature of the social-institutional setting in which they consider having children. They are saying that, in a different institutional setting, they believe they would have had more children (McDonald 2006: 485).

In the literature, the theoretical perspectives described above are employed to create a dialogue between agency and structure in regard to the fertility debate. More support exists for those approaches which emphasise the impact of external factors on reproductive decision-making, as opposed to preference theory’s “genuine choice” premise. It is common for the concepts behind the theories of rational choice, risk aversion and gender equity to be utilised to explore the context within which reproductive choices are made, although theorists seldom align themselves to a single perspective. Indeed a combined philosophy could compensate for perceived limitations within the individual theoretical perspectives, such as Mackinnon’s (1998: 162) criticism that rational choice theory is “too thin”, with its focus on the decision argued to exclude both individual preference and the broader socio-cultural context.

Research on women’s aspirations has borne out preference theory’s claim that the majority of women aspire to both paid work and motherhood (Johnstone and Lee 2009; Maher et al. 2004; Wicks and Mishra 1998). Evidence has also been found for the
three preference groups of “home-centred”, “adaptive” and “work-centred” (Johnstone and Lee 2009; McRae 2003b). However, discrepancies between women’s reproductive desires and their expectations, projections and outcomes, as outlined in detail in the previous chapter, are used in the literature to demonstrate that “preference” is not the only factor influencing childbearing choices (Berrington 2004; Cannold 2005; Johnstone and Lee 2009; Weston et al. 2004)

The constraints socio-demographic factors have been found to place on childbearing decisions also call into question the belief that reproductive outcomes are the product of “genuine choice”, and challenge preference theory (Johnstone and Lee 2009; see also Warner-Smith and Imbruglia 2001; Probert and MacDonald 1999). These findings are evidence of Giddens’ (1991: 6) stance that choice is impacted by circumstance. In particular, researchers have voiced the need for more research on the group of women which preference theory terms “adaptive”, arguing that this is not a meaningless “in the middle” category but a complex heterogeneous group (Johnstone and Lee 2009: 14; McRae 2003b; 2003a). The transitional nature of women’s aspirations for children over time also casts doubt over the predictive ability of reproductive aspirations data, contradicting the preference model (Johnstone and Lee 2009: 11).

Research which has found that a high number of women report having unplanned children (Maher et al. 2004; Weston et al. 2004), despite a culture of normalised contraceptive use (Bryson et al. 1999), further questions the emphasis on “preference” in regard to fertility aspirations and outcomes. These findings also suggest that without unplanned children the fertility rate could be even lower than it is at present, widening the disparity between aspired and actual births further still.

3.4.1 Explanations for reproductive aspirations and outcomes

Most people understand a choice as a decision a person makes freely when she has a full range of possible options from which to select, and is equally free to choose any one of them (Cannold 2005: 14).

In an attempt to unravel the complexities surrounding childbearing decisions a number of researchers have opted for an empirical approach, asking their participants about the reasoning behind their reproductive choices. When participants in the Fertility
Decision-Making Project (Weston et al. 2004) were asked to explain the difference between their ideal and expected family size aspirations, the latter almost always lower than the former, they spoke of both known “rational” and unknown “risk” factors that they felt had influenced their expectations for children. These included personal circumstances, such as economic position and career, and practical obstacles, like fertility, health, and age.

Research that demonstrates unplanned childlessness is particularly poignant in emphasising that reproductive decision-making is seldom based on “genuine choice” alone. This is illustrated clearly by Lesley Cannold’s (2005) empirical study of women whom she labelled as “involuntarily” childless, but who were not infertile. Cannold’s research, which excluded women who had made an active choice not to have children, found that her participants were often literally “circumstantially” childless, having made reproductive decisions in response to their current personal and social situations. The women were categorised into two groups. “Thwarted mothers” were generally childless as a result of the absence of a partner, or of one who was willing to have children. “Watchers and waiters” were found to be delaying having children due to a perception that motherhood was an irrational choice, believed to be incompatible with their other life goals. Gender inequity in the paid workforce was found to be a key factor for many of the “watchers and waiters” in delaying childbearing, in opposition to Hakim’s (1995) premise that women are choosing their place in the workforce. It was maintained that the circumstances of the women in Cannold’s (2005) study, whether practical or social, limited their reproductive choices.

Cannold argues that it is a human right for women to be able to choose motherhood should they wish, and maintains that the women in her study demonstrated a lack of choice in regard to motherhood, a situation that she believes is common for women in late modernity. This premise builds on the more established case for reproductive choice that enables women to be able to choose not to have children (Baker 2008). Catherine Hakim’s (2003) theory of preference, on the other hand, presents childlessness, outside of infertility, as being a voluntary choice that women as active agents have made.
Cannold's findings exemplify other research with childless women who were observed to have difficulty in viewing motherhood as a rational and risk free choice (Maher and Saugeres 2007: 33). These women often discussed both the unknown entity of motherhood, and the challenging, all encompassing, and life altering experience they perceived it to be. The literature also found that a number of women expressed concern about their ability to mother a child and be a “good” mother, an unknown “risk” factor for childless women (Cannold 2005; Maher and Saugeres 2007; Weston et al. 2004). This research supports those perspectives that emphasise the influence of structure on choices about having children. It also demonstrates the detailed reflexive process decision-making has become in late modernity (Giddens 1991).

In this context, an alternative viewpoint was expressed by some of the childless women in Maher and Saugeres’ (2007) empirical study who were postponing motherhood. They wanted to remove the rational thought process surrounding the childbearing choice by experiencing “a strong urge or desire [that would] overwhelm them and make the decision for them” (Maher and Saugeres 2007: 11). They believed this would eliminate the difficulty of making the choice that they felt was encouraging them to delay childbearing. Cannold’s (2005) “watchers and waiters” expressed a similar belief.

The trend toward delayed childbearing was found to create a fear of regret among some childless women, in case they were unable to conceive a child at an older age (Cannold 2005). A number of autobiographical accounts have also emerged lamenting the author’s age-related infertility, and subsequent childlessness (see for example Haussegger 2005). This literature demonstrates a preoccupation with the relationship between maternal age and the fertility rate on an empirical level. A perspective that is supported by quantitative evidence of an association between increased age and lower aspired and actual family size (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004), and medical research on age-related infertility (Bewley et al. 2005; Bewley et al. 2009; Chapman et al. 2006; Dunson et al. 2002). Cannold (2005: 294) argues that while reproductive technology exists and is utilised to mitigate age-related infertility, the increased need for such treatment is directly related to the social and cultural factors that result in women postponing having children, not a “problem” with women’s biology.
3.5 Enabling reproductive choice: possibilities for political and social change

[What is needed] is what feminists like to call enabling social policies: policies that provide women of reproductive age with the attitudinal and practical support they need to have the children they want (Cannold 2005: 15).

Two approaches to the fertility question are discussed in the literature, how to encourage women to want (more) children (earlier), and how to enable women to have the number of children they desire. The emphasis given to each solution depends on whether it is the issue of low fertility or reproductive choice that is prioritised.

The majority of the recommendations in the literature in regard to the fertility debate advocate the premise of gender equity (Maher et al. 2004; Summers 2003a). The literature widely supports the belief that new and improved policies that support women to more effectively and equally combine paid work and motherhood would provide “genuine choice” for both, encouraging and enabling more women to have more children (Baker 2008; Bryson 2001; Cannold 2005; Castles 2002; Heard 2006; Johnstone and Lee 2009; Maher et al. 2004; McDonald 2000a; Summers 2003a; Weston et al. 2004; Wicks and Mishra 1998). This approach is seen to have the potential both to improve the TFR and to facilitate women’s reproductive desires by making motherhood a more rational choice with less emphasis on risk (McDonald 2006). The aim is to enable, as opposed to encourage, women to have children (Baker 2008). Supporters of these recommendations argue that current government policies favour mothers in the home (McDonald 2006). The combined paid work/motherhood approach is in keeping with the finding that most women aspire to both a career and children (Hakim 2003; Johnstone and Lee 2009; Maher et al. 2004).

Those who share this perspective generally believe that a “whole of government” approach is necessary, with broad family-friendly workplace policies, along with childcare, health and education reform (Maher et al. 2004: 41; Bryson 2001; McDonald 2006; Read et al. 2007). One such suggestion is a reduction in the hours of the paid-working week (Bryson and Warner-Smith 1998; Trumbull 2001; Cannold 2005). In addition, the call for a national paid maternity leave scheme has been much debated in the literature, in relation, both to gender equity and whether it could enhance the fertility rate (Campo 2009; Costello 2002b; Hakim 2003; Heard 2008; HREOC 2002; Maher et
Belief in the family-friendly approach is supported by examples of countries, mainly Nordic and Scandinavian, that are already implementing successful gender-equalising policies in the workplace and achieving higher fertility rates than their counterparts (Coleman 2000: 2; see also Baker 2008; Bryson 2001; Castles 2002; Heard 2006).

A belief that social change resulting in the revaluation of motherhood would both encourage and enable more women to have more children is a common argument in the literature (Hakim 2003; Maher et al. 2004; Manne 2005; McDonald 2006). Both empirical and theoretical approaches found that in late modernity paid work is valued more than motherhood, encouraging women to prioritise the former (Bryson 2001; Maher et al. 2004; Summers 2003a). Through a revaluation of motherhood it is believed that motherhood would become a more desirable choice. This is an essential factor in the context of the choice culture of late modernity (McDonald 2006).

While Hakim (2003) is also an advocate for a revaluation of motherhood she provides an opposing perspective on government policy. Hakim believes that “neutral” policies or those that specifically support women in the home would be beneficial to the fertility rate (Hakim 2003: 366). Her proposal is based on the premise that women are not constrained in expressing their “genuine” reproductive choices (Hakim 2003: 355-57 & 369); that, while most women aspire to combine paid work and motherhood, it is generally women’s preference to prioritise family over career (Hakim 1995). From this perspective, gender inequity in the workplace is the result of women’s choices as opposed to discrimination and, consequently, women do not need enabling policies. Indeed she argues that the current workplace situation favours women in the workplace over those in the home.

Promotion of fertility knowledge (RCOG 2009; Bewley et al. 2009) and knowledge about the success rate of ART (Bell 2006) is also advocated in the literature in the belief that if women included information on the age-related limitations to their fertility they would start trying to conceive at younger ages. This would increase the potential for their reproductive desires to be fulfilled and the fertility rate to be improved through a reduction in “circumstantial” childlessness (Cannold 2005). However, de Vaus (2002a) argues that some changes to the social structure in late modernity that have been found to impact the fertility rate, such as later marriage, are unlikely to be affected by policy initiatives.
The ‘solutions’ to the fertility rate that are proposed in the literature talk to the three main perspectives in the debate: the government economic model, the medical knowledge model, and the feminist reproductive choice model, that were introduced in the previous chapter. “Enabling” government policies and the recognition of motherhood as valuable by society are capable of facilitating women to have children if and when they want to have them. Dissemination of fertility knowledge may encourage women to have children at a younger age than they had planned, but at an age they may have wanted. This has the potential to answer concerns about reproductive choice and changes to the fertility rate, in regard to smaller family-size, delayed childbearing, and increased childlessness. These, it is suggested, are often “circumstantial” as opposed to desired outcomes, the latter in regard to the finding that women often expect to and do have fewer children than they desire.

3.5.1 Government policy in action

Australia’s below replacement level TFR and the recommendations and policy discussion in the literature, therefore, suggest that, in general, government policy does not encourage or support women to have children. The history of Australian government comment and intervention in demographic and specifically fertility based issues has been well documented, with particular attention paid to the fertility agenda of the Howard Government (Heard 2006; 2010; Mackinnon 1998; Rottier 2005). From a government perspective the ‘greying’ of the population is the focus of concern in the fertility debate with the decision to have children viewed as an affordability issue, as discussed in the previous chapters. A number of “pro-natalist” policies have been implemented in recent years in response to this (Heard 2006).

Government policy is often viewed as supporting certain groups of women in society more so than others. The literature assesses which women are rewarded and which are penalised by policy for their reproductive choices: Ultimately which women are encouraged to mother? Heard (2006) notes that while the Federal Government under Prime Minister Howard adopted the language of gender equity in theory, in practice their policies supported and espoused Hakim’s (2003) preference theory which argued for “neutral” policies that supported all women. This approach enabled Prime Minister Howard’s Government to sidestep the question of maternity leave, ignoring recommendations from the then Sex Discrimination Commissioner Pru Goward (HREOC 2002) on the basis that maternity leave was unfair to women in the home (Campo 2009). In contrast, the maternity payment is an example of a “neutral” pro-
natalist policy. The payment has evolved from a lump sum provided to all new parents when it was introduced in 2004, to thirteen fortnightly payments with a generous means test in 2010. Presented as a family assistance benefit by the government, the literature often examines the maternity payment as both a pro-natalist policy and as a substitute for paid maternity leave, while not actually helping women to balance paid work and motherhood per se (Heard 2006).

The newly proposed paid maternity leave scheme, to be implemented in 2011 under Prime Minister Julia Gillard, has, therefore, been long awaited in Australia, which is often cited as one of few “developed” countries yet to have a national policy (Heard 2008). The policy will operate alongside the existing maternity payment, with those women on leave from paid work eligible for eighteen weeks pay at minimum wage or the maternity payment, while new mothers who are not in the workforce will continue to receive the maternity payment. Thus, the practice of providing different policies for different groups of women persists. While a far cry from maternity leave on full pay it will be interesting to see whether the new policy is found to impact young women’s reproductive decisions.

Similar assessments have already been made in relation to the association between the implementation of the maternity payment and a recent rise in the Australian fertility rate (ABS 2005b; 2009a; Heard 2007; 2010; Jackson 2006; Read et al. 2007; McDonald 2005), along with general evaluations of the policy-fertility decision-making relationship (Maher 2008). Much of the literature disputes the association between the maternity payment and demographic changes, citing factors such as a rise in the size of the childbearing population, reduced age at motherhood, and increased marriage rates as more likely catalysts (Heard 2007; Jackson 2006; Read et al. 2007). This includes the assertion that, despite a rise in the TFR, the current childbearing cohort’s “completed” family size may not rise (Jackson 2006), suggesting that the question of realising reproductive choice remains for many women. Furthermore, the TFR continues to be below population replacement level.

The finding that it is women living in areas of higher socio-economic status in Australia who have contributed most to the recent increase in the fertility rate is also highlighted, with the suggestion being that the small financial incentive of the maternity payment is unlikely to have influenced these women’s reproductive decisions (Heard 2010). When asked, women themselves tend to agree with this perspective, believing their childbearing decisions to be unrelated to specific policies (Maher 2008). However,
women frequently discuss the choices surrounding childbearing in the context of the difficulty of combining paid work and motherhood, a difficulty perpetuated by government policy (Maher 2008). This is evidence that government policy in Australia is yet to support a situation where women feel enabled to realise their aspirations for motherhood (Bryson 2001), particularly given the majority desire to combine family and paid work (Johnstone and Lee 2009; Hakim 2003; Maher et al. 2004).

3.6 Conclusion
The majority of the empirical research findings and the theoretical perspectives presented in this and the preceding chapter support the concept that reproductive choices are influenced by the circumstances in which they are made. This suggests that the current below replacement level fertility rate, and the demographic changes of delayed childbearing and smaller family size, are, at least in part, the consequence of the social structure in which women are making reproductive choices as opposed to a true representation of young Australian women’s preferences. Giddens’ (1991) model of late modernity offers a helpful description of this context.

The literature calls for further in-depth empirical investigation of young women’s reproductive decision-making, with particular emphasis on when women would like to have children, perceptions of motherhood as an identity, and recognition of women’s heterogeneity (Bryson 2001; Hakim 2003; Maher and Saugeres 2007; Weston et al. 2004). The objective is to gain a deeper understanding of how women make reproductive decisions, in order to contribute both to the goal of enabling women to have the number of children they would like, and to the evidence base that will inform policies that impact on reproductive decisions. A thorough exploration of the relationship between the social context of late modernity, including the ideology of motherhood, desires and expectations about having children and knowledge of fertility, is required. The literature suggests that it would be beneficial to gain an understanding of women’s childbearing choices at the early stages of their decision-making process, before they are at or nearing the end of their reproductive lives and age has begun to curtail their choices, as is often the case with studies of childlessness (Cannold 2005).

There is extensive evidence of reproductive aspirations, expectations, projections and outcomes, and the discrepancy often found between them (Berrington 2004; Johnstone and Lee 2009; Maher et al. 2004; Weston et al. 2004). We know that in general women want children and we know that in general they want two or three children. We know
they also want an education, a career, a partner, and financial backing. What research is limited in telling us is how women see their lives unfolding. How do they plan to balance their goals? When do they want to have children?

The relationship between maternal age and fertility is emphasised in the literature in relation to the negative implications of delayed motherhood on the TFR (ABS 2010; Berrington 2004; Bewley et al. 2005; Bewley et al. 2009; Cannold 2005; Chapman et al. 2006; Dunson et al. 2002; Johnstone and Lee 2009; Laws et al. 2010; Weston et al. 2004). This research highlights a paucity in the literature for in-depth empirical investigation into the age women would like to be when they have children and how this desire is integrated into their reproductive plans and actions. Exceptions in the literature include Read et al.’s (2007) small empirical study of rural women in Australia, and Weston et al.’s (2004) large national telephone survey of women and men’s Fertility Decision-Making. The former sample size lacked breadth and the latter method of enquiry precluded depth.

Evidence of the impact that demographic differentials have on reproductive aspirations and outcomes suggests that a detailed study of women’s childbearing plans needs to recognise their heterogeneity and that an investigation focussed on a particular group in society would provide a valuable contribution to the fertility debate. Johnstone and Lee (2009) and McRae (2003b) advocate a need for more in-depth research on the majority group among women in Australian society, those women who plan to combine paid work and motherhood and therefore fit Hakim’s (2003) “adaptive” criteria. This would enable further examination of how women intend to reconcile their multiple goals, a perspective which theories such as Hakim’s (2003), are not sufficiently grounded in empirical detail to provide.

Furthermore, while research looking at the fertility rate and women’s childbearing intentions almost always attributes some of the cause for the fall to reproductive technology, there is little research examining the relationship between technology and reproductive decision-making. This is particularly true in relation to perceptions of technologies that can assist with conception, which have gained prominence in recent years in regard to the tendency toward postponed childbearing (Bell 2006). Research on reproductive technology tends to focus on women’s agency to choose to use technology without exploring why they choose to use it (McDonald 2000b). Weston and Qu’s (2005) study of perceptions of potential use and success of assisted reproductive technology is an exception.
Research on reproductive decision-making tends to follow one of two patterns, breadth without depth, or depth without breadth, as indicated by research on ideal age at motherhood discussed above (Read et al. 2007; Weston et al. 2004). Those studies that focus on survey based methodology often lack interpretation of and insight into women’s experiences, while a qualitative approach that is likely to be indicative of women’s experiences is usually on a very small scale. Research by Maher et al. (2004) provides scope for both breadth and depth in their qualitative study of the childbearing choices of a sample of one hundred women (and fourteen men) living in Victoria. The study used selective sampling to canvas five different demographic groups, including women and men with and without children, along with single and partnered mothers, and women and men aged less than 26 years. The resulting sample ranged in age from 21 to 52 years old. By design, therefore, the women and men who participated were making their reproductive decisions from a broad variety of backgrounds, which reduced the depth of investigation into each demographic group.

My research, therefore, aims to provide both breadth and depth of enquiry through a mixed method approach to the question of young women’s reproductive decision-making in Australia with both local and national samples of women. The research takes the impact of context and demographic differentials into consideration by focussing the investigation to a particular group of women within society.
Chapter 4: Methodology

4.1 Introduction
As I have demonstrated in the previous chapters, the issue of if and when young women want to have children is of concern from a number of different perspectives. The government and policymakers focus on encouraging young women to have children, while a more feminist approach concentrates on enabling young women’s reproductive choices. Within this context researchers have called for more exploration of what motherhood means to women, and in particular whether there is a difference between women who already have children and those who are delaying the decision (Maher and Saugeres 2007). As will be explained, my research design started with a broad approach to the question based on the Australian Longitudinal Study on Women’s Health (ALSWH) but successive rounds of data collection and analysis narrowed the enquiry to address the question specifically in relation to the tertiary educated young women, aged in their 20s and early 30s, whose delayed fertility appears to be causing concern (see de Vaus 2002a; Franklin and Tueno 2004; Martin 2000; Mackinnon 1997; Quesnel-Vallée and Morgan 2003; Romeu Gordo 2009; Warner-Smith and Imbruglia 2001; Weston et al. 2004).

A mixed method research design was chosen to explore the reproductive decision-making of young Australian women, combining both qualitative and quantitative methods. The study was conducted from an interpretivist and broadly feminist perspective, with a focus on social structure and social context. In this chapter I outline how the research was conducted and why it was conducted in this way, discussing what is meant by a mixed method approach, in terms of both general theory and specific design. A detailed description of the three phases of the research is followed by a methodological reflection on the combination of methods involved.

The nature of the research question lent itself to a combined methodological approach. Concerns surrounding the fertility rate in Australia are based on a statistical framework that underpins government and societal debates about the ‘greying’ of the population. The reproductive decision-making behaviours behind these statistics are, however, situated in the lived experience of individuals. The research needed, therefore, to utilise methods with the ability to generate richly contextualised data that would facilitate analysis of meaning, investigating young women’s reproductive plans and experiences from their own perspective and in their own words. The capacity to generalise the
findings from the sample to the wider population, enabled by the ability to describe data in statistical detail, was also desired. This would assist the policy relevance of the research and strengthen its contribution to national and international debate. This generality would need to be achieved without attempting to assign a single voice to young women as they made decisions about having children if the interpretivist and feminist theoretical goals were to be upheld. Consequently, using both qualitative and quantitative tools and approaches to explore the research topic was viewed as the best means of achieving an understanding that was rich in both breadth and depth.

The resultant research model brought the study under the umbrella of a mixed method design, described by some as the “third” methodology, alongside the qualitative (second) and quantitative (first) traditions (Tashakkori and Teddlie 2003). Mixed method research is generally defined as:

*The collection of both quantitative and qualitative data in a single study, in which the data are collected concurrently or sequentially, and involves the integration of the data at one or more stages in the process of research* (Creswell et al. 2003: 212; see also Tashakkori and Teddlie 2003: 10-11).
Figure 4.1: The research model: a three-component mixed method design

Component one
Existing ALSWH data

Written (QUAL) comments

Written (quan) survey data

Component two
Community Sample

Focus group discussions (QUAL)

Component three
Sample from ALSWH 1973-78 cohort

Existing ALSWH (quan) survey data

Written (quan) Survey

Telephone interviews (QUAL)

Existing ALSWH (quan) survey data

Data interpretation

‘+’ indicates research conducted concurrently; > indicates research conducted sequentially; the arrows indicate direction of knowledge gained from findings; each circle represents the data analysis and interpretation of a single component; the box represents interpretation of data from the collective components; ‘QUAL’/'quan’ indicate qualitative/quantitative method with the use of capital letters denoting which data were given priority
4.2 My research design

My research design, illustrated in Figure 4.1, has a complex structure based on an integrated and interactive mixed method model (Maxwell and Loomis 2003). The design consisted of three research components:

1: Qualitative written comments and quantitative survey data from the ALSWH;
2: Qualitative focus group discussions and quantitative written survey with a community sample;
3: Qualitative telephone interviews and quantitative written survey with the ALSWH cohort.

The components were mixed method both individually and collectively, with each component employing both qualitative and quantitative data, forms of analysis, and methodologies. The social model of health advocated by the multidisciplinary nature of ALSWH supported the feminist structure of my research.

For component one I utilised a large database of existing snapshots of qualitative data. These written comments were provided in response to an open question at the end of the ALSWH longitudinal, mainly quantitative, survey. Comments from three survey time points were analysed. The demographic profile of the authors of the comments was assessed using existing quantitative data from the same surveys and compared with the ALSWH main cohort. For component two I conducted focus group discussions sampled from the general population. The women who participated in the focus groups also completed a short quantitative survey which provided a description of the sample. Components one and two were conducted concurrently and informed one another during data collection and analysis, as well as informing the design of component three. In component three I carried out a ‘substudy’ with a small sample of women from the ALSWH, the same longitudinal study utilised for component one. The women completed a mailed quantitative survey and those who were eligible (see Table 4.1) were interviewed by telephone. Existing and new quantitative data were used to describe and compare the sample to the main ALSWH cohort.

Components one and three of the research were nested within the 1973-78 cohort (n=14,765) of the ALSWH. This automatically facilitated the opportunity to combine methods and methodologies. ALSWH provides the potential for both richness and generalisation of data through the existing large scale linked qualitative and
quantitative datasets. The ability to draw on survey data to profile participants in precise socio-demographic detail, and make claims for generalisability, along with the opportunity to conduct research with a national sample are very valuable, particularly within a mixed method study that emphasises the qualitative approach. As noted above, components one and three utilised existing qualitative and quantitative datasets from the ALSWH. Component three also recruited participants from within the ALSWH 1973-78 cohort for additional data collection. The known national sample offered by the ALSWH cohort matched the overall research sampling criteria for my study of age and gender, young women, and had the potential for purposive sampling. When the 1973-78 cohort were first surveyed in 1996 they were found to be broadly representative of the same age group in the 1996 Australian census (Brown et al. 1999). Slight bias indicated an overrepresentation of women who were married or living in a de facto relationship, and women who had a tertiary education, and an underrepresentation of women from migrant groups and women in employment. As the longitudinal study has progressed research has found that the likelihood of women’s continued participation in the 1973-78 cohort was associated with being born in Australia, having more education, being a non-smoker, not having children, and having a higher socio-economic status (Powers and Loxton 2010; Young et al. 2006). The associations between health and expected predictors, however, remained robust (Powers and Loxton 2010). These research findings need to be taken into consideration with regard to the demographic profile of the samples at components one and three. Component two was conducted with a community sample.

4.2.1 A pragmatic and interactive model

My research design applied a pragmatic “toolkit” combination of methods (Snape and Spencer 2003: 15; Creswell 2009). The design corresponded with the interactive web-like model advocated by Maxwell and Loomis (2003). The key argument behind this approach is to build a research model from the actual research process, research in practice, detailing the relationship between each part of the research, as opposed to fitting the research process to a predetermined model, research by design. The interactive model allowed for the research design to develop as the research progressed (see also Robson 2002).

A number of factors commonly used to define and describe mixed method research influenced the final design of the research. These included: the theoretical perspective, including whether one methodology was given priority over the other; the order in which
the different components, and the methods within these components, were implemented, for example, concurrent or sequential; the stage and degree of integration between the qualitative and quantitative methods and methodology used (Flick 2006a: 42; Creswell et al. 2003: 215; Tashakkori and Teddlie 2003).

Overall priority was given to the qualitative approach throughout the research, in terms of both method and methodology (Morse 2003), as indicated by identifying each component by the qualitative method used. Priority is usually signified by the use of capital letters as in my research model, see Figure 4.1 above. The data from component three were also given more weight in analyses than that from components one and two, as the former was the most in-depth and largest volume of new data. My methodological stance is discussed in detail in the second half of this chapter. At component level, and within the components themselves, the research design included both concurrent and sequential implementation. This departs from the usual compartmentalised approach to research where designs are viewed as being either sequential, where one component follows on from another, with each informed by the preceding findings, or concurrent, where the different components are conducted simultaneously and the findings then compared (Creswell et al. 2003: 215-219). Sequential and concurrent ordering are often represented in models by an arrow (>) or plus sign (+) respectively (Morse 2003), as used in the model for this research (see Figure 4.1 above). An integrated design (Maxwell and Loomis 2003) was applied to my research, with integration between methods and methodologies taking place, to varying degrees, both within and between the three components at a number of stages throughout the research process.

Component one, the written comments, and component two, the focus groups, were conducted concurrently, with preliminary findings from each informing the ongoing conduct of both. This mutual exchange involved findings from both the written comments and focus groups being used to develop the focus group schedule employed for later discussion groups, adding or amending questions or prompts. The joint findings were also used to identify additional search terms for analysis of the written comments and focus group transcripts. The two components were integrated throughout their individual research processes, unlike the usual conduct of concurrent research which implies completely self-contained data collection with integration only beginning at either data analysis or more commonly not until interpretation (Maxwell and Loomis 2003; Morse 2003). Findings from components one and two, based on all four data sources, both qualitative and quantitative, informed the telephone interviews.
in component three. These were conducted after the completion of data collection and preliminary analyses of the first two components. This resulted in a more traditional sequential pattern. In addition existing ALSWH quantitative results were used for purposive sampling for the interview component. Findings from all three components were integrated at the interpretation phase of the research. Consequently, there was extensive interaction within and between the three research components in areas of data collection, data analysis and data interpretation.

Integrating data from different methodological approaches can be complex, particularly if the data contradict one another (Flick 2006b). Adhering to a qualitative theoretical drive (Morse 2003) within the mixed method design supported the ontological stance towards understanding multiple social realities expressed by the women and portrayed in the statistics (Snape and Spencer 2003; Ezzy 2002), whilst recognising the validity of each method (Meetoo and Temple 2003) and harnessing any diversity in the data to create a richer understanding of women’s reproductive decision-making.

4.3 The data: collection and analysis

4.3.1 The research sample: young women

Two specific sampling criteria were employed across all three research components. Participants had to be female and they had to be in the first ‘half’ of their childbearing years, between 18 and 32 years old. The decision to concentrate solely on women’s choices about if and when to have children was made partly as a consequence of the study being nested within the Australian Longitudinal Study on Women’s Health (ALSWH). Accessing a comparable sample of young men was not within the scope of the research. In addition, the gender criterion was chosen through a desire to focus the enquiry, and enable a more in-depth analysis.

The age criterion for component two was 18-30 years, while participants for components two and three were recruited from an existing sample, then aged 18-30 years and 27-32 years respectively. The criterion was chosen both from a practical perspective and in direct response to the literature findings. These age groups represent the life stage where women are most fertile, with the ability to conceive found to fall significantly after age 35 (Bewley et al. 2005; Dunson et al. 2002). Women of this age are likely to be considering the issues surrounding having children and making decisions about their reproductive lives (Berrington 2004; Johnstone and Lee 2009;
Maher et al. 2004; Weston et al. 2004). As participants were being asked about their reproductive plans they needed to be of an age where they still had a number of potential childbearing years left to ‘plan’. Consequently, it was decided specifically to explore reproductive decision-making, including the impact of age, from the perspective of younger women aged 32 years and below.

4.3.2 Component one: written comments and quantitative data from the ALSWH

Component one, the written comments, involved the analysis of existing qualitative and quantitative data collected from the ALSWH 1973-78 cohort at Survey 1 (1996), Survey 2 (2000) and Survey 3 (2003). The self-report postal survey consisted mainly of quantitative multiple choice questions. The qualitative comments were written in response to the final open question:

*Have we missed anything? If you have ANYTHING else you would like to tell us, please write on the lines below.*

The existing ALSWH qualitative data presented a unique resource. The participant-driven data content supported the feminist approach and provided an inductive method with the potential to identify the parameters of the research topic using a large national sample, ideal for the exploratory stages of the research process. The data enabled the investigation of, firstly, whether the 1973-78 ALSWH cohort, a nationally representative sample of Australian women of childbearing age (Brown et al. 1999), chose to write about their reproductive experiences, aspirations, and beliefs in their surveys and, secondly, to analyse what they wrote about these issues. As the written comments constituted responses to a completely open question it could be hypothesised that the subject choice represented topics of particular importance to the women.

The open directive and the participant-driven ‘snapshot’ nature of the qualitative data placed limitations on the depth of detail that was possible, as participants could give as much or as little information as they chose. This variability was compounded by the fact that the component was an existing source of data, meaning that data collection for each survey had ceased and I was not able to clarify or ask for further detail from participants. This was greatly compensated for by the ability to link the qualitative comments to detailed socio-demographic quantitative data, enabling a clear analysis of who the participants were and thus providing a context for the findings, adding depth, and situating them within the national population, adding breadth.
Utilising an existing data source for component one meant that there was no further contact with, and therefore no further burden on, the women involved. There was also no access to any identifying information about the participants, as the data were labelled with an ID number only and any potentially identifying content, such as names of people or places, had already been removed. The ALSWH participants had given their prior consent for their data to be accessed and analysed in accordance with the guidelines in the study’s ethics approval (University of Newcastle: H-0760795; University of Queensland: 2004000224).

4.3.2.1 Component one: the sample
The use of data from an existing cohort study predetermined that the participant sample were women who were aged 18-23 years, 22-27 years, and 25-30 years respectively at the first three time points. This meant that the participants were all within their childbearing years when the data were collected. Initial analyses involved all of the comments, regardless of their authors’ geographic residence. Recruitment problems in component two of the research, which was conducted concurrently, determined the research focus on urban dwelling women only, and the analysis at component one was adjusted accordingly.

The written comment participants were a sub-sample of the main ALSWH 1973-78 cohort (n=14,247), as only some of the cohort chose to write comments in their surveys (C=6,637), ‘c’ indicates number of comments. Only those comments from women living in urban areas were included (c=3,554): Survey 1: c=1,150; Survey 2: c=1,089; Survey 3: c=1,315. Furthermore, only some of the comments were relevant to the research question. Consequently, the final ALSWH written comment samples from Surveys 1, 2 and 3 each constituted a sample (‘reproductive’ written comments c=780) within a sample (written comments) within a sample (1973-78 ALSWH cohort). The scale of the participant sample is unusual in qualitative research (Miles and Huberman 1994) and enhances the scope of the results, highlighting the benefits of a mixed method research design.

4.3.2.2 Component one: data analysis
Qualitative analyses explored the content of the ALSWH written comments both descriptively and thematically. The data were read and reread, and searched using key
words to identify themes within the data. These themes were then coded with the assistance of the qualitative software NUD*IST version 6 (QSR 2002). The software was used as a data management tool, an electronic filing cabinet for the storage of data and the coding labels I attributed to the data. No automated coding processes were used, as any electronic search ‘find’ was read and assessed before a decision was made about coding. New themes were also searched for by repeated reading of the comments, as different terms were often used to describe the same theme. The qualitative analyses were both deductive and inductive in their reasoning. Anticipated reproductive topics such as pregnancy, fertility problems and motherhood were specifically searched for, while other reproductive events and themes, such as adoption and age at motherhood, developed during the analyses.

Initial analyses specifically coded those comments that discussed ‘reproductive’ experiences, plans and beliefs. This process established that 780 of the 3,554 urban participants who wrote comments chose to discuss reproductive issues and events (Survey 1 c=190; Survey 2 c=224; Survey 3 c=366), and provided the final sample of participants for more detailed analyses. A coding structure of the 780 ‘reproductive’ comments developed, with a secondary level of non-exclusive nodes identifying which ‘reproductive’ comments included discussion of: decision-making about having children; contraception; motherhood; and reproductive experiences. The comments were coded demographically, by age and educational attainment, and by overarching descriptive themes that developed during the analyses, such as social support. Further analyses provided a micro level descriptive coding structure for retrieval, interpretation and theory building. The analyses initially resulted in three separate coding structures, one for each of the three survey’s comments. These were then compared and combined to form one overall coding structure for the comments, enabling the findings to be compared across the different surveys. A table outlining the coding structure that resulted from these analyses is presented in Appendix 4.1.1. Further exploration of the data consisted of searching and comparing the different nodes to discover patterns both within the written comment data, and in comparison with components two, the focus groups, and three, the telephone interviews.

Some of the analyses and interpretations of the data at component one were integrated. This included the quantification of qualitative data, which was possible due to the large sample size, and triangulation of the findings with those from, firstly, component two, the focus groups, which was conducted concurrently, and latterly with component three, the telephone interviews.
4.3.2.3 Component one: describing the ALSWH written comment sample

Existing aggregate quantitative data from the ALSWH 1973-78 cohort were also analysed for component one. The participants’ quantitative data were gathered from the same survey as their qualitative comments and the two data sources were linked. It was therefore possible to compare the demographic profile of those women who chose to write ‘reproductive’ comments, as determined by my qualitative analyses, with the profiles of those women whose comments were not coded as having ‘reproductive’ content or who chose not to write a comment. Quantitative analyses specifically describing the written comment sample were necessary, as the comment sample may not have reflected the generally representative status of the ALSWH 1973-78 cohort as a whole (Brown et al. 1999). The quantitative analyses were undertaken, with the assistance of a statistician, in the software program SAS using chi square tests. The analyses of the qualitative and quantitative data were sequential. The thematic analysis of the qualitative comments determined their ‘reproductive’ content and therefore established the groupings for the quantitative chi square analyses.

There was a close relationship between what was coded as a ‘reproductive’ comment and the demographic profile of the sample. Qualitative analyses coded the participants’ comments as being about ‘reproduction’ if they wrote about: reproductive decision-making, such as intentions about having children; contraceptive use; motherhood experiences and expectations; and reproductive experiences, including pregnancy, and fertility problems [see Appendix 4.1.1: Written comment coding structure]. The quantitative analyses found that those women who wrote ‘reproductive’ comments were more likely to have given birth and/or be currently pregnant; to be seeking help for fertility problems and to aspire to have three or more children at age 35, as compared to the women who did not write ‘reproductive’ comments. In light of this, as might be expected, the ‘reproductive’ commenters were more likely to be married and less likely to be using contraception or to be in paid employment. They were also less likely to state that “managing on their available income” was “easy”. Weaker associations between those who did and did not write ‘reproductive’ comments were found for a number of other variables including some important demographic factors such as highest educational qualification and general health. The decision to focus on urban participants created an obvious geographical bias. Analyses prior to this sampling criterion had, however, found no association between area of residence and the likelihood of writing a ‘reproductive’ comment. A table describing the ‘reproductive’
commenters in comparison to participants from the ALSWH 1973-78 cohort who did not write ‘reproductive’ comments, can be found at Appendix 4.1.2.

Comparative chi square tests were also performed at secondary node level, to compare, for example, the demographic profiles of those women who wrote comments about ‘reproductive decision-making’ with those who wrote about ‘contraception’. In general these sub-samples were found to be similar to the primary ‘reproductive’ node sample. However, the smaller number of participants involved further compounded the relationship between the comments’ content and the group’s profile. This is illustrated by the finding that those who wrote ‘reproductive decision-making’ comments were less likely to have given birth than the ‘reproductive’ sample because this group were in a planning stage of their reproductive lives, usually discussing whether and when they wanted to have children, as opposed, for example, to those who wrote ‘motherhood’ comments or ‘reproductive experience’ comments who had often already had a child.

Overall, however, despite the ‘reproductive decision-making’ participants being less likely to be mothers, the ‘reproductive’ commenters as a whole were more likely to be married mothers, who were out of the paid workforce, and less able to manage on their income, though equally educated, in comparison with the main ALSWH 1973-78 cohort.

4.3.3 Component two: focus group and written survey with a community sample

Component two of the research was conducted in 2004 and involved the collection of original data from a community sample of young women using the qualitative and quantitative methods of focus group discussions and a written survey. This component was not derived from the ALSWH. The groups followed the traditional format where a small number of people met on one occasion to discuss the research topic (Finch and Lewis 2003; Bryman 2001; Morse and Richards 2002). Data collection was concurrent and not integrated. The qualitative data were given priority, enabling an inductive exploratory examination of the research question, while the quantitative data performed a supportive role by providing the demographic context of the focus groups.

Focus group discussions were chosen as a key exploratory method, ideal for garnering the parameters of the research question in the early stages of the project by providing richness of data and depth of understanding through both individual accounts and the interaction between participants (Morse and Richards 2002: 95). The group interaction
is fundamental to the method, perceived to be conducive to producing a more natural narrative that has the potential to emulate how people discuss issues in everyday life (Bryman 2001: 338; Finch and Lewis 2003: 197). The focus group method was in keeping with the overall feminist framework of the research, with the participant-driven discussions and the natural group setting going some way to equalise the power relations inherent within the research process (Bryman 2001: 348).

4.3.3.1 Component two: the sample
Selection of participants for the focus group component mirrored the gender and age profile of the participants in component one, women aged between 18 and 30 years old. This enabled the two components to work together to canvas a specific sector of the population.

The face-to-face nature of the focus group method meant that the focus group sampling frame was limited to New South Wales, as further travel was outside the time and cost constraints of the research budget. This localised data collection was partially compensated for by the national samples utilised for components one and three. Furthermore, six geographic areas, three urban and three rural, were selected to hold the discussions on the basis of their differing socio-demographic profiles (ABS 2004b), to increase the potential of recruiting participants from a variety of backgrounds. Area selection considered factors such as average income, unemployment, rurality, population fluctuation, and socio-economic status (ABS 2004b) [see Appendix 4.2.1]. Despite this purposive sampling technique, it was possible that the women who chose to participate in the focus groups may not have lived in the geographic area in which the group was advertised and held. Consequently, the geographical representativeness of the groups was assessed by demographic data from the written survey, which included a question asking participants for their residential postcode.

4.3.3.2 Component two: data collection and analysis
Recruitment material invited women to take part in a discussion on their reproductive beliefs, experiences and decision-making behaviour, and to complete a demographic survey. Public advertisements, including flyers and colour posters, were displayed in locations such as gyms, libraries and preschools. Advertisements were placed in community newspapers. Letters and flyers were sent to the chief executive officers of a number of local organisations, asking for the information to be distributed to staff members. Finally, women responding to the project advertisements were asked to pass
flyers on to interested friends. See Appendix 4.2.2 for a copy of all the recruitment materials used. The two methods of recruitment found to be most successful included the public advertisements, and word of mouth. There was little or no response using the other methods. Potential participants initiated contact with me, via email or a free-call telephone number, in response to an advertisement. Additional information about the groups was then provided to the potential participants verbally and in writing [see Appendix 4.2.3].

Focus groups are notoriously difficult to organise (Bryman 2001). This is due to recruitment methods usually involving non-direct participant contact, in this case via written advertisement, and the face-to-face method that requires participants to attend a discussion together at a prescribed time and place. Non-attendance and cancellation are common (Bryman 2001: 341 & 349). Consequently, there can be quite a discrepancy between desired and actual sample both in group number and size. A goal of between eight and ten focus groups, each with between four and eight participants was decided upon, based on current academic thinking of the number and size predicted to generate sufficient data saturation for analysis (Finch and Lewis 2003; Bryman 2001; Morse and Richards 2002). The proposed group size was chosen to stimulate discussion and the exploration of issues by the group as a whole, providing breadth through multiple perspectives, while allowing space for each individual to contribute comfortably to the discussion, adding depth through richness of detail (Finch and Lewis 2003: 192-3; Bryman 2001: 341; see also Morse and Richards 2002).

The same recruitment procedure was carried out in both urban and rural areas, producing a successful, although lower than expected, response in urban areas and no responses in rural areas. The impersonal nature of an advertisement may not have been sufficiently engaging to encourage women to give up their valuable time. In retrospect, findings from the research itself offered additional reasons for the recruitment problems, given the feelings of ambivalence expressed by some young women at the prospect of having children and the trend towards later motherhood highlighted by the literature (ABS 2010; Laws et al. 2010). Perhaps many women in the age group studied, under 30, just did not feel it was a relevant topic for them. The research design was adjusted for urban focus group data collection only.

Twenty-four women participated in six focus group discussions and one interview in three different urban areas across New South Wales. The groups varied in size
between two and seven participants, and varied in length between one and a half to two hours. The discussions were audi-taped, with the participants' consent. In half of the groups notes were taken by a second researcher to aid the accuracy of the transcription. The participants were reimbursed $25 to cover any expenses they incurred as a result of taking part in the focus group, such as travel expenses or childcare.

A semi-structured schedule was used to facilitate the group discussions. This included a number of topics and possible questions, such as the participants' childbearing intentions, reproductive experiences, fertility beliefs and perspective on the Australian fertility rate, refer to Appendix 4.2.4 for a copy of the schedule. The method provided breadth of understanding through multiple perspectives and a flexible forum that, as in component one, encouraged participants to introduce unanticipated themes to identify emergent issues relating to the research, enabling the voice of the participants to be heard (Bryman 2001: 338). Not only did this allow unforeseen issues to be discovered but, through their discussion by the group as a whole, also immediately provided a number of opinions on that issue, something that was not possible when a new finding was initiated by commenters or interview participants. Indeed, fellow participants are often able to question the inconsistencies of others in a way that would be inappropriate for the researcher to do (Bryman 2001: 338; Finch and Lewis 2003: 171). The degree of freedom allowed in the discussion also highlighted areas of non-importance to participants. Some issues that I introduced and expected to generate discussion were given cursory notice or ignored completely. It should be noted that the flexible structure can also be a weakness in the method when participants move too far from the topic at hand and unnecessary data is collected. However, I was able to prompt discussion to ensure the main topics of the investigation, as identified through the literature review, were covered.

As expected, while each discussion covered the majority of the issues in the schedule, the emphasis differed between groups, and some groups did not cover all of the questions. In addition, the focus group schedule underwent slight modification as the study progressed, to add relevant topics introduced by participants in previous groups, and alter or replace unsuccessful questions where necessary. To enable this, the audi-tapes from each focus group, with the exception of focus groups held on the same day, were transcribed and subjected to a preliminary analysis prior to conducting the next group. In addition, findings from component one, which was conducted concurrently, informed the ongoing development of the focus group schedule.
I transcribed the tape recording of each group discussion before importing them into the qualitative software program NUD*IST version 6 (QSR 2002). Within the transcript each participant was given a number to enable their ‘story’ to be traced throughout the discussion. This did not correspond with the ID label for the written survey which was anonymous. It was sometimes not possible to identify who was talking in the group discussion, due both to the quality of the tape recording and the nature of group discussions. The women sometimes talked at the same time making it difficult to distinguish between the many voices on the audiotapes. These sections of dialogue were given a generic speaker label. The focus group transcripts were subject to descriptive and thematic analysis. The discussion narratives were read and reread to identify and code themes and patterns within and between the groups. As with component one, the qualitative software provided an electronic storage system in which to build the coding structure, and retrieve the data during analyses. Each of the questions I, or the participants, asked during the discussion were coded in order to compare the variety of responses between groups [see Appendix 4.2.5: Focus group coding structure].

An anonymous written survey was completed by each participant when they arrived at the focus group venue. The survey consisted of seventeen quantitative multiple choice questions on a number of demographic variables and reproductive events, including marital status, educational qualifications and aspirations for children. Twelve of the seventeen multiple choice questions asked in the written survey were exact or modified measures previously used with the ALSWH 1973-78 cohort, which meant that the majority of the questions had been previously validated (see ALSWH 2010; and Lee et al. 2005 for a description of the ALSWH method and derivation of the ALSWH variables). The remaining questions asked for factual demographics: including age, and motherhood, employment and student status: see Appendix 4.2.6 for a copy of the survey and Appendix 4.2.7 for a table detailing the source of the questions asked. The written survey data were entered into an Excel file. As the data were anonymous, each record was labelled with an ID identifying only the focus group the participant attended. The socio-demographic make-up of the focus group participants was then compared to the target population.

At each point of contact participants were reminded that their participation was voluntary. Although the face-to-face nature of a focus group precluded guaranteeing anonymity, at the start of each group session the participants were requested to
respect the confidentiality of the group, and not to divulge the specific content of the discussion to outside parties [see Appendix 4.2.4: Focus group schedule]. No identifying information was included in the typed transcripts of the focus groups and all participants were given pseudonyms for the purpose of confidentiality when reporting the findings. The survey data were anonymous. Participants signed a consent form on their arrival at the venue [see Appendix 4.2.8].

4.3.3.3 Component two: describing the focus group sample
The quantitative data enabled a descriptive profile to be drawn for both individual discussion groups and the focus group sample as a whole. This was necessary as it is recognised that the relatively small focus group sample was unlikely to be representative of young women in general, despite the attempt made to recruit participants from a variety of different backgrounds.

The twenty-four women who participated in the focus groups represented a relatively even spread across the age criterion of 18-30 years old, with an average age of 24 years. All the participants lived in an urban area, creating a geographic bias which, while not part of the sampling criteria, worked alongside it to provide a common demographic profile for the sample. The majority of the focus group participants were unmarried (n=19) and childless (n=19). This profile fits with the general trend towards later marriage and motherhood in present day Australian society (de Vaus et al. 2003; Jain and McDonald 1997; Laws et al. 2010; Weston et al. 2004). Of the five married women who participated four were already mothers and one was currently pregnant. One single mother also participated. The mothers’ ages spanned that of the sample as a whole.

Half of the focus group participants reported having a tertiary education (n=12), including two of the mothers and the pregnant participant. Of these women, four were combining full or part-time study with full or part-time paid work, four were in paid work full-time, three in part-time paid work, and one was a stay-at-home mother. Five women held other qualifications, such as certificates, diplomas or trade qualifications. Of the five, one was a stay-at-home mother, two were combining part-time paid work with part-time study, one studied part-time, while another was in full-time paid employment. Seven women stated that Year 12, the completion of secondary schooling in New South Wales, was their highest qualification. Two were in casual employment while studying full-time, two were in part-time paid work, two were stay-at-home
mothers and one was unemployed. In total nine women were students and eighteen women were in paid employment. Of the women who were not in paid employment, four were mothers, and one was a part-time student. The majority (n=15) found managing on their available income “not too bad” or “easy”, six found it “difficult sometimes” and three found it “difficult all of the time”. A demographic profile of the focus group participants can be found at Appendix 4.2.9.

Evaluation of the quantitative focus group data suggests that women who were married, those with children, those from non-English speaking backgrounds (n=1), school leavers, the unemployed and those who felt economically insecure were not well represented in the groups. The qualitative stance given priority in this research views the rich and detailed life experience data from the discussions as outweighing the potential disadvantage of a non-representative sample (Flick 2006b). In addition, the mixed method research model combined the findings from the focus groups with those from components one and three, which utilised a large national sample.

4.3.3.4 Component two: group dynamic and composition
The focus group method depends on the interaction between the participants to create a true “discussion” of the research topic (Finch and Lewis 2003: 197). The researcher plays a facilitating role in the discussion, helping to balance the group dynamic by encouraging hesitant speakers and managing dominant ones, and by questioning the group consensus. The socio-demographic composition of the group was an important consideration when I arranged the discussions and analysed the transcripts (Finch and Lewis 2003: 190-91; Bryman 2001: 350). It has been found that group discussion works best when participants do not know one another and a certain degree of diversity exists among the participants, while too much difference of opinion can inhibit participants from expressing their accounts (Finch and Lewis 2003: 191-192).

This phenomenon was noticeable in several groups. A university student in a group of young professionals, who was notably younger than the other participants, became an outlier and contributed less to the discussion. In another group, consisting predominantly of idealistic university students, the diversity in educational background among the women created a scenario where the two less academic participants took a back seat in the discussions. A third ‘group’ of two women with similar low socio-economic and educational backgrounds but completely different family situations, one married with children, one single, was very successful with each woman quizzing the
other during the discussion. If a larger number of participants had been recruited it may have been advantageous to stratify the groups based on motherhood status, due to the fact that in two of the three groups where mothers participated they dominated the discussion. This would have served both to create a more balanced environment for participation and to enable the exploration of issues specific to currently having and not having children (Bryman 2001: 343).

A feeling of anonymity, created by a group of strangers, has also been found to be beneficial to the openness of the discussion (Finch and Lewis 2003: 191-192). This was supported by the observation that the two groups of all strangers and the largest group (n=7), which consisted of individuals and women who knew one another, appeared to be the most successful in terms of participants actively interacting with one another and asking one another questions. In the other groups, where often two or more of the participants knew one another, it was more common for interaction to involve affirming comments with discussion directed predominantly at the researcher, more in the style of an interview.

4.3.4 Interaction between components one and two
The use of a combination of qualitative and quantitative methods and data in components one and two facilitated a detailed exploration of the research question at the preliminary stages of the research. The two components were conducted concurrently with preliminary findings from each one informing the other during data collection and analyses. The different methods complemented one another, strengthening potential weaknesses, specifically in relation to breadth and depth. The small localised focus group sample was supported by the large national written comment sample, with the use of the same quantitative demographic measures enabling comparisons to be made between the two. Breadth of data was provided by the large sample of written comments and the multiple perspectives of the focus groups. The opportunity for both me and their fellow participants to question the narratives of focus group attendees, compensated for the isolated snapshots of data provided in the written comments.
4.3.5 Component three: telephone interview and written survey with ALSWH participants

Component three was conducted in 2005 and consisted of a written postal survey and semi-structured telephone interview, employing the ALSWH 1973-78 cohort for the sampling frame. This generated original quantitative and qualitative data for further in-depth exploration of young women’s reproductive decision-making. Existing quantitative data from the ALSWH 1973-78 cohort were also utilised. The findings from the written comment and focus group components informed the rationale for choice of method, measures, sampling frame, and focus of enquiry for this final component in a traditional sequential research design format, as illustrated in the research model at Figure 4.1.

The design of component three had a number of stages. Existing quantitative data from the 1973-78 cohort were used to draw a sample of women based on specific selection criteria (see Table 4.1). These women were sent a written mostly quantitative survey inviting them to participate. This survey confirmed selection criteria and collected additional demographic and reproductive data. To see copies of the invitation letter and the whole written survey refer to Appendices 4.3.1 and 4.3.2, respectively. Interested eligible participants were then interviewed by telephone using a qualitative semi-structured schedule, consisting of open-ended questions about their plans and beliefs in relation to motherhood, such as if and when they wanted to have children. A copy of the interview schedule and consent form can be found at Appendices 4.3.3 and 4.3.4. After data collection was complete, new and existing quantitative data were analysed to describe the interview sample and compare it with the wider ALSWH 1973-78 cohort, the findings of which are tabulated in Appendix 4.3.6.

4.3.5.1 Component three: the sample

Conclusions drawn from components one and two determined that a more detailed sampling criteria for the interview component than employed in the first two components would enable a deeper more focussed investigation of the research question, while still retaining the ability to compare findings across the three components. This included: retaining the requirement of an all female sample, concentrating the age specifications and determining a limit on their geographic, partner and motherhood statuses to urban, partnered, childless women.
The participant sample for the interview component was drawn from the ALSWH 1973-78 cohort. Utilising an existing sampling frame had a number of advantages. ALSWH has a national sample which, as discussed above, has been found to be broadly representative of the Australian population (Brown et al. 1999), increasing the potential socio-economic diversity of the component sample. As existing project participants, the 1973-78 cohort had already volunteered their contact details to the ALSWH researchers, and had agreed to be contacted in relation both to the main ALSWH project and to participate in additional smaller projects conducted through ALSWH, such as this one. Although it should be stated that it was made clear that participation in this project was voluntary and non-participation would not affect the woman’s continued involvement with the ALSWH.

Component three: sampling criteria
The ALSWH 1973-78 cohort fulfilled both the gender and age criteria of this research, being women aged in their mid-childbearing years, 27-32, in 2005. The narrower age range was at the upper end of the sampling frame used for components one and two (18-30 years). This criterion was chosen in response to the findings that younger women were less likely to discuss reproductive decision-making, in the case of the written commenters at ALSWH Survey 1 (18-23 years), or were more likely to express ambivalence about childbearing, specifically because they believed it to be so far in the future for them, as a number of the younger focus group attendees did. The literature supported the relevance of this age criterion in relation to questions about potential motherhood. The years 27-32 incorporated the national median maternal age at the time (2005) of 30.7 years, the age at which a woman’s fertility has been found to start declining, 27 years (Dunson et al. 2002) and the beginning of the most prolific childbearing population cohort, 30-34 years (ABS 2006a).

The longitudinal study design of the ALSWH meant that existing quantitative data from previous surveys could be used to select a purposive sample to be invited to participate in the interview component. Data gathered from the ALSWH 1973-78 cohort at Survey 3 (2003) were used by the ALSWH data manager to draw the interview sample which meant that eligible participants had to have completed ALSWH Survey 3 to be considered. The criteria included women who: had not had children, were not currently pregnant, were married or living in a de facto relationship, and were living in an urban area, as illustrated in Table 4.1. The sample was split by married and de facto status.
Those women who had experienced the death of a child were specifically excluded as it was decided that questions regarding reproductive decision-making could be distressing for this group of women. Those participants who had not provided ALSWH with a contact telephone number were excluded from the sampling frame, due to the nature of the research method necessitating access to a telephone for the interview.

These criteria were chosen for the purpose of investigating women’s views on their future plans for motherhood, and the trend towards delayed motherhood (ABS 2010; Laws et al. 2010). The question of delayed childbearing was hypothetical for those women who were already mothers. The childless criterion was also in keeping with the status of three-quarters of the focus group participants (n=18). The literature has found that having a partner impacts both aspirations for and actually having children (Berrington 2004; Weston et al. 2004). This is supported by findings from components one and two, where women without partners expressed difficulty in discussing their childbearing plans due to the hypothetical question of if and when they would meet someone to have children with. While not having a partner is a reason for delayed childbearing it was not the focus of this research. The urban criterion focussed the sample and was consistent with the demographic framework established in components one and two. Women living in urban areas have also been found to be more likely to aspire to and have fewer children than their rural and remote counterparts (Bryson 2001; de Vaus 2002a; Johnstone and Lee 2009; Read et al. 2007; Summers 2003a; Warner-Smith and Imbruglia 2001; Warner-Smith and Lee 2001).
Table 4.1: Component three: telephone interview sampling criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Data source</th>
<th>Question</th>
<th>Description</th>
<th>Required response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q82d and e</td>
<td>Life events: birth of children</td>
<td>did not answer yes to “given birth” either “last 12 months” or “more than 12 months ago”</td>
</tr>
<tr>
<td>Women without children</td>
<td></td>
<td>Q82p</td>
<td>Life events: death of a child</td>
<td>did not answer yes to “death of a child”: “last 12 months” or “more than 12 months ago”</td>
</tr>
<tr>
<td>Exclusion of those who have experienced death of a child</td>
<td></td>
<td>Q94</td>
<td>Marital status</td>
<td>“married” or “de facto”</td>
</tr>
<tr>
<td>Partnered women (married or living with a partner)</td>
<td></td>
<td>Q107a</td>
<td>Residential postcode</td>
<td>urban postcode (Capital city/large metropolitan) calculated using RRMA code or equivalent</td>
</tr>
<tr>
<td>Urban dwelling women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone contact details</td>
<td>ALSWH participant contact details database</td>
<td></td>
<td></td>
<td>telephone number present in home, work or mobile number fields</td>
</tr>
</tbody>
</table>

Component three: sample size
Two hundred women who fulfilled the selection criteria at ALSWH Survey 3 were invited to participate in component three. This sampling frame was anticipated to generate a final sample of approximately fifty interviewees, allowing for some women being ineligible to, uninterested in, or unable to take part, or being non-contactable.

The rationale for this sample size was based on the qualitative nature of the research, with fifty interviews providing a manageable number of in-depth interviews while at the same time allowing for saturation of research themes. The estimated response rate was based on previous qualitative studies conducted with the ALSWH 1973-78 cohort (Helman et al. 2007). While age and gender were predetermined by the sampling frame, the motherhood, partner and urban residence criteria were confirmed in the written survey prior to the conduct of the interview, as women's circumstances could have changed in the two years since the Survey 3 data were collected [see Appendix 4.3.2: Telephone interview written survey].
Fifty eligible women formed the final sample for component three. This resulted in a response rate of 25% of the overall invited sample of two hundred women. Over half of the invited sampling frame were found to be ineligible to participate. One hundred and seven women (54%) had become mothers, were currently pregnant and/or had separated from their partner since they provided their ALSWH Survey 3 data that was used to draw the sample. No women, however, had moved to a rural area. A further seven women were discovered to be travelling overseas or within Australia for a prolonged period of time preventing them from participating in the research due to lack of postal or telephone contact details. This left an ‘intention to treat’ sample of eighty-six eligible and non-contactable women (43%) of whom: fifty women participated in both the survey and the interview (58%), an additional sixteen women completed only the written survey (19%), ten women declined the invitation (12%) and ten women were unable to be contacted (12%). This gave a final response rate of 58% (N=50) of those who were eligible or non-contactable. See Appendix 4.3.5 for detailed response rates.

4.3.5.2 Component three: data collection
Participants for component three were recruited via written invitation and a follow up telephone call. The mailed invitation package included a letter of invitation, an information sheet, the written survey with attached consent form, and a reply paid envelope; refer to Appendices 4.3.1 and 4.3.2 for copies of these documents. To allow for unexpectedly high or low response rates, a staggered mailout system was employed over a five week period, the first two mailouts were sent to fifty women, the last to one hundred women. As the surveys were returned the woman’s eligibility to participate in the telephone interview was recorded, as determined by the first three questions in the survey which asked for the women’s motherhood, pregnancy and partner status [see Appendix 4.3.2: Telephone interview written survey]. A follow up telephone call was made to all eligible and non-respondent participants. This served two purposes: to establish the eligible women’s interest in taking part in the telephone interview component and, if interested, to schedule a convenient time for the interview, and as a reminder for non-respondents to return their survey. During the telephone call the latter group were also asked whether they were eligible to participate in the study. New packages were mailed as necessary. In accordance with ethical guidelines, up to five attempts were made to contact each participant by telephone before they were classified as non-contactable [see Appendix 4.3.3: Telephone interview invitation follow up telephone call].
The written survey included self-report questions, in predominantly multiple choice format, on both demographic and reproductive variables, including marital status, educational qualifications, contraceptive use, number of abortions and miscarriages experienced, and aspirations for children [see Appendix 4.3.2]. The survey was developed in accordance with the style and content of the surveys which ALSWH participants have previously received as part of the main study. Eighteen of the twenty-four questions asked were exact or modified versions of questions that had already been asked in ALSWH surveys and thus had been validated with a large national sample (see ALSWH 2010; and Lee et al. 2005 for a description of the ALSWH method and derivation of the ALSWH variables). The remaining questions included relationship length and knowledge and use of fertility treatment: see Appendix 4.3.2 for a copy of the survey and Appendix 4.2.7 for a table detailing the source of the questions asked. The quantitative data gathered through the written survey performed a number of functions. They confirmed specific selection criteria for component three. They enabled the socio-demographic background of the participants to be analysed, providing context for the qualitative data, and enabling the findings to be generalised to that particular section of the population. The survey was completed prior to the interview which meant that the quantitative data could be used to identify the appropriate interview schedule based on whether or not the participant aspired to have children.

The interviews were tape recorded with the participants’ permission and lasted between 35 minutes and one hour. Verbal consent to participate was obtained at the beginning of each interview. A semi-structured interview schedule was used to conduct the interviews [see Appendix 4.3.4]. The schedule listed a number of topics and possible questions, including: plans and aspirations for motherhood and paid work; potential influences on reproductive decision-making; beliefs about maternal age; perceptions of reproductive choice; fertility, both management and age-related potential; views on reproductive technology; and thoughts on the Australian fertility rate. It was anticipated that each interview would cover the majority of the issues from the schedule, although the emphasis would differ between interviews and some interviews would not cover all of the questions, depending on participant responses. The semi-structured nature of the interviews enabled participants to initiate issues related to the research questions that I may not have anticipated. The schedule was formulated in response to the findings from the written comment and focus group components and the literature. As the interview component progressed the schedule
was reviewed and revised in response to the developing findings from the participant narratives.

The telephone method of interviewing participants had a number of benefits, combining the opportunity for richness of data offered by the interview method (Ezzy 2002; Morse and Richards 2002) with the time and cost convenience for both me and the participants. In addition, a telephone interview enabled the participants to be drawn from a national, as opposed to state based or local, population sample. The geographical breadth offered by the national sampling frame is unusual in qualitative research, and greatly enlarged the scope of the research findings through the increased potential to generalise to the wider population. The telephone method creates obvious distance between the researcher and the researched. This can have a positive or negative impact. On the one hand, it may limit the ability for the researcher to establish a rapport with the participant, while on the other hand some participants may be more open as a consequence of the feeling of anonymity not being face-to-face provides.

Care was taken to uphold ethical research practice and ensure the confidentiality of participants. The voluntary nature of the women’s participation in the research was stated in the invitation letter, written survey, follow-up telephone call and at the start of the interview [see Appendices 4.3.1, 4.3.2, 4.3.3 and 4.3.4]. Participant consent was obtained both through a signed consent form in the written survey and through verbal consent secured on the tape recording at the start of each interview.

Only the electronic survey and telephone logs and paper consent forms included personally identifiable data. The electronic files were password protected and the consent forms and interview tapes were kept in separate locked filing cabinets. Once the outcome of the written survey was logged in the electronic database, the consent form was removed from the survey and stored in a locked cabinet separate from the survey responses. Any identifying details such as names or places that the participants may have added to their written survey were concealed.

No identifying information, such as names, addresses, or potentially identifying details such as specific place names, were included in the typed interview transcripts. Nor did the written survey contain personally identifying details. An ID number enabled the written survey and interview transcript to be linked. Only the ALSWH data manager had access to the information that linked the participants’ identity to their data. She was not,
however, in possession of the data. The audiotapes were wiped at the end of the research project. Pseudonyms were used for all participants.

It was felt that the conduct of a telephone interview allowed participants the security and privacy of completing the interview in familiar surroundings of their own choice. It was recognised that interviewees could become upset when talking about their reproductive experiences; participants were warned of this possibility prior to the interview. In this event participants were given the contact number of the support service Lifeline. This was also provided in the written survey. Participants were also made aware of the fact that they could skip any questions they did not want to answer and were free to take a break from or terminate the interview whenever they wished. One participant became upset during the conduct of the telephone interview. She was given the option of stopping the interview, taking a break and offered the freecall number of Lifeline, all of which she declined. She explained that she wanted to complete the interview as it was important to her. There was also the potential for participants to feel benefit from discussing their reproductive experiences or fertility choices in a forum where the results of their discussion would be used to produce scholarly publications with the potential to be passed on to policy makers.

4.3.5.3 Component three: data analysis
The information the interview sample group provided in the written surveys formed a further layer of the sampling process, with the first three questions assessing their eligibility based on their partner, motherhood and pregnancy status. If they were ineligible due to any of these reasons they were not required to complete the remainder of the survey. The eligible survey data were double entered into a purpose built Access database with each variable being assigned a numeric value. The two tables of data were then saved in text file format and verified using comparison software (Scooter Software 2006; Grig Software 2005). This highlighted any anomalies in data entry, which were then checked against the hard copy completed survey, resulting in the correct survey response being upheld. Each data record was identified by an ID number only. The coded quantitative survey data were imported into a statistical software program (SAS) with the assistance of a statistician in order to produce descriptive aggregate data for the interview sample. These demographic and reproductive survey data were analysed descriptively to investigate the research question. This occurred independently, with different quantitative variables being compared against one another, for example, the participants’ quantitative response to
the “aspirations for children” question and their age or highest educational qualification, and also in connection with their interview narratives, as described below. The interviewees’ quantitative survey data, alongside their existing aggregate data from the ALSWH, also facilitated a descriptive socio-demographic profile of the women in the interview component. This profile established the potential to generalise the findings that were generated from both the quantitative and qualitative data to that specific sector of the population [see Appendix 4.3.6: Telephone interview demographic profile].

Following an integrated approach, analysis of the interview data began while data collection was still underway (Ezzy 2002). Interpretation of the participant’s responses during the interview shaped the course of the questions I asked, for example, in regard to whether or not they wanted to have children and any unexpected topics that the women introduced. Notes that I made during the interview and transcription process informed the interview schedule used for the remaining interviews and assisted in my interpretation of the overall findings. The interviews were transcribed shortly after they were conducted and a brief memo was written for each one in order to record any initial themes and findings that developed while they were still fresh in my mind. I transcribed the interview audiotapes into an electronic format and imported the files into a qualitative software program, NUD*IST version 6 (QSR 2002). Each interview file was identified by an ID number, which corresponded with the quantitative survey data, and labelled with an interview number between one and fifty. Each interviewee was assigned a pseudonym.

Once transcribed, the interview narratives were read and reread to identify common patterns and themes in the data which were coded descriptively and thematically with the assistance of the qualitative software program (QSR 2002). As with components one and two, the software program was used as an electronic filing cabinet that enabled me to assign coding labels, known as “nodes”, to sections of the interview narratives, enabling easy retrieval and comparison of the data. An “open” exploratory approach to coding was employed to investigate meaning within the data, with themes being grouped under broader categories, broken down into subcategories, and renamed as part of the analysis process (Ezzy 2002). As the analyses progressed the narratives were also searched for key words, and data coded at different “nodes” were compared. This was part of what Ezzy (2002: 91) terms “axial” coding with additional nodes being developed around “the axes of central categories”. A careful balance between “open” and “axial” coding was required, with axial coding being delayed until later in the analyses, to facilitate an in-depth understanding of the findings without...
losing the significance attributed to the information by the participant themselves. A complex coding structure developed which was reviewed continually throughout the research process with nodes being created, compared and merged [see Appendix 4.3.7: Telephone interview coding structure].

The qualitative interview data were analysed alongside the quantitative survey data, enabling an integrated approach that provided a detailed picture of each participant’s reproductive decision-making and consequently of the research question. In some instances, questions had been asked of the participants using both the quantitative and qualitative methods, facilitating a comparison of the findings and a deeper understanding of the research question. A similar process was employed with regard to the comparison between findings from component three and components one and two, where similarities and differences in the reproductive decision-making of the three samples were identified and explored.

4.3.5.4 Component three: describing the telephone interview sample
Two sources of quantitative survey data were utilised to build a demographic profile of the interview sample. Existing aggregate data from Survey 3 (2003) of the ALSWH 1973-78 cohort enabled a comparison between the final interviewee sample of fifty women, the invited sample of two hundred, those ALSWH cohort participants who fulfilled the eligibility criteria of being partnered, childless, urban residents, but who were not sent an invitation to participate (n=1,720), and the ALSWH 1973-78 cohort as a whole (N=9,081). The latter main cohort has largely been found to be characteristic of young Australian women in general (Brown et al. 1999), creating the potential for the demographic comparison to be extended in theory to the wider population. The findings from this comparison are described below and presented in Appendix 4.3.6.

The written survey data the interviewees provided as part of my research gave a descriptive profile of the young women at the time they were interviewed in 2005. These data also enabled a further layer of comparison with the main ALSWH 1973-78 cohort, and ‘eligible’ subgroups. This was facilitated by my survey questions being exact or modified versions of the ALSWH survey questions. However, these data (2005) were gathered two years after the ALSWH Survey 3 data (2003) so a true comparison was not possible as the circumstances of the non participating women may have changed during this time.
A descriptive analysis of the aggregate data from ALSWH Survey 3 and the written survey completed by the interviewees revealed a number of similarities and differences between the interviewees, other eligible women and the main 1973-78 cohort [see Appendix 4.3.6]. In 2003, the interviewees were more educated and managed better on their available income, were more likely to live with only their partner and were less likely to speak a language other than English at home than the main 1973-78 cohort. The differences echo the slight diversity found between the ALSWH 1973-78 cohort and the 1996 census (Brown et al. 1999), and also young women’s attrition rates in the ALSWH (Powers and Loxton 2010; Young et al. 2006), suggesting that the women who were interviewed represented a more concentrated version of the main cohort in regard to these variables.

At ALSWH Survey 3 (2003) the interviewees were more likely to have a higher degree than both the main 1973-78 cohort and other eligible women from the cohort. In keeping with their more educated status the interviewees, and other eligible women from the 1973-78 cohort, were more likely to be in paid work than the main cohort as a whole, and more likely to be working in a professional or managerial position. At the time of the interviews, in 2005, all of the interviewees were in paid employment, with a third also studying. Several interviewees gained higher qualifications between 2003 and 2005, resulting in three-quarters of the interviewees having a tertiary education when they participated in the research for this thesis.

Around a third of the interviewees and other eligible women at Survey 3 found managing on their available income “easy” in comparison to a fifth of the main cohort. This finding was supported by the interviewees and other eligible women being less likely to have a health care card, the possession of which is often an indicator of lower socio-economic status (Charles et al. 2003). The self-rated general health of the different groups of women was similar in 2003 and continued to be so for the interviewees in 2005, with two-thirds of the interviewees rating their health as “very good” or “excellent” at the time of the interviews.

The selection criteria for component three influenced the demographic profile of the sample. The childless criterion meant that no interviewee, or eligible woman, had children, unlike a third of the main cohort. Similarly, geographic criteria determined that all the interviewees, and eligible women, lived in an urban area whereas over a third of the main cohort lived in rural or remote locations in Australia. The partner criterion requiring interviewees to be married or living in a de facto relationship meant that none
of the interviewees were “never married”, unlike a third of the main cohort. At ALSWH Survey 3 the interviewees, and those unselected eligible women from the cohort, were found to be more likely to be living in a de facto relationship, and less likely to be married than the main cohort. Interestingly, in the interim between ALSWH Survey 3 (2003) and my research (2005) a third of the interviewees had married, meaning that at the time of the interviews the interviewees were more likely to be married, two-thirds, than living in a de facto relationship, a third. This life event may also have been happening for the women in the main cohort during this time period. The interviewee sample represented a cross-section of the age range within the main cohort of 25-30 years in 2003, and 27-32 years in 2005.

The partner status criterion determined that the interviewees and other eligible women were more likely to be living only with a partner in 2003. By 2005 all of the interviewees were living only with their partner or husband. While the research was open to women in relationships with partners of the same or the opposite sex, none of the interviewees reported being in a same-sex relationship, although, as found in the 1973-78 cohort as a whole, ten percent of the interviewees identified as “other” than “exclusively heterosexual” at ALSWH Survey 3 (2003). In association with their childless status, in 2003, fewer interviewees had tried to conceive, and therefore they were less likely to report having experienced a miscarriage or fertility problems, and more likely to be using contraception, than the main 1973-78 cohort. There was a marked difference in this statistic by 2005, however, with a quarter of the interviewees reporting that they were trying to conceive, creating a bias presumably due to their childless but partnered status. A similar percentage of women across the different eligibility and selection groups, however, had terminated a pregnancy.

In 2003, the interviewees, and other eligible women, held almost identical aspirations for marriage, paid employment and further qualifications by the age of 35 as did the main 1973-78 cohort, preferring to be married, in full or part-time paid employment and to have more qualifications. However, possibly influenced by their childless status, the interviewees were more likely to aspire to have only one child and less likely to aspire to have three or more children at age 35 than the main cohort. This difference was more pronounced in the interviewees’ 2005 responses, although the main cohort may also have changed their preferences during this time period. These aspirations are the subject of detailed enquiry throughout the remainder of this thesis.
4.3.6 A description of the collective participant sample and presentation of the data

The descriptive quantitative data from the three research components demonstrate that each group of women had slightly different demographic profiles. While each group shared their urban residence and a similar age bracket, component one were more likely to be married mothers who were out of the paid workforce and less able to manage on their available income, while components two and three were more likely or, in the case of the interviewees, all childless women in the paid workforce who were more educated and better able to manage on their income. The women in component three were also all partnered unlike those in component two, and more like those women in component one. The findings from each group of women are discussed in each of the empirical chapters, however, given the weighting applied to the different components, more emphasis is given to the information shared by the women in component three, the interviewees, in the exploration of the research question.

Therefore, the sector of society for whom the results from this thesis speak most meaningfully are urban women around the age of 30 who are partnered and childless, tertiary educated, in paid employment and better off financially. These characteristics, with the exception of being partnered, have been found to be associated with delayed childbearing, and lower aspirations, expectations and outcomes for children (ABS 2008; Berrington 2004; Bryson 2001; de Vaus 2002a; Franklin and Tueno 2004; Johnstone and Lee 2009; Lee and Gramotnev 2006b; Mackinnon 1997; Quesnel-Vallée and Morgan 2003; Read et al. 2007; Romeu Gordo 2009; Summers 2003a; Warner-Smith and Imbruglia 2001; Warner-Smith and Lee 2001; Weston et al. 2004). As discussed in Chapter 2, these are all factors which contribute to a reduced total fertility rate (TFR) (Costello 2002a; Kippen 2004; 2006). The motherhood plans of this group of women are, therefore, of great significance to the questions asked in this thesis in regard to whether and when young Australian women want to have children.

Qualitative data from the research are presented in both number and quote form. The former are represented by either a ‘c’ for component one or an ‘i’ for component three, to denote the number of written commenters or interviewees, respectively, who discussed a particular theme or item, or shared a specific point of view. The use of ‘c’ or ‘i’ indicates that the finding was based on analysis of the qualitative comment or interview narrative data, as opposed to the quantitative written survey data. The focus group qualitative data were not ‘counted’ in this way. Quotes from component one, the written comments, include the survey number from which the comment came and the
participant’s age. Quotes from component two, the focus groups, include a number identifying the group the speaker participated in, along with a pseudonym and their age. Quotes from component three, the interviews, include a pseudonym, and the interviewee’s age and aspiration for children. The quantitative findings are presented in numerical form for each research component with ‘n’ indicating the number of participants who responded in a particular way in their written survey. For both qualitative and quantitative data the use of a capital letter refers to the whole sample while lower case indicates a sub-sample.

4.4 Methodological reflection

4.4.1 Why mixed methods?

_We have to face the fact that numbers and words are both needed if we are to understand the world_ (Miles and Huberman 1994: 40).

A mixed method design was chosen to match the complexity of the research question (Kellehear 1993: viii; see also Creswell et al. 2003: 211; Morse 2003: 189; Tashakkori and Teddlie 2003). Combining qualitative and quantitative methods is increasingly being chosen by researchers as the most appropriate means of studying society (Miles and Huberman 1994: 40; Oakley 2000). This approach is believed to compensate for the limitations inherent within the different methodologies by combining the benefits of each within a single research project (Creswell et al. 2003; Smyth 2006). Mixed method research is, therefore, seen to provide methodological findings which can support, complement or contradict one another (Flick 2006a; Tashakkori and Teddlie 2003: 16), and that have the potential to provide both depth and breadth, richness and generality (Miles and Huberman 1994: 41). Ezzy argues that all research, even that which is primarily inductive in scope, is theory driven, resulting in a combined inductive and deductive approach (2002: 10; see also Oakley 2000). This highlights the benefit of a mixed method approach, and underpins the importance of both the inductive qualitative and deductive quantitative components of the research.

The mixed method approach was, therefore, perceived to offer the tools that could best explore young women’s reproductive decision-making on a personal level in such a way that would enable transference of meaning to a wider population (Morse 2003: 189). An inductive interpretivist stance investigated the social meanings and processes
behind the current fertility rate statistics. Deductive reasoning, informed by the literature and findings from the research as it progressed, formed the basis of purposive sampling, facilitating a more focussed enquiry, while the descriptive profiles of the samples, generated by the quantitative data, provided the potential to generalise the findings.

Young women’s reproductive decision-making was explored using an integrated and interactive three-component design, with each component subject to both qualitative and quantitative methods of enquiry.

### 4.4.2 Why qualitative priority?

*Qualitative social scientists have strong reservations about imposing a pre-structured theory onto the world. Human beings are not physical objects but, rather, conscious, decision-making and often irrational beings* (Kellehear 1993: 26-27).

*Qualitative research, and qualitative data analysis, involves working out how the things that people do make sense from their perspective* (Ezzy 2002: xii).

The use of a dominant qualitative methodology with which to *drive* the study encouraged both methodological congruence within the research, and a close fit between method and research question (Morse 2003; Maxwell and Loomis 2003: 253). Qualitative methodology can ground quantitative data by exploring the social context of the research question and providing the tools to investigate the meanings behind the statistical findings that can be lost in a quantitative approach (Kellehear 1993: 57). Following Maxwell and Loomis’ (2003) stance, the qualitative and quantitative methodologies in my research support and complement one another within the research design while retaining their essential differences, converging at data collection, analysis and interpretation of findings.

The participant-centered nature of the qualitative method (Snape and Spencer 2003: 4) was an important factor in determining the dominant methodological drive for my research. The purpose of my research was to gain an understanding of women’s reproductive decision-making processes from their own perspective and in their own words. In keeping with the participant focus, the research design implemented methods
likely to promote equity within the participant-researcher relationship, or utilised data that had been gathered in this way, as espoused by a feminist stance (Snape and Spencer 2003: 9; Oakley 2000). These qualitative methods, including the open-ended written comment question, and the semi-structured focus group discussions and telephone interviews, were chosen as methods which enabled the participant ‘voice’ to resonate. Each was structured to facilitate the participants’ ability to introduce issues and topics of importance to them personally with regard to the research question, thus going some way to temper the dominance of the researcher in the research process. Allowing the ‘voice’ of the participant centre stage in the research process maintained the feminist approach to the investigation.

Feminist research advocates that there is no one way of knowing and, consequently, that there are multiple realities (Ezzy 2002: 22-23). This ontological belief is supported by the qualitative tradition, and interpretive approach (Snape and Spencer 2003) and facilitated by a mixed method design where each method was treated as producing equally valid results (Meetoo and Temple 2003: 17). A mixed method design facilitates this approach by producing multiple perspectives that mirror social reality to create an overall picture of the research topic (Flick 2006a: 37; Morse and Chung 2003: 1). In contrast, quantitative methodology usually places importance on a single “truth” (Denzin and Lincoln 2005b; Tashakkori and Teddlie 2003).

Combining approaches from such opposing philosophical fields has, consequently, caused much debate on the compatibility of qualitative and quantitative methodology, questioning whether it is possible, or even desirable, to reconcile such conflicting methodologies, and how to cope with the potentially contradictory findings generated by the various methods and techniques employed (Flick 2006b). These questions exist from both a quantitative and qualitative viewpoint and occur at all stages of the research where the two methods are integrated, posing particular questions in relation to assessing the validity of the study. Triangulation originated as a means of assessing the validity of findings, with the results from each method required to complement one another, supporting an ontological quantitative belief in a single reality. It has become more common, however, to view triangulation as a way of utilising multiple methods to provide a rich and “complete”, but not necessarily complementary, picture (Flick 2006b: 390), supporting an ontological framework of multiple ways of experiencing the world (Denzin and Lincoln 2005a: 6). For many researchers, diversity of findings is not an unexpected outcome as they recognise participants may answer questions on the same topic differently depending on the method used, the social context (Morse 2003: 197).
206; Meetoo and Temple 2003), and their mood on that day. Regardless of philosophical stance, contradictory findings need to be carefully examined to explore why they have occurred and how they can be further interpreted to complement rather than contradict one another.

Employing a mixed method design for my research supported the ontological belief that there is more than one way of understanding the world and meant that each method was treated as producing equally valid results (Meetoo and Temple 2003). The inductive drive central to the study, meant that the research was designed to enable findings from the different qualitative and quantitative methods to be compared, and similarities, differences and contradictions between them discussed. These principles made the qualitative methodological approach the most appropriate lens through which to explore the research question, studying human perceptions, choices, and experiences relating to reproductive decision-making from the viewpoint of a complex social world and numerous perspectives (Snape and Spencer 2003: 7).

The richness of the findings was achieved through the interaction between the qualitative and quantitative methodologies, methodological triangulation, which occurred at the data collection, analysis and interpretation phases of the research. During analysis and interpretation, points of quantitative enquiry, such as demographic factors gleaned using closed survey questions, were also explored in the narratives produced using the qualitative methods. The reverse was also true, with interpretation of the qualitative data expanded through additional investigation with the quantitative data. For example, the association between marriage and reproductive decision-making was explored by marital status, a quantitative finding, and by plans for children, a qualitative finding. This approach, of moving back and forth between the different methods and recognising the validity of each, provided a rich understanding of the research question.

4.4.3 A quantitative balance
The mixed method design justified the inclusion of quantitative methods alongside a qualitative drive, which sought to understand how young women experience reproductive decision-making. Quantitative methods offered the benefit of deductive sampling, and fundamentally, the potential to generalise the research findings (Denzin and Lincoln 2005b; Tashakkori and Teddlie 2003).
Quantitative methods enabled purposive sampling to be implemented for component three, the telephone interviews. Deductive selective sampling techniques were employed, utilising both existing and new quantitative survey data, to ensure participants satisfied a number of demographic criteria which had been identified during the literature review phase as having the potential to influence reproductive decision-making behaviour (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004). A greater degree of generalisability is a strength of quantitative methods, which can provide data describing who the sample are and enabling them to be compared to the wider population, thus increasing the scope of the research (Denzin and Lincoln 2005b; Tashakkori and Teddlie 2003). This is problematic within qualitative studies, where sample sizes are often small and findings are, by design, context specific.

The quantitative data utilised for, and generated by, my research provided demographic profiles for both the individual participants and the three component samples. These data were key to the research, and central to the mixed method approach, through the mutually supportive benefits of situating the individual narratives, exploring whether the participants' place in society impacted on their reproductive decision-making, while also providing the potential to generalise the findings to specific sectors of the wider population. The contextualisation was an important part of the qualitative approach underpinning the research, while the generalisability of findings is more common in quantitative studies. This illustrates the close working relationship between qualitative and quantitative methods and methodologies in the research. The ability to generalise the findings was enhanced by nesting the research within the ALSWH and both utilising existing qualitative and quantitative data, and drawing my interview sample from within a large national cohort that has been found to be broadly representative of their counterparts in society (Brown et al. 1999). These quantitative demographic data provided a context for the interpretation of the qualitative and quantitative data.

4.5 Conclusion
The research design and methodological stance that were chosen reflect the requirement of the research question based on existing literature for mixed methods to illuminate the decision-making process of a group of young women whose decisions were of theoretical and political interest, as well as to contribute to literature which is frequently quantitative in nature. The interpretive pragmatic methodological approach to the research facilitated a flexible, interactive design that developed as the research
progressed, particularly in relation to focussing the sampling frame. The demographic profile for the research participants as a whole group, incorporating all three components, was one of educated urban women in their 20s and early 30s, and, in the case of the majority of the focus group participants and all of the interviewees, who did not have children.

The sample was determined by design, opportunity, and as part of the interactive research process. It was facilitated by the mixed method design which enabled a dual deductive and inductive approach to the sampling frame and combined qualitative and quantitative methods and data. The literature informed the initial design, particularly with regard to age, focussing the study to women in the first half of their childbearing years. Nesting components one and three within the *Australian Longitudinal Study on Women’s Health* (ALSWH) prescribed certain characteristics, specifically gender and age, while also providing scope for further analytic criteria. Recruitment difficulties in component two resulted in the decision to restrict the research to urban dwelling women across all three components. This decision was supported by the literature that has found an association between rurality and both reproductive decision-making and outcomes, which made a geographically focussed enquiry appropriate. The literature also substantiated the conclusion from components one and two that in order to best explore the trend towards delayed childbearing the third, and main, component, the telephone interviews, should concentrate solely on childless women who had a partner and were aged in their late 20s and early 30s. The interview sample represented the most focussed level of enquiry in regard to the comparative population.

The mixed method research design driven by qualitative theoretical concerns has produced empirical accounts which combine both quantitative and qualitative data from all three components. This approach fits within the broadly feminist framework of the research and of the ALSWH, as the method is tailored to the issue at hand and uses multiple methodological resources (Oakley 2000; Ezzy 2002; Miles and Huberman 1994). The design generated data that provides both breadth and depth in understanding the point of view of these young women, contributing richness of detail from the qualitative data and a greater confidence that the findings can be generalised than is found in purely qualitative studies.
The following five empirical chapters each draw on the qualitative and quantitative findings from all three research components in a detailed exploration of young women’s reproductive decision-making. The findings answer calls in the literature for further explication of the ideology of motherhood in the context of young women’s choices about if and when to have children. An examination of women’s timing narratives for childbearing offers particular insight into the trend toward delayed motherhood.
Chapter 5: Preconceptions of motherhood

Motherhood is undergoing a paradigm shift with new work patterns. In practice it is shifting away from a model that placed the woman/mother at the centre of the domestic sphere. Now, mothers sit on unstable terrain. What should they be? What are they? The fact that there are so many ways, now, to be a mother has made society uncertain about mothers, and a profound anxiety frequently attaches to the business of being a mother. This anxiety is expressed through criticism (and self-criticism) of many forms of mothering and mother's decisions - even where these decisions are clearly household and community decisions, with partners, employers, government all ghosts at the table effectively shaping outcomes (Pocock 2003: 250).

5.1 Introduction

This chapter explores the question of motherhood on both a national and individual level, investigating the social and cultural context in which young Australian women make their reproductive decisions. It begins by situating the participants and arguably, given the demographic profile of the sample, young educated urban Australian women in general, within the national fertility debate. The women’s views of, and stance on, the declining fertility rate and related government concerns are examined. In general the participants were not concerned about the fertility rate; some were even unaware there were concerns about it.

The contextualising discussion is followed by an in-depth study of the participants’ preconceptions of motherhood as a construct and identity. The factors which appear to influence women’s desires and doubts about having children and becoming a mother are examined, with particular attention given to the traditional and modern ideologies of motherhood that often co-existed and conflicted with one another in the women’s narratives. These ideologies were influenced by what the women felt Australian society today expected of women their age in regard to motherhood and other roles, such as paid employment.

The chapter presents findings from all three research components, although the investigation of motherhood as an identity concentrates predominantly on the interview narratives rather than the survey comments and focus group data. While motherhood is
the central focus of the thesis, and all the participants were female, the findings sometimes focus on the needs of children and therefore relate to parenthood in general.

5.2 “I see pregnant women everywhere”

Perspectives on the fertility debate were mainly provided by the focus group and interview participants as opposed to the commenters, due to both the timing and method of each component. Data collection for the focus groups and interviews occurred during or after some key public events in the Australian fertility debate. Firstly, the publication of the Liberal Party’s *Intergenerational Report* (Costello 2002a), highlighted the government focus on fertility and the possible implications of a decline. This received considerable media attention, particularly in relation to remarks by the then Treasurer, Peter Costello, that the fertility rate would improve if women had three children each, including “one for the country” (Summers 2004). Secondly, the focus groups were conducted during the implementation of the maternity payment in July 2004, also referred to as the “baby bonus”, while the interviews occurred after this time. Media discussion again accompanied this government benefit which provided parents with a non-means tested payment for each new child. In 2004 the amount was a lump sum of $3,000. This has risen incrementally each year, reaching $5,185 in 2009 when a generous means test was added and it changed to a series of thirteen fortnightly payments. The policy is generally viewed as being pro-natalist (Heard 2006).

Both the focus group and interview participants noted the focus on childbearing and fertility in the media. In contrast, any mention of population or the fertility rate by the commenters was participant generated in response to the general question “Do you have anything to add?”, and relevant comments could not be probed further. Moreover, the comments at Surveys 1 (1996) and 2 (2000) were gathered before the political and social commentary on the fertility debate had become ‘mainstream’ in the Australian media. As such this topic was far less common among this research component, a handful among hundreds of written comments.

I was able to ask direct questions about the fertility rate decline in the focus groups and interviews. This was often necessary as few women considered the rate a concern, and therefore few brought up the topic independently. When asked for their views on the government concern about the falling Australian fertility rate the most common
response from the focus group participants was the cry “I see pregnant people everywhere”, and a discussion of world overpopulation.

I think it’s a joke really. There’s that many people in this world…I don’t see how they’re going to have a population problem. I don’t understand, I mean I know they’ve got all their research and everything but I really don’t think that it’s going to affect ‘the future’…that much. Like if someone doesn’t want to have kids because of whatever reason, then… So what! …I don’t think it’s a big deal.

Group 3: Bernadette, age 23

The focus group participants’ observations of pregnant women could be well founded given that the timing of the groups coincided with the beginning of a ‘bounce’ or stabilisation of the fertility rate recorded during 2004-2005 (ABS 2005a; McDonald 2005; ABS 2005b). However, as noted above, the fertility rate remains below population replacement level of TFR 2.1, meaning that the repercussions of an ageing population remain (Costello 2002a).

A similar picture was found among the few ALSWH commenters who chose to discuss population; these women focussed on the increasing world population not the decreasing Australian birth rate. A couple of women even stated that they would choose adoption over conceiving their own children, not as a consequence of fertility problems: “I do not plan to have children of my own, rather adopt them”. Another commenter suggested that women with fertility problems should look to adoption as opposed to technological assistance, believing this would solve both global overpopulation and unplanned childlessness.

I do not believe that the IVF program should be funded by Medicare. A first option should be to adopt a child from Australia or overseas. There are enough people in the world already and many children overseas in poor countries need a stable home. Solve two problems at the same time! Survey 1, age 20

Support for adoption was at odds with reviving the Australian fertility rate. This was not a topic introduced by the focus group or interviewee participants in relation to population. Although a third of the interviewees had considered the option of adoption (34%, i=17), only Laura and Peta spoke of adopting children instead of conceiving them (i=2). Most women described it as a possible response to infertility (i=14), or
something they would do as well as conceiving children (i=1) meaning it would not pose a threat to the fertility rate.

A number of the interviewees also spoke of global overpopulation, either voluntarily or when asked for their views on the fertility debate. This was regardless of their stance on the Australian situation. Consequently, several focus group and interview participants shared the view that the Australian population should be “maintained not expanded”:

_We should at least replace our population... just keep it level so that we're not contributing too much to world population._ Group 7, Siobhan, age 31

The interviewees expressed a variety of opinions about the national fertility rate, and often appeared to be more informed about the issue than women in the other components, although few were concerned. Many spoke of the increasing prominence of the fertility debate in the media, from which most had gleaned awareness of “declining birth rates”, “Australia as a nation getting older”, ”not enough babies being born” and “people putting [having children] off”.

Some women were more sceptical than others. Brooke held reservations about the government approach of “throwing three thousand dollars for people to have a baby” and Kirsten questioned whether the information she learned about the fertility rate from newspapers and television was “propaganda”. Indeed a number of women were enraged by the government and media message for women to have (more) children and to have them at younger ages, believing the government itself had created the situation and it was therefore “their own problem”.

_Oh I think they [the government] can just go and get f**ked. I mean they’re making it more and more difficult for people to [have children] and look at these industrial relations reforms [laughs]. They don’t help families at all with work, childcare is a joke… We can’t live on one income and even if we could I’d go absolutely mad staying at home, I think my partner probably would as well so that’s not really an option. So what are you supposed to do, they don’t give you any support and then they turn around and you’re made to feel like some sort of selfish cretin because you’re not popping them out. So yeah I don’t have any sympathy for them whatever [laughs]._ Kirsten, age 30, wants kids in 2-5 yrs
Immigration was also mentioned by some as a reason for their lack of concern and as an alternative to raising the Australian fertility rate.

*I can understand why the government would be concerned in terms of an older ageing population and not enough taxes to pay for everyone but yeah I'm not really overly concerned with that at the moment. I think that there are a lot of other options out there than Australia itself actually breeding.* Bronwyn, age 27, wants kids in 5+yrs

5.2.1 Who’s going to look after me when I get old?

Despite an overall lack of concern, a number of women in the focus groups and interviews discussed the potential implications for Australia of people having fewer children. Some women referred to these consequences as being purely the “government’s concerns” not their own, specifically mentioning the economy and taxation. A minority described personal worries which often focussed on the issue of social support. In separate focus group discussions both Wendy and Maria spoke of anxiety as to who would care for them and their generation as they got older.

*Australia[s] got all the baby boomers. There’s going to be so many old people very very soon… who’s going to look after all these people and who’s going to look after me when I get that old?* Group 7: Wendy, age 27

Maria, who worked in aged care, had observed how the quality of life of elderly people was determined by how much their children did for them. As a result she advocated having a large family to allow for children who move away, die or “don’t like her anymore”, ensuring that at least one or two children would be there to support her in her old age:

*If you’ve got really good social supports... you can stay in your home longer… But if you don’t have many kids to look after you, then basically you go to a nursing home and the government's supporting you.* Group 6: Maria, age 22

Consequently, this view, consciously or unconsciously, backs the government suggestion that larger families could reduce the taxation burden of a top-heavy population.
A couple of the interviewees also looked at the ‘big picture’ repercussions of a reduced fertility rate where resources for children were under utilised, and, therefore, potentially removed, creating a society that was unfriendly towards children, as discussed by Macken (2005).

We need to produce [children] to bring through new generations… which leads to lots of things like people utilising the schools that are built for children, high schools, university to carry on trades and just to keep the world going. Nadine, age 31, wants kids now

5.2.2 Dislocation between self and society
Interestingly, the focus group and interview participants often separated their own reproductive plans from those of the general population, placing themselves to one side of the social whole and disconnected from “other” women’s choices. Many held dual perspectives on the fertility rate debate and few associated their own, mostly positive, aspirations for children with their awareness of the potentially negative implications of low national fertility or high global fertility. Some women explained they felt the issues relating to an ageing population were “not critical” as they were “in the future” and wouldn’t really affect them personally.

To me it doesn’t affect me… I suppose for our economy it probably is a bad thing that the birth rate is falling but in terms of the world in general I don’t think it matters [laughs]… It doesn’t matter to me if we don’t have a huge population. Samantha, age 28, wants kids in <2yrs

Wendy (Group 7) was unusual in that she recognised the inconsistencies between her personal and global fertility rate perspectives, explaining that her teenage concerns about world population had been suppressed now she was a mother and wanted more children. She did not however associate her desire for children with assisting the national fertility rate.

The dislocation between personal decision-making and acknowledgement of a societal and government ‘need’ highlights the prioritising of the self in Australian society. It illustrates the complexity of the interaction between the self and the global that is
argued to be characteristic of modern society (Giddens 1991). While Giddens describes the relationship as “interconnected”, the participants’ narratives often present the two as parallel, marked by a general lack of concern about the national fertility rate and the antipathy some felt towards the government approach, along with a belief in world overpopulation. These findings emphasise the difficulty faced by policy makers concerned about reproductive decision-making when women do not recognise themselves as being a part of a national fertility rate.

5.2.3 Identifying the causes behind the decline

The reasoning the participants applied to “other” women’s reproductive choices was often echoed in their personal decision-making narratives, regardless of the separation they expressed between themselves and society in terms of the national fertility rate. A number of women spoke of an association between delayed childbearing and smaller family size and the effect on falling fertility rates, although they often described learning of this connection through the media.

Many participants felt the fertility rate changes were related to the emancipation of women, the existence of a culture of “choice” and the lower value society placed on motherhood in comparison to other aspects of life such as career and the concept of “success”.

RM: Why do you think the fertility rate is falling?

Laura: I guess because of the whole thing about society wanting children later and success is more important and having money and being successful in career is the real focus and to do that I guess you’ve got to put children off till later so I’d say that’s the main thing.

Age 27, wants kids in 5+yrs

While some stated the fertility rate was “all about people’s choice”, this was countered by an impression that continuing gender inequity in society influenced women’s choices about having children.
The fact that we have more choice, we think about it more often and we delay the process of having kids… then this is how the birth rate decreases… Women just have the kids later, [or] because of the choices we have you just don't have them at all because if we want to have it like a man, why shouldn’t we? Group 2: Nicole, age 25

Society, it’s not really encouraging women [to have children]. You see more women progressing their careers and things like that and women want to be as equal with men and so it’s enforced in to them that you can’t have a baby and be as good as a man type thing or work the same hours and have the same commitment. Nadine, age 31, wants kids now

Furthermore, the multiplicity of choice was also associated with stress.

I think perhaps we do have more choices… like there’s options after you have a baby as well as having a lot of choices before you have a baby, maybe more so than our mothers’ generation had… But that also increases the stress as well. Because you have to make the choices, instead of just being a nurse, a teacher or a mother. You can be anything you want. Group 2: Brianna, age 25

The participants’ perceptions about the reproductive decision-making of women in general are examined in detail throughout the remainder of the thesis, accompanied by an exploration of personal reasoning behind choices about whether and when to have children.

5.3 Motherhood as a construct and an identity
The following qualitative analyses examine reproductive decision-making from the perspective of whether women want to become mothers. This focuses the enquiry on the interaction between perceptions of motherhood, the question of identity, and aspirations for children.

Perceptions of identity are significant in relation to the emphasis which Australia, and other countries in late modernity, place on the importance of the individual (Giddens 1991). Individualism has already been identified as negatively impacting the fertility rate. Goals of independence and autonomy, and an increase in risk awareness and personal responsibility (McDonald 2006: 489) result in caution as opposed to action in
fertility. This is accompanied by a move away from “the family” as the primary organising structure (Bryson 2001; Bittman and Pixley 1997). Furthermore, a culture of choice and what Giddens (1991) terms the “reflexive project of the self” focus attention on creating an identity as opposed to simply having one.

The findings discussed below loosely divide into the theory and practice of the mother identity, each based on preconceptions. Motherhood as a construct, the role and its desired traits, is explored first, followed by motherhood as an embodied experience, an imagined reality. Several concerns dominated the interview and focus group narratives, each focused on notions of “self” and “value”. The ideology of the selfless “good” mother was central, along with women’s own perceived ability to achieve this goal, and their feelings about whether this imagined identity is one they would like for themselves. In an age described by many of the interviewees as full of choices and increasing opportunities for women, is motherhood viewed as an attractive proposition? (See Figure 5.1 below).

The lack of personal experience of the mother-role meant the interviewees’ preconceptions were built from a number of factors, including: role models, through their observations of other mothers, especially their own; contact with children; their sense of self and identity; their maternal desire; their internalised beliefs about paid work; and their perceptions of social expectations for women their age, and women in general. Each of these factors helped to determine whether or not motherhood as an identity appealed to them.

Motherhood as a construct and identity was discussed across the interview narratives; however, this was primarily in the context of making decisions about “having children”, as opposed to being about “becoming a mother” per se. While the two are inextricably linked, motherhood as an entity in itself was seldom forthcoming in the data. This became apparent early on in the data collection process and the decision was made to include a direct question in the interview schedule asking women “what the mother-role meant to them”, with some women who requested clarification also asked why they wanted children [see Appendix 4.3.4: Telephone interview schedule]. These questions were left to the end of each interview to allow for the topic to be introduced by the participants themselves earlier in the session, although this rarely happened. While these questions elicited more overt references to motherhood itself, the responses were often cursory, and did not fit with the free flowing, seemingly more ‘personal’, answers to other questions. This was possibly due to the intangible nature of the
mother-role for women without children, being asked to explain and rationalise an identity of which they have no personal experience. Consequently, these analyses are based largely on the interviewees’ responses to direct “motherhood” questions as well as their narratives as a whole.

5.3.1 The mother-role

Being a mother was described on both a detached and a personal level, and portrayed as both a positive and negative role, often within the same narrative. An overall theme from the data was of motherhood as a life changing experience. In addition, three subsidiary themes developed: motherhood as rewarding; motherhood as a responsibility; and motherhood as a restriction. These diverse qualities can clearly be seen in the common traits of motherhood and reasons for wanting or not wanting to be a mother that the interviewees listed (see Figures 5.1 and 5.2 below).

The “rewards” of motherhood, the least common of the three themes, were sometimes literally defined as the children who would be produced, and were almost always described as the positive aspects of the role (see Figures 5.1 and 5.2). The interviewees who emphasised the rewards of motherhood spoke of mothers as giving and receiving “unconditional love”, creating a family with their partner and a biological connection with their children. Some felt motherhood would bring “meaning” to their lives and viewed the changes it brought as growth of the self, with associated altruistic effects being the “next step in my development as a person to be able to care for someone else and have that role”. The concept of “reward” was also linked with fulfilling a maternal desire to experience being a mother, or rather how “horrible [it would be] to leave this world and not leave anyone behind”, to “miss out” on motherhood and not fulfil this desire. Consequently, the “reward” theme often translated into a definition of why the interviewee wanted to have children. A decision to mother based on this reasoning alone would suggest that preference was the predominant factor involved in the decision, but this was seldom the case. A heightened perception of the “rewards” could also serve to reduce the perception of the “risk” factors associated with the unknowns of the motherhood experience.
Figure 5.1: The relationship between preconceptions of motherhood and reproductive decision-making

Maternal desire

Imagined identity

Reproductive decision-making

Perceived ability

Mother construct

Reward
- “Growth” of self
- “Next step in my development as a person”
- “Create a family”
- Bring “meaning”

Responsibility
- “Commitment”
- “Caregiver”
- “Teacher”
- “instil a sense of wrong and right”

Restriction
- “Loss” of self
- “Give up life”
- “Drudgery”
- Practical restriction on paid work/career/finances

“Life changing”

“Just a mother”

The “good” mother
There’s a **responsibility** thing as well, I mean I can’t imagine looking after an animal right now let alone a child. Penelope

**What does the role of being a mother mean to you?**

When/if I decide that I’d like to become a mother I know **my entire life would change**. Maybe I’m **selfish** because I don’t know if I want that. Georgina

*It’s an expression…of love*, it’s a sense of being in an intimate bond with, and creating a family… I think it’s just an extra complement to your personality…an ability [to] be able to shape somebody’s life… and extend who you are… it gives you more of a sense of… **meaning and pleasure** in life I think… So I think it would just be rewarding. Simone

The “responsibility” associated with motherhood was seen as both positive and negative, and was discussed by almost all of the interviewees (see Figures 5.1 and 5.2). This theme was the most like a job description with participants describing the need for mothers to be selfless providers, teachers, “caregivers”, and “nurturers”, who supply commitment, security, stability, and unconditional love. These responsibilities sometimes sounded impersonal and formulaic, such as the belief in “raising people to be part of society and to contribute positively to society”, “instilling a sense of wrong and right in a person”. This was particularly true when compared with the more romantic “rewards” above. Some women felt these characteristics were part of the rewards of motherhood, while others viewed them as negative tasks, “work and drudgery”. It was common for the interviewees to question their ability to fulfil the “responsibility” demands they deemed necessary. Furthermore, the financial side to the “responsibility” of motherhood meant that until a certain economic standing was achieved it was hard to view having children as a rational choice.

Motherhood as a “restriction” was mainly described in negative terms, and was common in the interview narratives (see Figures 5.1 and 5.2). Here the overall theme of motherhood as life changing focussed on the characteristic of “selflessness”, which was perceived to be a necessary trait, and viewed as a loss of self by those who felt they would have to “give up life” when they had children. A couple of women spoke of
their proposed solutions to this concern, including Tara who planned to have one child because "one child sort of fits in to your lifestyle. More than that, then the traditional family sort of thing becomes your lifestyle". This was in contrast to those who felt selflessness would result in their "development as a person", and thus a "reward" as described above. The importance of the self in modern society enhanced the "risk" perceived by those interviewees who foresaw its loss and restriction through having children. More literal restrictions on paid work, career and finances questioned whether the decision to mother was economically rational or supportive of gender equity.

5.3.2 Embodying motherhood
The themes of motherhood as life changing, a reward, a responsibility and a restriction highlight the finding that questions of self and identity are at the heart of young women’s perceptions of the mother construct. The prospect of moving from deciding whether or not to have children to actually having children and embodying these preconceived motherhood constructs prompted participants to express concern about their imagined identity and perceived ability as a mother. The following analyses investigate how the participants’ preconceptions of motherhood shaped their reproductive decision-making.

5.3.2.1 The “good” mother: selfless versus selfish
Underpinning much of the motherhood construct was the ambiguous concept of being a “good” mother. The term arose from a combination of the participants’ personal beliefs and their perceptions of societal expectations of motherhood. It was also used as a label to judge as well as to praise other mothers.

*I think middle-class women are expected to be “good mums”. It’s just so stereotyped isn’t it? A good mum, have a good clean house and have a job…Yeah. It’s dreadful [laughs]. It is absolutely dreadful. And I can see that is what moulds us and my answers to your questions fall straight in to that in that, yeah I want to be a mum, I want to work part-time and I want to [do] both things too.* Andrea, age 32, wants kids <2yrs

The use of class in Andrea’s description of “good” motherhood emphasises which women in society are the subject of the fertility rate concern, educated “middle-class” women who tend to delay childbearing, in comparison to their “working class”
counterparts who tend not to (Lee and Gramotnev 2006b; Warner-Smith and Imbruglia 2001).

While the goal of being a “good” mother was laughed at by some interviewees most still upheld it as the ideal, as Andrea’s comment illustrates. It is an unsurprising aspiration for women who want children, and has been found in other Australian studies (Maher and Saugerés 2007; see also Pocock 2003). While largely undefined, the interviewees felt that being a “good” mother was achieved by embodying the “responsibility” characteristics of motherhood, being “successful” at the role, particularly fulfilling the ideal of selflessness, and “coping” seamlessly with the anticipated challenges of motherhood. Selflessness was central: the “good” mother must always prioritise the child’s needs over and above her own (Pocock 2003), thus reducing her own previous levels of independence.

The image of the “good” selfless mother was often placed in opposition to women who prioritised other aspects of their lives, were not prepared to change their lives for their children, delayed childbearing or did not want children.

RM: Do you feel that women are tending to become mothers a bit later on at the moment?

Nadine: I do… I just look at the people around me and money…they’re absorbed in themselves and their own lives. Age 31, wants kids now

In this context a number of interviewees applied the term “selfish” to themselves as well as to other women. Georgina described herself and her husband as being labelled by “friends” as being “too selfish” to have children because they were “so involved in their own lives”. While she stated she would like to have children, she was uncertain, noting that her friends’ doubts in her ability had increased her own. She planned to start a family in more than five years time. Interestingly, Georgina wrote a comment on her survey prior to the interview labelling herself as selfish for not being sure she wants her “entire life” to change, which she believed would be the consequence of having children (see Figure 5.2). Self deprecation for not upholding the goal of perceived ideal motherhood was not uncommon among the interviewees, particularly those who expressed uncertainty about having children. This appeared to encourage delayed childbearing, possibly until a time when they felt they would be more prepared to be “selfless”.
For want of a better word I think…that I’m quite selfish about what my life is now, about my career and wanting to have those things for myself and also my relationship… We have a very good relationship and I’m selfish about not impacting on that [by having children too soon]. Tara, age 32, wants kids in 5+ yrs

In the literature women also described themselves as “selfish” for limiting their family size to one child in an attempt to balance family and career (Maher et al. 2004).

5.3.2.2 “Just a mum”: the revaluation of motherhood
Many interviewees believed they would experience an identity crisis if and when they became a mother. This was in response to the anticipated “selflessness” of the role and the predicted restrictions children were seen to create. The caring responsibilities and time pressures that were perceived to accompany the mother-role were believed to reduce the mother’s level of independence, threatening her other pre-existing identities which might include worker, careerist, partner, traveller, student, friend and individual. This fear was perhaps exacerbated for the interviewees who were aged in their late 20s and early 30s and yet to become mothers. Compared to younger women they had often established a particular life style and developed a number of roles and identities which they felt would be impacted by motherhood and which they were concerned about losing.

I think there’s no way I could be happy being a mum not working outside of the house… I think maybe if I hadn’t have been with my partner I probably wouldn’t have chosen to have children at all… I haven’t talked to anyone about this but I like where I am, I like having my freedom, I like my sleep and my long baths and I like reading a book from start to finish and I see a lot of people that I work with [who have children] and they’ve got no lives at all and… they’re stressed and they’re upset and they’re depressed and you go “well when was the last time you did something for yourself?” And they have to think about it and then they can’t think of anything at all. And I just don’t want to end up like that. I don’t think I will but it’s scary how many people [do]. Olivia, age 31, wants kids now

A quarter of the interviewees explained that they did not want to be “just a mum”. Indeed the label of “mother” was seldom aspired to as the sum total of their identity and
a few actively looked down on others or even themselves when they were younger for having that goal.

I struggle with that traditional female role model of being home and having a child and looking after a child and doing the housework and [laughs] all that sort of stuff. That's something I don't want for me and I don't have that now and I know if my life went that way I would be really unhappy with that… it means giving up a lot of me, of my identity and of who I am. I think I need to be prepared to do [that] before I go down that path and I think more so for women than for men giving up that identity. I think once you have children then you're a “mother” and that's what you are and I want to be more than that so… Tara, age 32, wants kids in 5+yrs

On the other hand, some women did view motherhood as a positive addition to their identity ‘portfolio’. Belinda, Sonya, and Kym even described themselves using the label of “mother”, while Georgina and Carolyn felt they would be “good” at it. Tamara represented both these views explaining: “I want to be a mother because I think I would be good at it… I’ve always seen myself as someday being a mum”. However this was not a common occurrence. These women usually spoke of motherhood as “rewarding” and felt that they would gain as a person as opposed to losing part of themselves when they had children. Their reproductive plan was usually to have their first child within the next five years, perhaps making the prospect more tangible. A number also spoke of their perceptions of motherhood becoming more positive over time.

The extent to which the participants had thought about motherhood and focussed on their imagined identity as a mother exemplifies Giddens’ (1991) concept of the reflexive project of the self.

The problem at the heart of the participants’ perceived mother identity was that motherhood was felt to be less valued than other identities, particularly that of a worker or career woman. This was despite the message that women should have children
which women felt society promoted. Furthermore what was valued, and also often
aspired to by the participants, namely career, “individuality”, “independence” and the
aforementioned “success”, were all believed to be challenged by becoming a mother.
The lack of respect for the mother-role understandably encouraged feelings of
ambivalence towards having children. This was particularly problematic for those who
also felt motherhood would be the only identity they would end up with due to the
restrictions and responsibilities involved. This low-value label was also applied to the
motherhood rhetoric by a number of the interviewees, either consciously or
unconsciously, such as those who spoke disparagingly of being “just a mum”. Some
women, including Sonya, believed this was the main reason behind the falling fertility
rate.

\textit{Working in western countries where career and individuality [are] the
predominant things that [are] important, children and family and love and caring
and all of those sort of things are respected less and that’s being expressed by
people not wanting to share and have families and things like that because
having wealth and doing your own thing is more highly regarded. Sonya, age
27, wants kids in 2-5yrs}

This observation is well established in the literature and a “revaluation” of motherhood
is often proposed as a solution to reducing the costs and risks many women associate
with motherhood in comparison to their other aspirations (Maher and Saugeres 2007;
Maher et al. 2004; Maher 2005; Read et al. 2007; Summers 2003a; Pocock 2003).
Potentially this would reduce the trends toward smaller family sizes and delayed
childbearing and revive the fertility rate.

\textbf{5.3.2.3 “Have it all…breastfeed in the boardroom”}

“Proper” motherhood, according to both the participants and the literature, has
traditionally been associated with being a “stay-at-home” mother (Pocock 2003), the
epitome of the “good” selfless mother.

\textit{I see it very much as a choice…that you need, that a professional woman has
to make, either having a family or working. Group 1: Heidi, age 26 years}

However, there was also a belief that an ideological shift had moved the ideal mother
from the home to the workplace in the space of their lifetime, in line with the goal of
“having it all” that society promoted. This construct combines the “good” stay-at-home mother with the modern high achieving career woman.

I think society expects people of my age to be working and to have children and to somehow be able to manage both and magically juggle it all [laughs]. So I do sense that there’s an element of being the perfect mother and the perfect worker. I think there’s a lot of pressure on people my age. Brooke, age 30, wants kids in 2-5yrs

The ideology of “having it all” was seen to enable the dual aspirations for paid work and children that most women in my research expressed, alongside providing a solution to concerns about being “just a mum”. The concept has been associated with the feminist goal of gender equity, although it is argued that this is more often in the form of critique as opposed to underlying theoretical principles (Campo 2005).

5.3.2.4 Mixed messages: conflicting ideologies
The premise of the “have it all” ideology supports women in having children and a career, among other roles. However, many participants expressed confusion and frustration at the mixed messages they felt society espoused. The stereotypes of the “good” stay-at-home mother and “bad” (paid) working mother were believed to persist, along with the addition of the “lazy” stay-at-home mother (Pocock 2003). These labels, and personal doubts about the practicality of managing to achieve both, clouded the possibility of a successful work-life balance for many.

The participants’ concept of the ideal mother was inextricably linked to the question of whether a woman can be a “good” (read “successful”) mother and also have a successful career, as assessed from both a personal and public perspective. Mothering was often perceived to be a full-time role, particularly while children were small: “I do think that a child needs its mother at home for the first little while”. There seemed to be a belief that a “supermum” needed to simultaneously stay at home full-time with her children and be in the paid workforce. This obviously impossible goal was already perceived as a source of potential stress by the participants, even before they had had children. The resulting social expectation to “have it all” was viewed as creating new pressure to become a “supermum”, combining the conflicting objectives of the selfless good mother with the modern day success mantra of individualism (Manne 2005; Pocock 2003).
Beliefs about the relationship between paid work and motherhood are significant in trying to understand the complex decision to have a first child. If a woman without children, as the majority of the participants were, wants to combine motherhood with paid work, as the majority of the participants did, but envisages that this will challenge their ability to be a “good” mother, and conversely also to be a “good” worker, a risk free choice becomes difficult to make.

An Australian study found that childless women were more likely to associate “good” motherhood with being full-time than women with children, who were “less stringent in their definition of motherhood and often felt able to negotiate the role alongside their other life goals” (Maher and Saugeres 2007: 18; see also Maher 2005). Crucially, the mothers in the study viewed motherhood as something they did as opposed to who they were. This pragmatic task-based approach to motherhood served to lessen the tension between different aspects of women’s lives, particularly between motherhood and worker. If it is the practice of motherhood, as Maher and Saugeres’ findings suggest, that makes motherhood seem less all-consuming, policymakers who wish to encourage childless women to move beyond their preconceptions and make the initial decision to mother face a significant challenge.

5.3.2.5 “Successful” motherhood

Many of the participants focussed on whether or not they would be “successful” at motherhood. It was common for them to express doubts about their ability to parent well and to cope as a mother. There was evidence of an internal dialogue which usually questioned whether they felt maternal, whether they would be able to provide for their child, if they were ready to “give up” their lives for a child, if they would be able to juggle paid work and mothering simultaneously, and whether they could live up to the mothering ideal they and society had created.

The need to “cope” was influenced by their personal beliefs about the challenges of motherhood, perceived societal expectations of what a mother should be, the unknown nature of what it would actually be like for them, and a general desire to be successful. Success was a theme throughout the interview narratives, both as a social expectation and as pressure they put upon themselves to achieve. This pressure is articulated here by Laura in response to a question about society’s expectations for women her age, 27 years.
To be successful I think. At the moment that would probably be the strongest and to be like independent, independently successful. Independently capable. That would be the main thing. Laura, age 27 yrs, wants kids in 5+yrs

In many ways, therefore, discussion of the “good” mother was less a fear of failure, although this was voiced by some women, and more an aspiration to achieve.

“Having it all” required the accomplishment of “good” motherhood alongside success in other areas of their lives, such as career. This supported the participants’ general belief that it was a woman’s “right” to have choices, and to be able to combine motherhood with a career. However, the incompatibility many participants foresaw between these different areas of life made success appear fragile and contradictory, “good” motherhood less attainable and life more stressful. Stay-at-home mothers were seen to “fail” at having it all, while being in paid work meant you “failed” at “good” selfless mothering.

My sister has now had three children and has always been a mum but she struggles so much with that being her only identity. And I see that struggle. I think that women my age have opportunities and we get so much fulfilment out of that… Some women may get as much fulfilment out of being a mother but it’s not valued as much so you don’t feel as valued. Because I know that women of my age who choose that traditional role of being a stay-at-home mum are almost talked down or looked down upon by their peers at times I think because it’s almost like they’re letting down the sisterhood or something [laughs]… I also think that that whole concept of “we can have it all” doesn’t work. So you feel like you’re failing at your career and you’re failing at being a mother as well and I think that scares people… I think it’s really difficult [to combine motherhood and paid work]… but I wouldn’t do it any other way because… just being, and saying “just being” a mother just says it all, wouldn’t be fulfilling enough for me. Tara, age 32, wants kids in 5+yrs (emphasis added)

Concern about the unachievable goal of “having it all” has been the focus of an ongoing anti-feminist backlash that blames feminism for creating the ideology and expectation among women that they can do anything (Haussegger 2005; Campo 2005; 2009). However, the finding that the majority of the women in this study expressed a desire to “do it all”, namely to have a career and have children, supports the argument
that women must be offered real choices that include the option of having it all (Cannold 2005: 289; Campo 2005; 2009; Ginn et al. 1996).

5.3.2.6 Following by example
Cindy held a more pragmatic approach than most and laughed off anxieties about parenting skills, believing it impossible to fully prepare for the role. She stated: “Motherhood [laughs], I think you will need to learn from actually your personal experience”. This supports the finding that a lack of personal motherhood experience made it difficult for women to comprehend the role and be confident in making motherhood a risk free choice.

A combination of witnessing siblings or friends coping with the mother-role, and the contact the participants had with these children, sometimes served to make motherhood a more realistic and appealing prospect. Samantha described being surprised that the idea of being a stay-at-home mother was now acceptable to her. Watching her sister-in-law's experiences of motherhood had reconciled her with the identity she imagined she would have as a mother, one that fulfilled her perception of what a “good” mother was.

I suppose my recent choices, deciding that I would like to have children in the near future is just...spending time around my little nephews and my partner, his sister has had a new baby so just being around these little babies and I suppose that's influenced my decision... previously I thought perhaps that being a mother at home might be not all that exciting [laughs] but now that I've seen women with children I think perhaps, I wouldn't mind doing that. Samantha, age 28, wants kids in <2yrs

However, in a society with increasingly smaller families and delayed childbearing not all participants were exposed to this family dynamic. Belinda, Kirsten, Cherie and Teresa all described having no close friends with children. In addition, some felt their concerns about motherhood were justified after watching others' experiences. Penelope was pleased when her partner spent time with friends who had children and realised how “full on” parenthood was. According to Penelope this had brought her partner's thinking into line with her own desire to delay having children or not have them at all.
While some women did not have the example of their contemporaries as mothers, most interviewees discussed their own mothers' experiences of motherhood. These perceptions were usually tied to whether their mothers were stay-at-home mums or in paid work. As case studies they often held a comparative element with the participant either aspiring to emulate or avoid their own mother’s experience.

Many inherited an expectation and desire to be in paid work, following their mother’s example. Tara’s experiences of growing up with a single mother instilled a need for self-sufficiency before having children.

She was left alone to raise these children and had to really struggle to get herself to the position where she could get back in to work and support herself and her kids. And I think living through that experience I was determined that I was going to have something for me and I would be able to look after myself and that’s where career became so important for me. Tara, age 32, wants kids in 5+yrs

On the other hand, those women whose mothers had “stayed-at-home” held mixed views on this option. Kirsten had always planned a career for herself, believing her own stay-at-home mother’s life to be “unexciting” and “constant work”; while Karen wanted to provide her children with the same security her stay-at-home mother had given her as a child by always being available, if that was a financial possibility.

I remember when I was a kid other girls seemed to be planning when they were going to get married and have kids and whatever and I remember myself and my best friend we were sort of planning our career and that was about it really and being friends and all that sort of thing. It didn’t enter my awareness at all and if it did it was not really in a positive way I suppose. ‘Cause my mum was a stay-at-home mum and she just worked constantly I guess and it didn’t look like a very exciting thing to be doing so it didn’t really interest me to take that up.
Kirsten, age 30, wants kids in 2-5yrs

My mum has always been home with us. So that’s something that I’ve loved as growing up and just being able to ring her at any time and she’s available. Yeah. It’s sort of something that I would love to have for my kids but you know financially it may not be possible. Karen, age 29, wants kids in <2yrs
One strategy which the participants believed to reduce the negative impact of motherhood on their lives was to have smaller families. Preferred family size was often compared to how many siblings they themselves had. Those from large families often planned to have fewer children than their mothers had. Amy, who was one of eight children and planned to have one child herself, stated: “That’s how I remember my mother, pregnant”, while Samantha intended to downsize from being one of four to having two children.

Even when I was younger and hadn’t seriously thought about having children [laughs] I always sort of thought two would be a good number. I don’t know why. I come from a family of four children and, which is fine, but I couldn’t personally see myself [laughs] looking after four children. I think it was a big job for my mum. Samantha, age 28, wants kids in <2 yrs

5.3.2.7 A “natural” choice

The question of good motherhood often ran alongside the question of good womanhood. While the participants generally associated motherhood with being “maternal” and “motherly”, few felt it was necessary for women to have children. This belief was assisted by the importance the participants placed on individual choice (Giddens 1991) and their recognition of increased equity for women in ‘non-traditional’ roles (McDonald 2006). It was also in keeping with other Australian research which found women without children were less likely than those with children to view motherhood as a “natural” essential part of being a woman (Maher and Saugeres 2007: 18-19). These factors present motherhood as a choice for women to make.

Despite these views, the participants felt that society expected women to have children. Some women personified this social expectation, such as one commenter, who was experiencing infertility, explaining:

For a wife and a female to not be able to fulfil a dream of children is extremely difficult. Survey 3, age 26

While motherhood as an identity was considered not to allow enough “self”, many believed childlessness was seen to have too much. The view of childless women as selfish continues to persist over time (Bryson et al. 1999), sometimes perpetuated by women themselves. A few of the participants shared Leah’s stance that it was “a
natural instinct to want to have children", subscribing to the traditional woman-mother binary (Everingham 1994). This perception created concern among those participants who did not feel maternal, particularly those who were struggling with the decision of whether or not to have children, such as Fiona.

I always thought when I turned 30 I’d suddenly get this urge to have a baby, which has happened to many of my friends. Not to me though and I wonder if I’m unnatural not feeling motherly, sometimes. Fiona, age 30, wants no kids

Julie, who was unwavering in her intention not to have children, described the confusion surrounding expectations for women in Australian society today:

There seems to be this big push for women to have babies and to have babies earlier... In the media they’re talking about it, you know the baby bonus and all that kind of stuff and I think... women have had a whole series of pressures on them. Not that men haven’t. You know coming out of feminism and realising that feminism is about having choices and having the right to do whatever it is you want to do. And I think that the role of woman or the role of mother is very sort of problematised in lots of ways in terms of their perceptions of what it should be and society’s perceptions of what it is... crèche or at home or you know part-part... There’s a whole lot of judgement attached to all that stuff as well in terms of there’s no right way. So I think all those kinds of things make it really hard to know exactly what it is that society wants us to do. Julie, age 28, wants no children (emphasis added)

5.4 Conclusion

Women feel that they are expected to have children. Recent government and societal concerns over fertility rate lows and changing childbearing patterns have strengthened this belief. Few participants, however, described taking the directive to have children on board, often in response to their lack of concern about the number of babies being born in Australia. This view was supported by their individual, generally positive, aspirations for children, which the women themselves appeared not to associate with the national fertility rate or the apprehension some of the women expressed about world overpopulation.
While the majority of the women seemed to dislocate their reproductive plans from the social whole, the social context in which they lived, including their perceptions about what was expected of them, ideologies of motherhood and their belief in their ability to fulfil these ideals were crucial in shaping their views on motherhood as an identity. Many women felt that they were expected to have children alongside numerous other roles. The inconsistencies between the traditional, and persistent, "good" stay-at-home mother ideal and the more modern "have it all" model combined with an increasing pressure to be successful, made motherhood a daunting prospect for most women. Having children was seen to be rewarding but was also perceived to be undervalued, a massive financial and emotional commitment and responsibility, not to mention physical undertaking, that would completely change their life, usually placing restrictions on existing valued roles and identities, such as career. The perceived loss of self, autonomy and value that would be experienced through becoming a mother challenged the importance society and the participants placed on the “individual”, and understandably encouraged feelings of ambivalence towards having children among many of the women.

These findings suggest that both internal and external pressures to perform the mother-role to perfection, to achieve a gold standard, could be hampering some women’s decision to parent. Furthermore, the women’s, mostly negative, preconception of motherhood as an all-consuming identity were channelled into the complex decision-making processes at the heart of whether and when they planned to have children. These beliefs appear to have contributed significantly to a conscious or subconscious decision to delay having children for many of the women, impacting on the future realisation of their reproductive plans.
Chapter 6: Choosing motherhood: doubts and desires

If we actually made the decision then, you know, having a child would become a huge priority. Until then it just doesn’t seem like a concrete sort of aim… ’cause we’re still sort of umming and ahhing and all that sort of thing but you know should the decision be made it’d be like “okay” then we’ll do what we need to do and get all ready and stuff like that but, I don’t know, it just doesn’t feel like a huge priority right now. Georgina, age 29, wants kids in 5+yrs

6.1 Introduction

The previous chapter showed not only that young Australian women feel that they are expected to have children but that the fertility debate has strengthened this belief. Yet the majority of the women in this study did not position themselves as active participants in the debate, giving rise to the question of whether they actually wanted or expected to have children themselves. This question is compounded by the negative image motherhood held for many of the participants. This chapter therefore explores the question of whether or not women aspire to have children, firstly through an analysis of straightforward statistical yes/no responses, and then expanding the investigation through their qualitative narratives. The open response format of the interviews in particular provided an opportunity to go beneath the structured survey responses to explicate the data.

In the first section of the chapter, findings from quantitative multiple choice aspirations questions are presented. All three participant groups were asked whether they wanted children and if so, when they wanted to have them, and how many children they would like. These data provide a statistical springboard into the complex arena of reproductive decision-making. The relationship between these aspirations and the participants’ perceptions of both social expectation and motherhood are examined. Given the high profile of work-life balance debate (Pocock 2003), aspirations for children are then compared to women’s aspirations for paid work and whether and how they planned to combine the two.

Finally, the strength of conviction with which women discuss their childbearing aspirations is explored. This analysis brings together quantitative and qualitative responses to the question of whether women want to have children; a statistical “yes” or “no” confirmed, conflicted, explained and confounded by written comments, focus
group transcripts, and interview narratives that detail the thought processes, perceptions, experiences and beliefs that shape reproductive plans.

6.2 Counting aspirations

6.2.1 Aspirations for children

The majority of participants across all three research components stated that they “would like” to have children. This was the overwhelming consensus from their responses to the multiple choice question: “When you are 35, would you like to have: no children, one child, two children, or three or more children?” These findings are presented in Table 6.1, below, which shows that between 94-100% of the women in each research component expressed a desire to have one or more child/ren, with 90-100% wanting their first child by the time they are 35 years old. These figures are in sharp contrast to their ambivalence about a national ‘need’ for children, which was discussed in the previous chapter, and the serious reservations most held about motherhood as an identity. The commenters and interviewees were asked about their aspirations for children in ALSWH Surveys 1 (1996), 2 (2000), and 3 (2003) prior to the research for this thesis. The interviewees answered the question again in a written survey they completed just prior to their interview (2005), along with an additional question that asked how many children they would like to have in their “lifetime”. The focus group participants also completed the question in a written survey when they attended the group discussion.

It is perhaps unsurprising that all of the focus group participants aspired to become mothers by age 35 considering that a fifth were already mothers and that they had all responded to a community advertisement to attend a group discussion about their “reproductive decisions, plans and beliefs”. Similarly, the commenter participants, who were part of the ALSWH and for whom aspirations for children by age 35 varied between 94-97%, had been selected on the basis that the comment they wrote on their written survey was coded as having ‘reproductive’ content. ‘Reproductive’ content was often found to be associated with reproductive experience as opposed to intentions; between a third and half of the commenters were already mothers, up to a third were “currently pregnant” and around 6-8% were “trying to conceive”. These groups were not exclusive (see Chapter 4).
Table 6.1: Aspirations for children: a comparison between components one, two and three and the ALSWH 1973-78 urban cohort

<table>
<thead>
<tr>
<th>Participant group</th>
<th>National comparison group</th>
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<tbody>
<tr>
<td></td>
<td>ALSWH 1973-78 urban cohort</td>
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<tr>
<td></td>
<td>urban residents</td>
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<tr>
<td></td>
<td>national sample</td>
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<tr>
<td>Survey 1 (1996)</td>
<td>18-23 yrs</td>
</tr>
<tr>
<td>N=8,166</td>
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<tr>
<td>Survey 2 (2000)</td>
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<tr>
<td>N=5,543</td>
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<tr>
<td>Survey 3 (2003)</td>
<td>25-30 yrs</td>
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<tr>
<td>N=5,330</td>
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<tr>
<td>Survey 1 (1996)</td>
<td>18-23 yrs</td>
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<tr>
<td>N=190</td>
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<tr>
<td>Survey 2 (2000)</td>
<td>22-27 yrs</td>
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<tr>
<td>N=224</td>
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<tr>
<td>Survey 3 (2003)</td>
<td>25-30 yrs</td>
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<td>N=366</td>
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<thead>
<tr>
<th>Component 1</th>
<th>‘Reproductive’ commenters</th>
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<tbody>
<tr>
<td></td>
<td>urban residents</td>
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<tr>
<td></td>
<td>national sample</td>
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<tr>
<td>ALSWH 1973-78 participants</td>
<td></td>
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<tr>
<td>Wrote ‘reproductive’ comment</td>
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<th>Focus Group attendees</th>
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<td></td>
<td>urban residents</td>
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<td></td>
<td>New South Wales</td>
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<tr>
<td></td>
<td>community sample</td>
</tr>
<tr>
<td>(2004)</td>
<td>18-30 yrs</td>
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<th>Interviewees</th>
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<td></td>
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<td></td>
<td>national sample</td>
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<tr>
<td>ALSWH 1973-78 participants</td>
<td></td>
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<tr>
<td>Have partner/no children/not pregnant</td>
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How many children would you like: ...by age 35? ...in your lifetime?

<table>
<thead>
<tr>
<th></th>
<th>No children</th>
<th>One child</th>
<th>Two children</th>
<th>Three+ children</th>
<th>Already mothers</th>
<th>Currently pregnant</th>
<th>Trying to conceive</th>
<th>n’ = the number of ALSWH, commenter, focus group or interview participants and indicates the finding is based on written survey data, as opposed to the content of the comments or the focus group or interview narratives</th>
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<tbody>
<tr>
<td></td>
<td>8.7% (n=710)</td>
<td>8.1% (n=449)</td>
<td>8.6% (n=458)</td>
<td>6% (n=8)</td>
<td>6% (n=13)</td>
<td>3% (n=10)</td>
<td>0% (n=0)</td>
<td>10% (n=5)</td>
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<td></td>
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<td>13.3% (n=737)</td>
<td>17% (n=906)</td>
<td>58% (n=80)</td>
<td>9% (n=19)</td>
<td>7% (n=27)</td>
<td>21% (n=5)</td>
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<td>53% (n=113)</td>
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<td>63% (n=15)</td>
<td>63% (n=27)</td>
<td>54% (n=35)</td>
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<td>26.4% (n=2,156)</td>
<td>21.0% (n=1,164)</td>
<td>18.3% (n=975)</td>
<td>36% (n=50)</td>
<td>33% (n=70)</td>
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<td>Three+ children</td>
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<td>2% (n=1)</td>
<td>14% (n=7)</td>
<td>10% (n=5)</td>
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<tr>
<td>3 kids</td>
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<td>(n=2)</td>
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<td></td>
<td>6.2% (n=506)</td>
<td>11.9% (n=660)</td>
<td>24.5% (n=1,306)</td>
<td>34% (n=53)</td>
<td>49% (n=77)</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>1.9% (n=155)</td>
<td>3.7% (n=205)</td>
<td>6.6% (n=352)</td>
<td>14% (n=22)</td>
<td>23% (n=51)</td>
<td>35% (n=127)</td>
<td>4% (n=1)</td>
<td>n/a</td>
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<td>0</td>
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<tr>
<td></td>
<td>1.9% (n=155)</td>
<td>5.6% (n=310)</td>
<td>5.6% (n=298)</td>
<td>6% (n=9)</td>
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<tr>
<td></td>
<td>(ALSWH 1997; 2002; 2005)</td>
<td>(see Appendix 4.1.2 for more variables)</td>
<td>(see Appendix 4.2.9 for more variables)</td>
<td>(see Appendix 4.3.6 for more variables)</td>
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In contrast, eligibility criteria determined that none of the interviewees, who were also a sub-sample of the ALSWH, were already mothers or “currently pregnant”. This perhaps explains their slightly lower 90% aspiration for children by age 35, although a quarter of the interviewees reported they were “trying to conceive”. Furthermore, the interviewees were also asked how many children they “would like in their lifetime?” This brought the motherhood goal up to 94% as two interviewees planned to have all their children after age 35. This finding made the interviewees’ aspirations for children comparable with the other research components. It is possible that the option of selecting a “lifetime” number of children, combined with the interviewees being the oldest participant group, reduced the number of women who foresaw having children by age 35. Furthermore, the literature has found that women’s aspirations for children decline with age (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004).

Table 6.1 also compares the quantitative aspirations findings from my research with those of the ALSWH 1973-78 urban dwelling cohort. This area criterion was chosen to replicate the urban residence of the comment, focus group and interview participants. Comparison was possible as the same question wording was used across the three components and in the ALSWH survey. The thesis participants were found to be slightly more likely to aspire to have children by age 35 than the urban ALSWH cohort as a whole. Between 91-92% of the ALSWH cohort wanted children, while a quarter were already mothers (ALSWH 1997; 2002; 2005; Johnstone and Lee 2009; Lee and Gramotnev 2006a; Wicks and Mishra 1998).

There were only small differences between the urban only and main ALSWH 1973-78 cohort data (ALSWH 1997; 2002; 2005). The difference suggests that rural and remote women were more likely to want more than two children and to have them at younger ages than their urban counterparts. This supposition is supported by Australian research on both rural and remote women’s aspirations for children (Johnstone and Lee 2009) and their actual reproductive outcomes (Bryson 2001; de Vaus 2002a; Read et al. 2007; Summers 2003a; Warner-Smith and Imbruglia 2001; Warner-Smith and Lee 2001) (see Chapter 2).

The disparities between the aspirations for children of the women in the different thesis components were also small, with the overall goal of motherhood in the majority. This is supported by other Australian (Weston et al. 2004) and international (Berrington 2004; Goldstein et al. 2003) research, although lower aspirations have been found in
some European countries (Goldstein et al. 2003), and among older women without children (Berrington 2004; Weston et al. 2004).

6.2.2 Family size
Over half of the women in all three components aspired to have two children by the age of 35 (see Table 6.1). This rose to over two-thirds for the interviewees when they were asked how many children they wanted in their “lifetime”, as around a quarter of the interviewees planned to have some or all of their children after this age. For those wanting three or more children by age 35 a spectrum can be seen across the table findings. While this was the family size of choice for a third of the commenters across all three ALSWH surveys when looked at cross-sectionally, just under a fifth of the focus group participants and only 4% of the interviewees had this goal. A further five interviewees (10%) planned to reach three or more children after the age of 35. By age 35 the interviewees aspired to have the smallest families overall in the research, while the commenters aspired to have the largest.

These findings highlight the impact of parity on reproductive aspirations. Previous research examining the ALSWH 1973-78 cohort aspirations data found that women who were already mothers, such as many of the commenters and some of the focus group participants, aspired to have larger families than those who were not yet mothers (Johnstone and Lee 2009; see also Berrington 2004; Weston et al. 2004). This suggests that as women become mothers their aspirations for family size may increase. However, family size aspirations have also been found to decline with maternal age (Berrington 2004; Weston et al. 2004) and as women are often delaying childbearing this could create a status quo and maintain the two child ideal.

The reverse pattern was found for those who would like only one child by age 35, with 7-8% of the commenters, a fifth of the focus group participants, and a third of the interviewees proposing this family size. However, as before, “lifetime” aspirations altered the interviewees’ plans. Eleven women, a fifth of the whole, planned to add to their one-child family after they turned 35 years old which meant that only five women (10%) planned to only have one child ever. Aspirations for having only one child have been found to be consistently low in other research (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004; Lee and Gramotnev 2006a). The reality of the one-child family was, however, more common (Maher et al. 2004).
Just as already being a mother, participant age, and recruitment method may have impacted aspirations for children, they also appeared to impact plans not to have them. Those aspiring to have no children by age 35 were the minority ‘group’ for the commenters across all three surveys (5%, 6%, 3% respectively), and for the focus group participants (0%). In contrast, more interviewees “would like” to be childless at age 35 than have three or more children. However, for their “lifetime” aspirations the interviewees followed the norm, with only three women (6%) aspiring to childlessness. Although the self-selection of the focus group participants who wanted to discuss “motherhood” may have potentially missed those women not interested in having children, the fact that only three (6%) of the interviewees, a small national purposive sample of childless urban women, aspired to remain childless during their “lifetime” suggests it is not a common goal. This is supported by the ALSWH finding that only 8-9% of the large urban 1973-78 cohort had aspired to have no children by age 35 across the first three surveys, when taken cross-sectionally (ALSWH 1997; 2002; 2005).

Furthermore, the same low percentages were found for the cohort as a whole regardless of area of residence, and when these ALSWH data were explored longitudinally less than 3% of the whole cohort consistently aspired to remain childless (Johnstone and Lee 2009; see also Lee and Gramotnev 2006a; Weston et al. 2004). Predictions for childlessness, however, are higher, suggesting some women may indeed “miss out” (Kippen 2006; McDonald 1998). The increasing prevalence of childlessness may serve to increase aspirations for childlessness and could improve society’s perception and acceptance of childless women to an extent, as it has been suggested has happened in some European countries (Goldstein et al. 2003). This could in theory reduce the “selfish” label associated with being childless (Bryson 2001). Interestingly, despite concerns about the fertility rate, Australian women appeared to be slightly more likely to aspire to have children than their British (Berrington 2004) and (some) European (Goldstein et al. 2003) counterparts.

The fact that a third (n=18) of the interviewees “would like” to have one or more child/ren after age 35 is an important finding. It highlights the range of ages at which women intend to have their children, and the impact of current age and parity, in keeping with the national trend toward delayed childbearing (ABS 2010; Kippen 2006). The findings also point to the limitations of age based aspirations questions which could miss births aspired to at older ages. These figures reflect other Australian
(Weston et al. 2004; Maher et al. 2004; Johnstone and Lee 2009; Lee and Gramotnev 2006a) and international research (Berrington 2004; Goldstein et al. 2003).

6.2.3 Reproductive action

It is clear therefore that the vast majority of young Australian women say that they would like to have children, most by the age of 35. Despite this many of the participants, including all of the interviewees, were yet to realise their tick box aspirations for children, as shown in Table 6.1. For the interviewees this finding is unsurprising given that childlessness and not being pregnant were part of the component’s eligibility criteria, in order to enable an exploration of their future childbearing plans. However, at the age of 27-32 only a quarter of the interviewees were even trying to conceive (n=12) despite all but five of this component having expressed a desire to have children by age 35.

As already noted, the sampling and data collection process made it more likely that the comment and focus group participants would be mothers (up to half) and/or pregnant (up to a third). The impact of these research methods is evidenced by the fact that of the urban resident ALSWH 1973-78 cohort, the national representative sample from which the commenters (and the interviewees) came, only up to a quarter (Survey 3: n=1306) were mothers and 7% (Survey 3: n=352) were pregnant. On the other hand, the interviewees were much more likely to be trying to conceive (24%) than the commenters, focus group participants or urban ALSWH cohort (2-8%), possibly due to the fact that sampling criteria determined none were already mothers.

Consequently, in regard to the declining fertility rate these quantitative data appear to point not to the question of “why not kids?”, but to “why not now?”; with aspirations for children remaining theory as opposed to being put into practice. Given that the oldest participant in all of the components was 32 years of age, it should be noted that, fertility problems aside, the participants had not yet completed their ‘childbearing’ years. However, the motherhood, pregnancy and “trying to conceive” data give pause for thought, suggesting that many women were delaying starting to have a family, particularly as they were being asked about children they would like by age 35, which for some was not far away. This is important in relation both to women achieving their desired family size and to reviving the fertility rate, as delayed childbearing has been found to result in smaller than planned families or unplanned childlessness (Berrington 2004; Cannold 2005; Quesnel-Vallée and Morgan 2003).
The remainder of this chapter considers how individual women’s reproductive decision-making develops, and why women who, at face value, would like children appeared to be delaying having them. The participants’ aspirations for paid work are discussed first, assessing their stance on work-life balance. This is followed by an in-depth examination of the strength of conviction women apply to their reproductive aspirations.

These analyses focussed predominantly on the interviewee participants, as opposed to the commenters and focus group participants, due to the diversity of motherhood status in the latter two components. This was in order to gain an in-depth understanding of how women without children felt about their aspirations to become first-time mothers or, for a few, their decision to remain childless. It is important to make this distinction as research has found that just as women without children generally aspire to have fewer children than those with children (Johnstone and Lee 2009; Berrington 2004; Weston et al. 2004), they also expressed more concerns about motherhood as an identity (Maher and Saugeres 2007). This disparity can be explained as a consequence of perceptions of motherhood evolving from an unknown to an informed experience which greatly reduces the perception of risk in the decision-making process.

6.2.4 Aspirations for paid work

A combination of motherhood and paid work has become normalised in contemporary Australian society (Pocock 2003). It was therefore to be expected that the vast majority of participants in this research planned to combine having children with paid work (see Table 6.2). The participants felt their aspirations complied with the general social expectation for, and of, women to “have it all”, the phenomenon that is discussed in the previous chapter. At the time of the research all of the interviewees were in paid work and fit a ‘career first-children second’ model of childbearing either intentionally or through circumstance. This was linked to the sampling criteria of childlessness and age. Many women aspired to stay in paid work after they had children. Common reasons for this plan included: a genuine desire to retain and return to a “career”; financial necessity; and retaining an identity outside of being “just a mum”. The aspiration to combine paid work and motherhood is supported in the literature (Johnstone and Lee 2009; Hakim 2003; Maher et al. 2004) and by the national trend toward Australian women, including mothers, being in the paid workforce (ABS 2006b; Macken 2005; Mackinnon 1997; McDonald 2001; Summers 2003a; 2003b).
Table 6.2: The interviewees’ aspirations for paid work by age 35 compared with their aspired number of children and educational achievements and aspirations

<table>
<thead>
<tr>
<th>When you are 35 would you like to be in:</th>
<th>% Total work preference</th>
<th>Aspired number of children by age 35</th>
<th>Aspired number of children in lifetime</th>
<th>% Tertiary educated</th>
<th>% Aspire to more qualifications by age 35</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3+</td>
</tr>
<tr>
<td>Full-time paid employment</td>
<td>32% (n=16)</td>
<td>n=2</td>
<td>n=7</td>
<td>n=7</td>
<td>n=0</td>
</tr>
<tr>
<td>Part-time paid employment</td>
<td>44% (n=22)</td>
<td>n=1</td>
<td>n=7</td>
<td>n=13</td>
<td>n=1</td>
</tr>
<tr>
<td>Self employed</td>
<td>14% (n=7)</td>
<td>n=2</td>
<td>n=2</td>
<td>n=2</td>
<td>n=1</td>
</tr>
<tr>
<td>Full-time unpaid work in the home</td>
<td>10% (n=5)</td>
<td>n=0</td>
<td>n=0</td>
<td>n=5</td>
<td>n=0</td>
</tr>
</tbody>
</table>

*n* = the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives.
The story of dual aspirations for motherhood and career from the interview narratives was confirmed by the quantitative multiple choice survey findings (see Table 6.2). A question about aspirations for paid work was included alongside aspirations for motherhood in the written surveys completed by participants in all three research components. The question asked: “When you are 35 would you like to be in: full-time paid work; part-time paid work; full-time unpaid work in the home; self-employed/ own business?” Of the interviewees, by age 35, a third aspired to be in full-time paid work (n=16), while almost half (n=22) planned to be in part-time paid work, five wanted to be undertaking full-time unpaid work in the home and seven wanted to be self-employed or own their own business.

The questions did not specifically link aspirations for motherhood and aspirations for paid work. The interviewees could have answered each question independently, and not, for example, taken their aspired parenting role into consideration when they considered their aspirations for work. However, the age frame for each question was 35 years old and as all but two of the interviewees who planned to have children intended to have at least one child by this age, the work aspirations could also be interpreted as those of (intended) mothers.

Among the interviewees’ survey data some patterns between paid work aspirations and motherhood aspirations can be seen, although the numbers involved were small (see Table 6.2). The most common plan was to be working part-time by age 35 and to have two children, both by the age of 35 (26%, n=13), and in their lifetime (34%, n=17). Those planning to work full-time at age 35 were more likely to aspire to have only one child by this age, or in their lifetime, than any other work preference group. In contrast the five women who aspired to be doing unpaid work in the home at the age of 35 all planned to have two children by this time, with one intending to have another two children after this age.

Only seven interviewees aspired to have three or more children in their lifetime. Taking this small number into consideration it was interesting to note that a similar percentage of each work preference group aspired to this family size, with those planning to be “full-time unpaid in the home” the most likely to want a larger family. Those women who aspired to be self-employed at age 35 represented a cross section of motherhood aspirations by that age. The small numbers involved in this group resulted in these women being the most likely to plan to have no children by age 35 or ever.
The findings suggest that the three women who planned to remain childless and the two who planned to have all their children after age 35, prioritised career and education over motherhood. The two women who planned to have all their children after age 35 aimed to either work full-time or be self-employed at age 35, while those intending to remain childless represented each of the paid employment categories. None, either childless or delayed, intended to be full-time unpaid in the home. All intended to have more qualifications by the age of 35, although all but one already had a tertiary education, including two with higher degrees.

Other associations between level of education, aspirations for more qualifications and paid-work aspiration category were also found. Aspirations to participate in the paid workforce, and full-time paid work status were positively associated with having a tertiary education, while aspirations to work full-time in the home were negatively associated with having a tertiary education and with aspiring to more qualifications. The desire to have children by age 35 could impact the desire for additional qualifications by this age.

In keeping with most current research on women’s aspirations (see for example Johnstone and Lee 2009; Maher et al. 2004), the majority of the women in my study fell into the “adaptive” group from Hakim’s (2003) preference model, aspiring to both paid work and children. Using Johnstone and Lee’s (2009) principles for applying Hakim’s (2003) three preference categories to the ALSWH 1973-78 cohort, it appeared that half of the women I interviewed (n=24) were “adaptive”, aspiring to some form of paid employment and two or more children by the age of 35. Seven women intended to be in full-time employment and have two children, fourteen women wanted part-time work and two children (four children in one case), and three women planned to be self-employed and have two or three children. Three women from these groups aspired to have another child after the age of 35. A fifth of the interviewees (n=9) corresponded to the “work-centred” model, aspiring to full-time paid work and either no children (n=2) or one child (n=7) by age 35. However, half of these women planned to have (more) children after age 35 and only one woman intended to remain childless. This suggests this group is more inclined to delay childbearing than the “adaptive” women. Only 10% of the interviewees (n=5) fulfilled the “home-centred” label, aspiring to full-time unpaid work in the home and two children at age 35, only one of whom planned having another child after this time. The remaining women, between a fifth and a quarter of the interviewees, aspired to a different pattern based, for most, on delayed childbearing.
Eight women aspired to part-time paid employment and one child (n=7) or no children (n=1) by age 35. Six of these women wanted another child after this time. Four women wanted to be self-employed and have one (n=2) or no (n=2) children at age 35, again planning to have (more) children later.

When the interviewees' lifetime aspirations for children are combined with their employment aspirations for age 35 a simpler picture emerges. Ten percent of women were “work-centred”, ten percent were “home-centred”, and 74% were “adaptive”. Three women still evaded the mould. Two planned to remain childless and either be self-employed or work part-time, and two wanted more qualifications by age 35. These findings illustrate the heterogeneity of women’s aspirations in late modernity and highlight patterns of delayed childbearing, each of which require further explication, particularly in regard to research that has stressed the likelihood of women being unable to achieve their reproductive plans (de Vaus 2002a; Kippen 2006; McDonald 1998; 2000b; Quesnel-Vallée and Morgan 2003; Read et al. 2007; Weston et al. 2004).

While the majority of participants planned to combine paid work with motherhood few felt this would be an easy arrangement (see Chapter 5). Goals of “good” motherhood created doubts about the possibility of combining a career and children, while goals of selfhood suggested that combining these identities was the only way forward. This was alongside the practical problems of the work-life balance. Many women spoke of part-time and flexible paid work options as either their desired approach or a coping mechanism for the “juggle” they perceived. Therefore, unlike Hakim’s (2003) premise, the planning and decision-making surrounding motherhood and paid work expressed by the interviewees in their narratives highlighted compromises and concerns that could not be described as “genuine choices”. This perspective is emphasised in the literature (Johnstone and Lee 2009; Wicks and Mishra 1998).

Women frequently expressed a conflict of ideals. Many felt being a stay-at-home mum would be best for children, though only a minority (10% n=5) aspired to this option by age 35, an age when most planned to have already had children. These views also existed among those who did not plan to have any children.
For women, for mothers to have to work as well and raise a baby and all that sort of thing... it doesn’t really work I don’t think. Like it’s a full-time job and so I’d like to be in that position where I would be able to give full on a hundred percent focus on the baby. Laura, age 27, wants 2 kids in 5+yrs

Hypothetically I suppose a big part of me would like to be home full-time with children. But another part of me knows that I’d go a bit bonkers I think if that happened. Julie, age 28, wants no kids

The problem of how to combine motherhood and children successfully was a factor for a number of women in their decision to delay having children. Laura, who felt she should be a stay-at-home mum, did not plan to have children for five or more years. On the other hand, while Julie’s decision was purely hypothetical given her childless stance, her contradictory beliefs could have influenced her choice to remain childless.

The practical issues of the mother-worker juggle were already a concern for many interviewees despite their current childless status, and were a common theme in the data. The cost and availability of childcare was also a common unasked and unprompted topic, an issue at the forefront of combining motherhood and paid work. Many were already contemplating coping strategies they felt could make the balance work for them, and serve as a compromise between being a “good” selfless mother, retaining their worker identity, and achieving success in each aspect of their lives.

Many wanted to, and believed women should, be at home with young children, and planned to take “time out” from the paid workforce during this time; “the first year” was often mentioned. The majority planned to undertake part-time paid work both for the benefit of the child and for themselves. Many focussed on how family-friendly their career was; the type of job, the hours involved, provision for maternity leave and part-time options. Some women had made conscious decisions to choose a particular career precisely because they felt they could combine it with having a family. The “flexibility” of working from home was mentioned as a way they could do so successfully. Research has found that partnered women’s life satisfaction and happiness improves if they are in paid work part-time as opposed to full-time (Booth and van Ours 2005).
Originally I would have said that I would have been happy to be a stay-at-home mum, a full-time mum, but given where I’ve gotten to in my career now and I’m not sure that I could stay at home five days a week. So my ideal situation would be working two or three days a week. Susan, age 30, wants kids now

These proposed ‘solutions’ to fulfilling “supermum” status created immediate concerns for many who felt taking “time out” from paid work and working part-time could result in inequity in the workplace, while being in paid work meant they could not fulfil the “always available” “good” mother ideal (Manne 2005; Pocock 2003).

I think it’s harder for the higher management positions because they really don’t operate on a part-time basis and it’s just the same old story that they assume as soon as you have kids that you’re no longer committed to your work… I think you give up a lot in terms of opportunities when you have kids, especially women, because there’s an assumption with career path that “well there’s no point in getting her to do it because she’s got kids” and they don’t apply those same sorts of assumptions to men I don’t think. Kirsten, age 30, wants kids in 2-5yrs

This situation was epitomised by Ellie, a focus group participant, who described her experience of resigning from her job after becoming pregnant due to the lack of flexible working arrangements available to her and her desire not to be working full-time when she was a mother.

An additional coping strategy involved intending to limit the number of children they had. “Two hands” equalled “two children” for many, evidenced by the majority aspiration for a two-child family in Table 6.1, above. This plan was presented as both risk averting and self-preserving, thought to ease the work-life balance and retain more of a sense of selfhood.

The participants’ concerns about their work-life balance were in contrast to the findings of a recent qualitative Australian study of thirteen childless psychology students aged 18-25 years (Arthur and Lee 2008). These young women also expected to “have it all” and planned to combine paid work and motherhood, however they did not anticipate having to compromise in this endeavour. This suggests that younger women are either less realistic about the difficulties involved in the “juggle” or more optimistic about the supports on offer, such as family-friendly workplaces.
6.3 A study of conviction

The interview narratives were explored to examine the extent to which women’s “yes” or “no” aspirations for children were supported by the strength of conviction with which they went on to discuss their childbearing plans. These analyses explored both the participants’ desire for children, and their strength of feeling about fulfilling their childbearing plans, and included those who aspired not to have children. The open response format of the interviews provided an opportunity to go beneath the structured survey responses to explicate the apparent contradiction between the two types of data.

The interviewees were asked:

- Have you always wanted children? Why? When did/do you think having children became/will become important to you?
- When do you want/expect to have children? At what age?
- Have you given much thought to how many children you might like to have?

[See Appendix 4.3.4: Telephone interview schedule for more questions].

A set of ‘conviction’ categories were developed, as illustrated in Table 6.3 which shows that three-quarters of interviewees were defined as ‘certain’ about having children and a quarter were defined as ‘uncertain’. The analyses revealed a sliding scale of conviction, and a number of subcategories were developed to accommodate this. The interviewees' degree of certainty about having children exemplified Giddens’ (1991) concept of reflexivity, being impacted by an awareness of choice and risk. Although only three interviewees stated in the survey that they wanted “no children”, many more expressed ambivalence and indecision about childbearing in their interview narrative. This finding is tied to the negative preconceptions the interviewees held about motherhood as an identity that were outlined in the previous chapter.

The analyses examine the level of agreement between quantitatively and qualitatively measured childbearing intentions. Given the scope of the research these intentions could not be measured against whether or not the participants actually went on to have children.
Table 6.3: A study of conviction: the interviewees level of desire towards having children

<table>
<thead>
<tr>
<th>STRENGTH OF CONVICTION</th>
<th>WANTS KIDS (i*=47)</th>
<th>WANTS NO KIDS (i=3)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CERTAIN i=37</td>
<td>DEFINITE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desires children</td>
<td></td>
<td>i=11</td>
</tr>
<tr>
<td></td>
<td>High priority</td>
<td></td>
<td>i=2</td>
</tr>
<tr>
<td></td>
<td>Inevitable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incomplete without</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conviction lessened by partner’s lack of desire</td>
<td>i=5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems conceiving: Could be happy without</td>
<td>i=2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CERTAIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIKELY i=12</td>
<td>Desires children</td>
<td></td>
<td>i=12</td>
</tr>
<tr>
<td></td>
<td>Conviction impacted by competing priorities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conviction lessened by distance of plan</td>
<td>i=4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problems conceiving: Could be happy without</td>
<td>i=1</td>
<td></td>
</tr>
<tr>
<td>UNCERTAIN i=13</td>
<td>Trying but unsure</td>
<td></td>
<td>i=1</td>
</tr>
<tr>
<td>UNCERTAIN</td>
<td>Indecisive</td>
<td></td>
<td>i=5</td>
</tr>
<tr>
<td></td>
<td>Lack of desire</td>
<td></td>
<td>i=6</td>
</tr>
<tr>
<td></td>
<td>Other priorities</td>
<td></td>
<td>i=1</td>
</tr>
</tbody>
</table>

"i" = number of interviewees and indicates finding based on analysis of the interview narrative data, as opposed to the written survey data
For some interviewees categorisation was determined by literal statements they made about being ‘certain’ or ‘uncertain’ about having children and becoming a mother, such as those who spoke of “when” they had children, and those who spoke of “if” they had them. A decision made; a decision in the making.

More often conviction was less clear cut, with many participants expressing both desire for and doubts about having children. Indeed it was rare for the young women to be unavering in their conviction, supporting arguments that aspirations data are seldom predictive over the life course (Johnstone and Lee 2009). Consequently, while the interview schedule contained a number of direct open-ended questions relating to certainty and priority, the analyses of conviction were based on the narratives as a whole and the overall sense of ‘feeling’ the participant generated. Factors found to shape the interviewees’ conviction included: their maternal desire for children, sometimes influenced by contact with or absence of children in their lives; time, in relation to their childbearing plan, preconceptions of motherhood, competing priorities, and getting older; and perceptions of choice.

These qualitative findings are used to uncover what is behind the quantitative findings (see Table 6.3 above). How ‘true’ are the survey aspirations data when discussed in an open response format? Do those women who ticked “yes” to having children really want and plan to have them?

6.3.1 The ‘certain’

The ‘certain’ three-quarters of the interviewees (i=36) were first divided into two groups, labelling their degree of conviction as ‘definite’ or ‘likely’. Both groups of women generally described having children as a high priority but subtle differences between them further stratified their conviction.

The ‘definite’

For the third (i=18) at the ‘top’ positive end of the spectrum, having children was a ‘desire’. They “definitely” wanted children, and often made statements that it had “always been important”, was “inevitable”, and that life would be “incomplete” without them. “Creating a family” was a common goal in this group. Participants often linked their strength of feeling to a “maternal” desire for children.
I just really want to have a baby and look after it and nurture it and watch it grow and develop… I think it’s a miracle of life really to bring your own flesh and blood into the world… it’s definitely something I’d want to do with my partner. Allison, age 31, wants kids now

‘Partner lacks desire’
The conviction of five women, Brooke, Amy, Andrea, Denise and Kylie, within the ‘definite’ group was tempered somewhat by the lack of desire they reported their partner as having, in contrast to their own. A few actively stated that the absence of a “willing” partner was an impediment to their childbearing choice.

In some respects I feel I have no choice about it because I can’t just have a baby… my partner has to want one as well… I don’t think it’s just a woman’s choice… it really depends on two people agreeing and at the moment we don’t… In the next five years I would like two children. He’s not prepared to say that… he won’t… put a time frame around it… which makes me think [laughs] it might never happen but… we’ve talked about it. It is in our future. Brooke, age 30, wants kids in 2-5yrs

Others in this group appeared to be curbing their own desire, consciously or unconsciously, in their partner’s favour. For example, although Amy believed her partner’s desire to delay childbearing and have fewer children had influenced her own aspirations, she also questioned why she had been in such a hurry to have children in the first place.

In the last couple of years I’ve… had a real bee in my bonnet “I’ve got to have a baby before I’m 30”. Like after we had agreed that “yes we will start a family when the time’s right” I was really sort of starting to push it and he was like “oh it’s not right yet… just wait”… we sat down and had the talk and I thought “well I don’t know why I was in such a hurry… You’re right I’d rather get the house done and I’d rather be set up”. So it’s probably a lot of his influence but it is a matter that we do sit down and discuss. Amy, age 30, wants kids in 2-5yrs

More women reported that their partner was less keen than they were to have children than more keen. Penelope, whose partner had changed his mind in line with her desire to delay motherhood or remain childless, was an exception. This is supported by
findings that men report more uncertainty than women about having children (Berrington 2004).

Fertility problems: ‘Could be happy without’

Nadine, Allison and Leah created a third (‘definite’ i=2) and fourth (‘likely’ i=1) subgroup based, paradoxically, on their openness not to have children, and the fact they described the possibility that they ‘could be happy without’ having children. Here, despite a strong desire for children, their strength of conviction was lessened by their experience of and reaction to fertility problems.

As with the lack of a “willing” partner, the possibility of reduced choice, this time through a lack of biological means, appeared to dampen desire. What could initially be interpreted as ambivalence actually appeared to be resignation that motherhood may not be an option for them.

This reduced conviction was influenced by the participants’ positive view of childlessness and concerns they held about the use of fertility treatment. This included beliefs about having their “own” genetic children, as opposed to using donor gametes or adopting a child. Leah felt “the whole point of having children…is to pass on a little bit of yourself”, and the extent of her negative feelings towards needing sperm donation made her doubt her conviction about having children. She reflected, “maybe I don’t want kids that much then”.

In contrast, three other interviewees who were experiencing problems conceiving remained confident in their conviction. For example, Cindy who was undergoing in vitro fertilisation (IVF) stated she would continue with fertility treatment, including sperm donation, until she had a child.

\[I\text{ am still young… I don’t know how many times [IVF cycles] it will take but I’ll try maybe until I have a baby because there’s no other way [laughs].}\]

Cindy, age 31, wants kids now

Overall, regardless of whether they were experiencing infertility or simply knew of it as a possibility, how the interviewees spoke of the potential of not being able to have children was telling in regard to their certainty. With the exception of Nadine, Allison
and Leah, those who were most ‘certain’ about having children seemed most horrified at the prospect of childlessness.

*I want my husband and I to have a family… I’ve always seen it as a part of my life, the next sort of stage. So to not be able to do it would be crushing, would be awful [laughs].* Teresa, age 29, wants kids in <2yrs

Those interviewees who were unsure often viewed it as fate: “The decision’s been made for you”.

Furthermore, as well as indicating decision-making certainty, the interviewees who spoke of children as a ‘given’ sometimes held assumptions about their ability to conceive while those who expressed doubts were less sure of their fertility. Susan, who was having problems conceiving and was ‘definite’ about having children recognised the potential for unplanned childlessness or smaller than intended family size and qualified her reproductive plans by saying: “if I’m lucky enough to have two [children]”.

**The ‘likely’**
Moving down from the most certain, the ‘likely’ were less effusive but confirmed their quantitative survey responses by discussing positive aspirations for children. For them, although they felt motherhood was “on the cards” it was not a pressing concern, even for those who were already trying to conceive.

Frequently, other factors impacted a singular desire for children. They *wanted* children but they also wanted other things in their lives. Competing priorities included their career, travel, and economic security, among many others. These were both personal aspirations and achievements which participants perceived necessary prior to motherhood, often directly linked to the restrictions and responsibilities which having children were seen to entail. Samantha described her goal to be financially secure *before* having children, a circumstance she felt would be difficult to achieve after she became a mother.
I don't want to put ourselves in any difficult financial situation by having children because I know it is a great expense and I also wouldn't want to bring up children in a situation where they would be without things. Samantha, age 28, wants kids in <2yrs

Yvette’s belief that motherhood was incompatible with her planned overseas holiday postponed her childbearing intentions by a further two years:

We’re wanting to go overseas… and so, whilst…a part of me would really like to have children before then… [it] is quite important to me to have that trip. And I don’t think that’s something you’d do with a young infant so…I don’t think I would have them until after then…and that just gives me and my partner a little bit more time together on our own to build our relationship further… but I have mixed feelings… I don’t know whether it’s a valid thing to wait for the sake of a holiday [laughs]. Yvette, age 29, wants kids in 2-5yrs

6.3.2 A comparison between strength of conviction and the timing of childbearing

Samantha and Yvette are examples of competing priorities resulting in delayed childbearing and reduced conviction. The findings in Table 6.4 support this, illustrating a pattern between the timing of when participants planned to start having children and their strength of conviction. As you might expect, the more certain participants were, the sooner they wanted children, although ‘not now’ did not automatically mean ‘not certain’ and vice versa. Interestingly, participant age was only loosely linked to conviction through its association with the planned timing of children, with those trying to conceive generally being aged 30 or over. No specific age-certainty connection was found.

Level of education was found to be associated with conviction toward and intended timing of childbearing. Those interviewees without a tertiary education were more likely to be ‘certain’ about having children and wanted to have their children sooner, within the next five years, than their tertiary educated counterparts, with a higher proportion already trying to conceive.
Table 6.4: A comparison between strength of conviction and the timing of childbearing: the interviewees

<table>
<thead>
<tr>
<th>Strength of conviction</th>
<th>Plans to start having children…</th>
<th>Now</th>
<th>&lt;2 years</th>
<th>2-5 years</th>
<th>5+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definite</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i=4</td>
<td>i=4</td>
<td>i=3</td>
<td>-</td>
</tr>
<tr>
<td>Partner lacks desire</td>
<td></td>
<td>i=1</td>
<td>i=4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fertility problems:</td>
<td></td>
<td>i=2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Could be happy without</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Likely</strong></td>
<td></td>
<td>i=4</td>
<td>i=4</td>
<td>i=4</td>
<td></td>
</tr>
<tr>
<td>Distance of plan</td>
<td></td>
<td>-</td>
<td>-</td>
<td>i=1</td>
<td>i=3</td>
</tr>
<tr>
<td>Fertility problems:</td>
<td></td>
<td>i=1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Could be happy without</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Uncertain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trying but unsure</td>
<td></td>
<td>i=1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Indecisive</td>
<td></td>
<td>-</td>
<td>-</td>
<td>i=1</td>
<td>i=4</td>
</tr>
<tr>
<td>Lack of desire</td>
<td></td>
<td>-</td>
<td>-</td>
<td>i=3</td>
<td>i=3</td>
</tr>
</tbody>
</table>

*i*i = number of interviewees and indicates finding based on analysis of the interview narrative data, as opposed to the written survey data.

Over two-thirds (i=8) of women who were ‘definite’ about having children wanted to have them now or within the next two years, while most of those who were impacted by their partner’s lack of desire reflected this by planning to have children in two to five years (i=4). The ‘likely’ were evenly divided across the soonest three timing categories. Those who were experiencing problems conceiving were clearly all trying ‘now’.

The women who were planning to wait a further five or more years before starting to have children were found to be either ‘uncertain’ in their conviction, including the two women who wanted to have all their children after age 35, or formed a subgroup within the ‘likely’ category. For this latter group, the distance from their childbearing plan appeared to reduce their desire. For example, Jennifer explained that having children was in the “background” but was not and had never been a particular focus of hers. Plans that people express uncertainty about, and have an extended timeframe for, have been associated with not being fulfilled (Weston et al. 2004: 93; Ajzen 1985). This highlights the difficulty many women in the study demonstrated in relation to putting their reproductive intentions into action.
6.3.3 The ‘uncertain’

Jennifer’s way of thinking was experienced more acutely by those women at the ‘uncertain’ end of the spectrum (i=12), who were characterised by their level of ‘indecision’ about whether and when to have children and their ‘lack of desire’ to do so; factors which created the labels loosely dividing this group. Louise described having an ongoing debate within herself:

I actually found the [multiple choice question in the] survey quite difficult to answer because…literally I’m making decisions almost week by week because this week I just can’t imagine having them [children] so I answered “yes” just because I guess that’s the predominant thing….it’s like “oh yeah maybe one day in five years”… Louise, age 31, wants kids in 5+yrs

In a lot of ways I think…that I would like to have two [children] but at the same time I’m not even sure if I want one… Georgina, age 29, wants kids in 5+yrs

Others were simply disinterested in the prospect of having children. They described a lack of “maternal” feeling or desire. Penelope explained: “I just don’t really like children [laughs]… I don’t have any maternal instincts”.

For both the ‘indecisive’ and those ‘lacking the desire’, their doubts were often pronounced versions of those mentioned by more certain participants: they enjoyed their current lifestyle and had other priorities, which they usually felt would be incompatible with and potentially threatened by motherhood. This belief was shared by Olivia, who, despite currently trying to conceive, expressed significant misgivings about wanting to have children to the extent that she was coded as ‘uncertain’. She wrote a note on her survey before completing the interview which read:

I haven’t told anyone this: I’m in two minds as to whether I want children or not…I’m able to do what I want, when I want, within reason, and I need my own space and time by myself. This won’t be possible when I have kids. The older I get, the less I want to have kids. I’ll never tell my husband this because, until recently, I never questioned whether I wanted kids or not. Olivia, age 31, wants kids now

Olivia’s conviction was therefore lessened by concerns about how her life would change if she had children and the restrictions they would create. She also mentioned
doubts about whether she would be a “good mum”, a concern raised by a number of participants across the conviction spectrum and also found in the literature (Maher and Saugeres 2007; Pocock 2003).

6.3.4 Children: want versus should
Given the extent of the uncertainty held by these participants, why did they state in the survey, and again in the interview narratives, that they wanted to have children?

The ‘uncertain’ represent a group of women who, like those who plan not to have children, challenge the woman-mother binary that society generally supports (Everingham 1994; Bryson et al. 1999). It has been found that women without children are more likely to feel this way than mothers (Maher and Saugeres 2007: 11). However, the contrast between their negative narratives and their positive tick box “yes” suggests that the uncertain women doubt themselves and may have internalised the social view that women should have children to the extent that they cannot believe they might not want to have children, and indeed may not become mothers.

At this point, the distinction between the ‘certain’ and the ‘uncertain’ seems to be based on want versus should; those who were ‘certain’ often simply wanted to have children.

   It’s just natural life. I just want to have kids. So nothing’s made me think “oh I have to have children” or “I don’t want to have children”. Kym, age 27, wants kids now

Many of those who were unsure spoke of feeling they should have children, often in spite of a lack of interest in having them or even a dislike of children. This was commonly explained in relation to a “fear of regret”; including the concerns that waiting until they felt “maternal” might result in being unable to have children due to age-related infertility or that childlessness results in “a bit of a shallow life”.

   It’s not of great importance to me to have children but we would like someone I suppose to… teach and inherit everything we have so yeah one would be plenty I think. Melanie, age 29, wants kids in 2-5yrs
I'm not one of these really maternal sort of people, so it hasn't really hit me yet, “oh I really want children”, but I just kind of think that I should have them. I don't know. It is kind of, not dictated to you but kind of, you don't want to put it off till once you start feeling maternal which could be another ten years which might be too late. Alicia, age 28, wants kids in 2-5yrs

Both the concept of feeling you should have children and the fear of missing out have been found in other Australian research (Maher and Saugeres 2007). Here the participants, women without children who were delaying having them, spoke of hoping that maternal desire would overcome them and “make the decision for them”, removing the need to make a rational choice about whether and when to have children (2007: 11).

6.3.5: Aspirations for “no kids”
This brings us to those who went against the expectation that women become mothers. Conviction was also important among the three women who had stated in their survey, and again in the interview, that they did not want to have children. Heather and Julie were adamant about their plan, stating they had always felt that way: “I didn’t have to think about answering the question. I knew that we didn’t want children”. The third, Fiona, expressed uncertainty, explaining that childlessness was her current plan and therefore open to change: “At the moment, I don’t want to”.

One of Fiona’s reasons for not wanting children was the difficulty she foresaw in trying to combine a career with motherhood, believing that women either “run themselves ragged” doing both or are unable to “gain back” time spent out of the workforce. This was a key competing priority for other women as well who described the need to “establish” a career prior to having children.

6.3.6 Transitions of certainty
Fiona’s comments highlight the importance of recognising the fluidity of the conviction categories. While some women remained fixed on early goals of motherhood or childlessness, the majority found their desire for children changed as they got older. Some women spoke of “get out clauses”, the potential for them to change their mind, become clucky, delay having children for longer, and the possibility of infertility. This transitional nature of reproductive decision-making, and its recognition by many of the
participants, adds to the debate on fixed and flexible reproductive plans and their predictive power, and questions of choice and circumstance (Cannold 2005; Hakim 2003; Johnstone and Lee 2009).

Although Olivia described experiencing a decrease in her desire for children as she got older despite her continuing to try and conceive, it was more common for participants to report an increase in their desire and certainty over time.

*It’s probably only in the last two years that I’ve started sort of feeling more receptive to the idea of children and probably more so even in the last six months…I think it’s because, I haven’t had any actual exposure to children in the past and…my partner’s sister had a child and…just having some, even minimal exposure to that child…would be the first reason, just the exposure. The second reason I think would be my age, since I’ve turned 30 I’ve suddenly started thinking more seriously about children because…I just feel that 30 changes things for me just because of reaching that milestone and because of…potential problems with reproduction later on the older I get at this point.*

Cherie, age 30, wants kids in 5+yrs

This finding was at odds with research that points to a decline in aspirations for children as women age (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004), suggesting other influencing factors aside from desire.

Furthermore, regardless of their indecision, uncertainty and ambivalence the majority of the interviewees anticipated following through with their intention to have or not have children. Many spoke of only “unforeseeable” circumstances impacting their plans for or against, such as breaking up with their partner, job loss, sickness, financial difficulties or “fertility issues”, or, for those who intended to remain childless, unplanned pregnancy. This suggests the transitions of certainty set out above are more related to timing than whether or not to have children, although research suggests delay could increase the chance of childlessness (Berrington 2004; Cannold 2005).

**6.3.7 How many children?**

One very fluid finding from the research was how many children the interviewees aspired to have. The existing ALSWH survey data meant that the interviewees’ aspirations for children by age 35 could be examined across four survey time points.
Over half (64%) held consistent or very similar aspirations over that time, holding the same aspirations for two, three or more surveys and not varying their family size by more than one child. While ten participants gave mixed responses with no clear pattern, six women increased the number of children they wanted and three decreased. The three women who had reduced their aspired family size were all ‘uncertain’ about having children, while there was no clear association between conviction and intention among the other groups. Two of the three women who planned to remain childless had been consistent in this intention and were coded as ‘certain’ in their plan, while Fiona, who was coded as ‘uncertain’, had reduced her plans for children. A further six women had each answered on a single occasion that they wanted to have “no children by age 35”. Five of these women only responded this way at ALSWH Survey 1 or 2, the anomaly possibly a consequence of the transition of time since their answers, and their young age at the earlier surveys. Samantha only answered this way at ALSWH Survey 3, two years before her interview when she returned to her original plan of “two children by age 35”. In the interview she explained that she had recently experienced an unexpected desire to have children earlier than she had previously wanted, suggesting her “no children by age 35” response was linked to wanting children after age 35 not an aspiration to remain childless. These findings are similar to longitudinal analyses of the whole ALSWH 1973-78 cohort over three time points which found around half the participants were consistent in their aspirations, a quarter downsized, 17% upsized, and 10% gave mixed responses (Johnstone and Lee 2009).

Furthermore, when the qualitative findings were quantified, over 40% (i=20) of the interview sample spoke in their narratives about having a different number of children than they had stated they wanted to have in the written survey. Of these a third spoke of lowering family size, including a couple who spoke of the possibility of having no children. While the remaining two-thirds spoke of having more, this was usually only by one additional child. The majority of women still wanted two children, either consistent or inconsistent with their survey response. Nadine highlights the difficulty of ticking a box in relation to discussing planned family size. She described her chosen number/s in relation to her perceived ability to cope and, like a number of women, used the flexibility of the interview format to talk of wanting two or three children.
Either two [children], ‘cause in the survey you could only tick one answer…But I was actually talking with my husband and two to three. Probably suit us if that’s possible…Any more than three I don’t think I could cope or handle, even right through from like young children, like babies, right through to adulthood. I think two to three would be a nice balance. Nadine, age 31, wants kids now

The question of “how many” children has different dimensions to choosing whether or not to have any children. After having one child, “how many” children becomes an incremental decision, which the interviewees were aware could be changed and informed by their personal experiences of motherhood, whereas there is no practice run for having any children. There were no clear associations between family size and level of conviction.

Each of these analyses question the predictable nature of aspirations for children over time as espoused by Hakim (2003).

6.3.8 Scales of desire: importance and priority

Other measures of ‘conviction’ were also implemented with the interviewee sample, including a quantitative written question on the importance of motherhood and a qualitative interview question on priority.

The written survey question asked participants to number eight areas of their life in terms of their relative importance to them: partner relationship, career, work, family relationships, friendships, study, motherhood, and social activities [See Appendix 4.3.2: Telephone interview written survey]. The majority of the women placed their “partner” at number one (84%) in terms of importance. “family” was often placed at number two (66%), but after this point no clear pattern exists until number eight where half of the participants chose “study”, presumably because the majority had already achieved a tertiary qualification. The importance attributed to motherhood ranged from one through to eight, with a third of the interviewees giving it the lowest relative level of importance.

A comparison between these written responses and the ‘conviction’ label coding revealed a number of patterns but also highlighted several anomalies. A general pattern existed with the importance attributed to motherhood declining alongside levels of conviction. The third (n=15) who placed motherhood between numbers one and four in terms of importance were all coded as ‘certain’ in their conviction. Similarly, all but
two of those women who were classified as ‘uncertain’ placed motherhood at number seven or eight in terms of importance, the exceptions being Olivia who was trying to conceive despite being ‘uncertain’, and placed motherhood at number six, and Alicia who was ‘uncertain’ and gave motherhood a rating of five. However, a number of inconsistencies existed. For example, the eighteen women who were labelled as being ‘definite’ about having children varied in the importance they gave to motherhood from one through to eight. It should be noted that the level of importance the participants attributed to motherhood in this question is associated with the importance they gave to the other seven areas of their life.

Correspondingly, those interviewees who described having children as a “huge”, “very high” or “high” priority in the interview narratives were all categorised as ‘certain’ about having children, again with the exception of Olivia. On the other hand, descriptions of having children as being “pretty important”, “a medium priority” or “not a priority” were mostly, though not exclusively, held by those labelled as ‘uncertain’.

6.4 Conclusion

Choosing motherhood has become a collision between an irrational ‘innate’ desire for children and a rational desire to control and plan. While women do not seem to be overly concerned about Australia’s fertility rate, they do generally aspire to have children. Indeed perhaps it is their knowledge of their personal plans for motherhood that makes them feel the fertility rate is not a concern, although few appeared to associate their own intentions with the national or global fertility rate. However, the analysis found that while the ‘tick box’ data pointed overwhelmingly to aspirations for children, the interview narratives revealed a sliding scale of certainty. Participants often expressed both desires and doubts about having children, and their conviction was usually shaped by a complex interplay between maternal feeling, competing priorities, planned timing, and available choices, all of which had the potential to change over time. One key competing priority was a desire and/or financial necessity for paid work. This creates questions as to whether women will follow through with their intentions to have children.

On a practical level, choice was impacted by factors such as a willing partner and the ability to conceive. A more elaborate relationship existed between choice and the priority women attributed to motherhood. Indeed, the importance of circumstance was emphasised by the rational assessment many women described making of the costs
and benefits of having children. Already having children was perceived to compromise the potential achievement of other life goals, such as economic stability, career establishment and overseas travel, which were all, therefore, seen as precursors to motherhood. This assessment usually resulted in these ‘other’ aspirations being prioritised over motherhood in order to assure their completion, thus contributing to delayed childbearing. This was particularly the case for career establishment as many women expressed the belief that combining paid work with motherhood would be difficult. It is clear that from both a practical and emotional perspective it is difficult to discuss aspirations for children as concrete. The majority of the women in this study described childbearing plans as an ongoing process, involving numerous revisions. This concept of rescheduling goes against Hakim’s (2003) theory of fixed preferences.

A desire to avoid unknown risks created two opposing responses. The lack of confidence some women had in their, as yet untested, ability to be a “good” mother had the potential to reduce their aspirations for children. Conversely, and sometimes simultaneously, the chance of age-related infertility resulted in a number of women feeling that they “should” have children before it was “too late” despite their uncertainty. This cautious calculating approach to childbearing aligns the research with perspectives that emphasise rational choice, risk aversion and gender equity, over preference.

On the other hand, the existence, or lack of, maternal desire was found to be central to the reproductive aspirations expressed by the quarter of the sample whose desire for, or against, children was matched by a strong conviction: the ‘definite’. This suggests that personal choice was the primary influencer of their motherhood plans, supporting preference theory (Hakim 2003). However, in keeping with the main conclusions of the research, it could also be argued that the circumstances in which the ‘definite’ group live may be more conducive to their aspirations.

Overall, therefore, although the qualitative findings largely upheld the quantitative in terms of positive aspirations for children, they also emphasised the complexity of unpacking reproductive decision-making. The potential for delayed childbearing was highlighted, along with the number of participants open to the possibility of not having children. Of particular note are those women, a quarter of the sample, who spoke with uncertainty about their positive aspirations for children. The interview narratives, therefore, work in combination with the multiple choice data to present a more complete picture of women’s childbearing aspirations, emphasising the worth of being
able to ask the same or similar questions from both a quantitative and qualitative approach.

Consequently, both quantitative and qualitative aspirations data show that generally speaking most women would like to have children. The qualitative data at this point upholds the quantitative in terms of aspirations for children, though many questions and much ambivalence have been added to the equation, and the number discussing the potential of not having children has grown. The certainty and uncertainty expressed by the interviewees in their narratives highlight reproductive decision-making as a reflective process (Giddens 1991), and point to the importance of qualitative data in bringing out, exploring and explaining the quantitative yes or no of having children.

In conclusion the majority of women, even those who were less certain, or even uncertain, planned and expected to have children. For many women this intention was almost in spite of what they expected their identity as a mother would be like. This suggests a dislocation between the participants’ generally negative perceptions of motherhood and their positive aspiration to have children, especially if the latter is to be achieved. However, the findings argue that perceptions of motherhood play a significant part in the timing of motherhood, and particularly the tendency to delay childbearing.
Chapter 7: Finding the right time to have children: an assessment of risk

I have been in a relationship for ten years and would have preferred to have a baby at 25 yrs of age [five years ago] - we decided not to as financially, study, work etc was not how/where we wanted it to be when having children. I don't like the idea of having a first baby after 30 years but unfortunately time goes so quick. Karen, age 29, wants kids in <2yrs

7.1 Introduction

The vast majority of young Australian women aspire to have children. Nevertheless, as the previous chapters have shown, there are many misgivings in regard to the mother-role, and doubts and uncertainties about having children. Most of the participants in this study had not yet had children, exemplifying the national trend toward delayed childbearing (ABS 2010). Furthermore, the goal most often expressed by participants - to “have it all” – suggests a significant need to plan for this imagined life of achievements. The question of timing is therefore central to this research.

This chapter explores the issue of when women want to have children. What do they feel is the right time? Do they anticipate being able to have children when they want to have them? What influences their reproductive decision-making in regard to timing? In discussions of childbearing, “delay” refers to the increase in the average age of mothers and therefore, the phenomenon of the ageing first-time mother (Kippen 2006; Laws et al. 2010). There continues to be concern over this trend due to medical research which has found an association between age and infertility, and maternal age and morbidity and mortality (Bewley et al. 2005; Dunson et al. 2002).

Interview data linking the participants’ age and projected timing of childbearing with a number of other factors were used to explore the question of finding the “right time” for children in greater detail. Analysis of these data found that most women make a complex risk assessment in relation to the timing of childbearing, impacted by numerous factors both within and beyond their control.

Two main themes emerged, forming the first two sections of this chapter: the life circumstances in which they would like to have their children, and the age they would like to be. These two ideals were potentially contradictory. Ideal circumstances often
comprised a list of precursors to parenthood. These were chosen in response to perceptions of motherhood as a responsibility, and also the restrictions they foresaw children placing on their lives. These perceptions frequently resulted in delayed childbearing. *Ideal age* considered the participants' beliefs about fertility, and the risks and benefits associated with “younger” and “older” motherhood. These considerations favoured younger motherhood.

The chapter concludes with an exploration of the contradictions that exist between these two ideologies, and the resulting negotiations women make as they attempt to find the “right time” to have children. For the most part, the decision is based on an assessment of the potential risks women foresee if they are *not* in their ideal circumstances and at the ideal age for motherhood. On the one hand, they see that younger motherhood poses the risk of not providing adequately for their child, or of being unable to achieve their other life goals. On the other hand, they are concerned about the health risks of older motherhood and infertility should they delay childbearing until they feel the circumstances are right. Ultimately, the compromise favours either being in the “right” circumstances or being the “right” age, and it is usually the former.

**7.1.1 First-time motherhood?**

Both the focus group and interview schedules contained a number of open ended questions relating to the question of when to have children. Findings from each component generally supported one another, although the interviews provided a more ‘complete’, and often chronological, picture of individual reproductive decision-making. Consequently, the analyses for this chapter focus predominantly on the interviewees, while also discussing the broader concepts introduced by the focus group and commenter participants. As you would expect, the proposed timing of childbearing varied enormously, ranging from those who were currently trying to conceive to those who did not plan to start trying to have children for over five years. The inclusion of a specific age, 35 years, in the quantitative “aspirations for children” question enabled these data to be compared with the timing discussed in the narratives.

The research questions asked when participants wanted to have children in general, leaving the interpretation of this to the participants themselves. Some clarified that they were referring to the timing of their *first* child in their responses, and often did not discuss the planned timing of any subsequent or final children in detail. However, others implied that their overall timing incorporated any children they might have. The
preoccupation with when to have their first child was clearly linked to the fact that the majority were yet to have children.

It is important to emphasise the issue of ‘which birth’ as it is particularly pertinent for analysis of participants’ “ideal” age, given that many held “upper” age limits that could impact subsequent births. This is in contrast to their “ideal” circumstances which were mainly achievement based and therefore tended only to improve with time (and age). Consequently, this chapter focuses primarily on when women want to have their first child, although the timing of first versus later children is revisited in the “ideal” age section, and the timing of last children is also discussed.

7.2 The right circumstances

7.2.1 Precursors to motherhood

I really do think careers are the reason that people are having children later and of course career does come down to financial reasons as well… We want to own the four bedroom house… the two cars in the driveway… and we know the financial burden of having children. I guess I’m just a stereotype person that sits in that category. I wanted to do this, this, this, this first. Oh and the overseas trip I did that too [laughs]. Andrea, age 32, wants kids in <2yrs

If I look at my life now…we’ve just bought a house and we’ve got two dogs and we have this excellent free lifestyle and to have a child now or even in the next two or three years would just be a bit of a bummer versus a blessing. Louise, age 31, wants kids in 5+yrs

The concerns articulated by Andrea and Louise were commonly held in tandem with an innate desire to have children, or with an anticipated desire to have them in the future. This was variously described as being “inevitable”, a “maternal feeling” and “a strong inner biological urge”. The way in which many women resolved the conflict between desire and doubt that they articulated in their family planning narratives appeared to be the achievement of a list of precursors prior to having children. Waiting until these other goals had been completed usually resulted in delayed childbearing, but was consistent with the “have it all” ideal of balance (Bewley et al. 2005; Haussegger 2005; Manne
2005; Pocock 2003): i.e., if you set yourself up prior to having children, life will be easier afterwards.

This provides a different perspective on the question of whether women are choosing if and when to have children, or whether they are having their reproductive lives dictated by circumstance. In this strategy, circumstance is paramount but particular circumstances are chosen and planned as far as is possible, highlighting a need for control in the face of difficult circumstances. Participants viewed these precursors as combining to provide a robust basis for the mother-role, in terms of fulfilling the material and emotional needs of both child and mother, and assisting them to be a “good” mother, to “cope” with having children, and to prevent identity loss.

The main precursors focussed on the perceived fundamentals: a strong financial position, including purchasing a home; a secure personal relationship, often represented by marriage; an established career identity, and therefore, usually a completed education; previous travel experiences; a sense of self-fulfilment, and emotional maturity. Similar goals have been found in other Australian research (Maher et al. 2004; Maher and Saugeres 2007; Weston et al. 2004). Although she was speaking tongue-in-cheek, Carrisa described the ideal:

*I think now it’s having this neat little package… like you go to uni till you’re 21, and then you go overseas for two years and then you work proper for two years and get your house deposit. And then you’ve got to, that’s when you find the man somewhere … when you’ve gone travelling or when you’re working… And then you’re married, once you’ve bought the house. You don’t want to be married and not have a real place to live. And then two years down the track, once you’ve had your time to enjoy it, then you’ve got to have the kids.* Group 5, Carissa, age 24

Carissa was defining an ‘ideal type’, an acceptable pattern for young women in Australian society today, and many of the focus group and interviewee participants did describe aspiring to this timetable. Carissa was not unusual in mocking the situation, however. A number of women seemed almost surprised that, in a modern culture which they felt emphasised choice, they themselves wanted to adhere to both traditional as well as new values. This “retraditionalization” fits with the goal of succeeding at “life”, attempting to achieve perfection in each of their life goals that is explored in the previous chapter. While the goal of perfectionism is in keeping with the
ideology of individualism, support for “retraditionalization” contrasts with Giddens’ (1991) emphasis on “detrationalization” in late modernity (Kirby 2008).

The precursor finding from the focus groups prompted the inclusion of a specific question in the interview schedule that asked whether there was anything the women wanted to achieve before they had children. The interviewees echoed and elaborated on the focus groups’ pre-motherhood goals, which were also found in the commenters’ open responses.

7.2.2 “Security”, “stability” and being “ready”
Central to the construction of these ideal circumstances, and in response to the responsibilities, costs and limitations that participants associated with having a child, were the interlinked concepts of “security”, “stability”, and being “ready” (see also Weston et al. 2004). Cindy explained she had achieved “stability, then marriage and relationship with my husband and financial and emotional sort of readiness”, before starting to try to conceive.

“Security” and “stability” were key terms used by over 80% of the interviewees in their timing narratives (i=42). While some mentioned being “secure” or “stable” as circumstances in themselves, most linked these conditions with particular criteria, such as financial and job “security”, a “stable” relationship and being “settled” in one place. Heather and Brooke spoke on a world scale. Heather, who did not plan to have children, felt “the insecurity in the world now, [would make others] wonder whether they should be bringing children in to a world like this”. Brooke, who wanted children, supported this by speaking of her doubts about having children after the terrorist attacks of “September 11th”, accentuating the relationship between the global and the self in modern society (Giddens 1991). Some also mentioned their stable upbringing and the continuing support of their families in assisting them in being “ready” to become a mother. The participants’ concept of “readiness”, both in terms of the achievement of their pre-motherhood goals as well as an embodied feeling, referred to being practically and emotionally prepared.

Overall the language of being secure and stable is in keeping with the general theme of risk aversion that emerged from the research as a whole. These findings reflect the emphasis on risk in modern society (Beck 1992; Giddens 1991). Circumstances must be assured in order for participants to feel certain and safe in their decision to have a
family. The direct threat many felt that children placed on their “career stability and...financial security”, highlighted in the previous chapter, made this feat even more complex. This added personal risks, such as identity loss, necessitating emotional readiness. However, several women believed that actually having children, and being “a family”, would create more emotional stability.

Emotional readiness was defined as a combination of being mature enough for the responsibility of parenthood, having fulfilled their other life goals to cope with the restrictions they foresaw children creating, and being sufficiently confident in their own identity to cope with the potentially all-consuming mother-role.

*We’re trying to have children. I think we have had that maturity and we’ve had those experiences in terms of travel and work that makes [us] really ready to have children.* Susan, age 30, wants kids now

In contrast, a few participants mentioned that if they didn’t have children, through choice or circumstance, their focus would change and the specifics of security, stability and readiness would not be as necessary.

*If...I was infertile or my husband was… your outlook on how you would live your life and what you would do with yourself changes a lot...I don’t think I’d have the same sort of focus on work and having a stable income. I’d be a lot more inclined to travel around the world and live in different places.* Allison, age 31, wants kids now

7.2.3 Financial security, the house in the suburbs, the “Pajero” and the plasma television...

In terms of traditional goals, the participants were particularly mocking of their own and others’ material aspirations, yet financial security and buying a home prior to having children were constant themes in all three research components. Almost 90% of the interviewees (i=44) introduced one or both topics. Some women referred to “purchasing” a house, while others discussed paying off all or some of the mortgage, an ambitious plan for many and impossible for others. House or apartment size was sometimes mentioned as limiting the number of children the participants planned to have. A preoccupation with the financial cost of motherhood was also found to be a
determining factor in childbearing decisions in other Australian research (Maher et al. 2004; Weston et al. 2004).

This economic focus is not surprising considering that for a middle income couple, the lifetime (0-20 years) costs of raising the first child are around $264,000, with a second child adding about $184,000 to the bill (Percival and Harding 2002). This estimate does not include hidden costs such as the loss of the mother’s earning capacity during her childbearing years (Gray and Chapman 2001), which further inflates the final sum. Most participants seemed aware of, and were often preoccupied by, the economic costs of motherhood. Indeed around a fifth of the interviewees referred to children as “expensive” (i=9). This expense was on top of the general view that the cost of living was too high, with many pinpointing childcare as a major cost. These beliefs were important given that the majority were currently in paid work and planned to combine paid work with motherhood.

Many participants described financial security as both the reason for their own delayed childbearing and hypothesised that it was a key factor influencing the Australian fertility rate. Some women, such as Denise and Jacqueline, associated this with a culture of materialism and expectations for a high quality of life.

I think that a lot of the reasons are because of the big mortgage and the Pajero and, the huge capital lifestyles that people are living. They want everything. They’ve got to have a plasma TV, they’ve got to have this and that and the other and they just can’t afford to be having the amount of children that they were… Denise, age 30, wants kids in 2-5yrs

... the great Australian dream of owning a house and getting a huge mortgage and whatever is just making everything unattainable… I’ve got friends, they can’t reach that [on] one wage…if they did fall pregnant then they’ve got to go back to work very quickly. Group 2: Jacqueline, age 28

This perspective supports the concept of “affluenza”, the desire to achieve the “Australian dream” regardless of the personal and economic costs involved, that is argued to be gripping contemporary society (Hamilton and Denniss 2005).
It was more common for participants to speak of the peace of mind they would have if they waited until they could simply support their children without, as Samantha said, “struggling with money and perhaps be[ing] stressed”. An extreme example of this mindset was Vanessa who, while now trying to conceive, had actively delayed childbearing in the past, choosing to terminate an unplanned pregnancy for a number of financial and health-based reasons, including her husband’s gambling addiction. The goal to provide the ideal financial environment in which to bring up a child therefore rested on beliefs about what children need, ranging from basic needs to wanting to provide the “best” start in life for the child. As a financial decision, having children was a “rational choice” based on literal costs and individual economic standing (Coleman 2000; McDonald 2000b). Awaiting financial security was also a strategy in risk avoidance (Maher et al. 2004).

The importance of perceived financial security is highlighted by a direct association between the certainty with which the interviewees spoke of their plan for (or against) having children, the proposed timing of that plan, and their responses to a multiple choice survey question about how they felt they managed on their available income. The majority of the interviewees found their income “easy” or “not too bad” to manage on (n=35, 70%), with only four women feeling that their financial situation was “impossible/difficult all the time” (see Table 7.1).

Women who were defined as ‘certain’ and/or were ‘trying to conceive’ or wanting children in the next two years felt it was “easy”, “not too bad”, or “difficult some of the time” to manage on their available income. All but one woman wanting children in the next five years also felt this way. In contrast, although the ‘uncertain’ interviewees were spread across all of the “income management” categories, this group included all four women who described finding it “difficult all the time” or “impossible” to manage. Similarly, those women wanting children in five or more years spanned the ability to cope financially. Financial security did not, however, have a strong relationship to the aspiration not to have children.
Table 7.1: Associations between the interviewees’ perceptions of financial security and their certainty towards and timing of childbearing

<table>
<thead>
<tr>
<th>Managing on available income is:</th>
<th>Certain about childbearing plan</th>
<th>Uncertain about childbearing plan</th>
<th>Trying now</th>
<th>Kids in &lt;2 yrs</th>
<th>Kids in 2-5 yrs</th>
<th>Kids in 5+ yrs</th>
<th>No kids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy</td>
<td>n*=19</td>
<td>i**=18</td>
<td>i=1</td>
<td>i=5</td>
<td>i=2</td>
<td>i=8</td>
<td>i=4</td>
</tr>
<tr>
<td>Not too bad</td>
<td>n=16</td>
<td>i=10</td>
<td>i=6</td>
<td>i=5</td>
<td>i=3</td>
<td>i=4</td>
<td>i=2</td>
</tr>
<tr>
<td>Difficult some of the time</td>
<td>n=11</td>
<td>i=9</td>
<td>i=2</td>
<td>i=2</td>
<td>i=3</td>
<td>i=5</td>
<td>i=0</td>
</tr>
<tr>
<td>Difficult all the time/ Impossible</td>
<td>n=4</td>
<td>i=0</td>
<td>i=4</td>
<td>i=0</td>
<td>i=0</td>
<td>i=1</td>
<td>i=3</td>
</tr>
</tbody>
</table>

*n*= the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives. 
**i**= the number of interview participants and indicates the finding is based on interview narrative data, as opposed to the written survey data.

Older motherhood was often seen to have had the advantage of time to accrue money and rise to a decent wage, providing greater economic security than parenthood at a younger age. The decision to delay having children due to monetary concerns was part rational choice, part risk aversion and part an aspiration to achieve the perfect life.

7.2.4 “It’s nicer to be married”

Having a partner was cited as both a practical and emotional prerequisite to motherhood by the focus group and interview participants, being of equal importance to financial security. Sampling criteria required the interviewees to have a partner. This was in response to the focus group finding that not having a partner created a situation where the hypothetical question of if and when they would meet someone to have children with made discussion of their possible reproductive plans more difficult than for those with partners. This resulted in two-thirds (n=32) of the interviewees being married and a third (n=18) living in a de facto relationship. Over half of the focus group participants (n=15) stated they were single, although a number of these women discussed having a boyfriend, which often appeared to make the prospect of having children more tangible.

“I’ll definitely have one or two [children]…I mean if I meet the right person, otherwise I guess you’ve got no choice [laughs]. Group 5: Gabrielle, age 30
While the biological imperative for a man in the reproductive process was acknowledged, “it takes two to tango”, it was more often implicit than stated. “Sex” was only mentioned by one interviewee who wrote on her survey that she and her husband were not having sex as a result of a disagreement about the timing of children. Being heterosexual was not part of the research criteria, but none of the focus group or interview participants identified as being in a same sex relationship.

The main reason participants felt having a partner was a necessary precursor to children was an overwhelming desire for a committed relationship that would provide a stable and secure foundation for their family. This ideology was tied to their perceptions of the needs of children and responsibilities of motherhood. Almost 90% of the interviewees referred directly to such a relationship (i=44, 88%), with the majority believing it to be best symbolised by marriage (i=29, 58%). Most of these women were already married or engaged. A further third (i=15) of the interviewees emphasised the stability of the relationship over the importance of being married, although over half of this group were already married. This traditional stance was unanticipated, particularly given the trend toward children born to unmarried parents in Australia (ABS 2010: 13). However while being married before having children was deemed “nicer” than the alternative by some, the interviewees clarified that this was what they wanted for themselves as opposed to what they felt others should do. The participants themselves often expressed surprise at their “traditional” beliefs, particularly as they did not consider marriage to be necessary in today’s society. This is in keeping with a general relaxation of the socio-cultural association between marriage and children in Australia (de Vaus 2002b), but also with a “retraditionalization” of social values that has found support for marriage among young people (Kirby 2008).

*I think on the surface I like to think I don’t have to do things the conventional way or the way that is expected, but I think deep down I really wanted to have that piece of paper for some stupid reason [laughs]. Maybe it was the security.*

Belinda, age 30, wants kids in <2yrs

All of the interviewees who were currently trying to conceive were already married (i=12). This supports a strong association between marriage and childbearing plans, in some cases regardless of the value the participants voiced about this relationship. Similarly, four of the five focus group participants who were married had children and the fifth was pregnant. Furthermore, analyses comparing the interviewees’ narratives and the survey data found a relationship between the length of time the participant had
been with their partner, regardless of marriage, and their intended timing of children: the longer the relationship, the more ‘certain’ participants were about having children and the sooner children were planned. Marital status was also associated with relationship length. If the interviewees had been with their partner for more than five years they were more likely to be married, possibly influencing the earlier finding. The delay to childbearing caused by the desire for marriage prior to having children was exacerbated by the current trend toward living with a partner for a number of years before marriage and children (ABS 2009b; de Vaus et al. 2003). Many of the participants described wanting “my partner and I having enough time to ourselves in our relationship” before they had children.

Single motherhood was therefore not aspired to, nor did the only single mother from the focus group discussions plan to maintain her status, stating in her written survey she “would like” to be married by the age of 35. Only Denise, an interviewee, spoke of “just getting pregnant and raising a child by myself”. While she would much prefer to have a “willing partner to share the experience with” her current partner’s lack of desire for children and his terminal illness combined with her own strong desire to have children before she was “too old” meant she felt she may be “stuck” with this option. Cannold (2005) found that having a partner was inseparable from the decision to have children for the majority of her participants.

Denise highlighted the need not just for a partner prior to having children but one who shares the same childbearing aspirations and is “ready” for parenthood at the same time. This aspect of reproductive decision-making, and its, often negative, impact on reproductive outcomes has been identified in the literature (Berrington 2004; Cannold 2005), although research on men’s aspirations for children is less common than that on women’s (Berrington 2004; Weston et al. 2004).

Many of the interviewees spoke of making joint decisions with their partner about if and when to have children. Often this resulted in compromises of timing or family size. A few, like Denise, described holding opposing viewpoints from their partner. In the majority of these cases women wanted children earlier than their partners did, and were coded as ‘certain but partner lacks desire’, as discussed in the previous chapter. Previous research has found that if couples’ plans for children conflicted they were less likely to have a first or subsequent child (Berrington 2004; see also Cannold 2005).
He’s just that bit younger than me, he’s just not mature and ready from an age point of view… Andrea, age 32, wants kids in <2 yrs

I feel sad and lonely only because I wish to have a child but my partner is not ready. Survey 1: age 21

In contrast, and despite their own association between partnering and/or marriage and having children, several women expressed anger at the assumptions of family, friends, and strangers that having a partner or being married meant they would have children soon, or ever.

7.2.5 “I wanted to have my 20s to just be me”

While establishing financial and relationship security prior to having children was seen by the participants to be necessary for fulfilling the responsibilities of the mother-role, this focussed mainly on the needs of the child. Achieving a sense of self and self-fulfilment in their own lives were also primary precursors for the majority of the participants. This was mainly associated with the restrictions they perceived that motherhood would place on their own needs and desires, as discussed in the previous chapters. Many spoke of wanting to live their “own” life and “be me” prior to motherhood. This went along with establishing a career they could return to after they had children, retaining an alter-ego, as it were, as an antidote for combating any potential loss of identity. Research has also found a positive association between the amount of time childless women spend on leisure pursuits and the delay of childbearing (Nomaguchi 2006).

Here being ready to have children referred to the participant’s readiness to share themselves, and move on from living an individual “me” centred life, revisiting the concept of a need for maternal selflessness introduced in Chapter 5. Underpinning this was the premise that women have to be emotionally ready to put their children first, to be selfless, as many of the interviewees felt they should be and often wanted to be, in order to achieve their goal of “good” motherhood. There was a recognition however that in order to do this willingly they must feel fulfilled prior to having children and to have established a strong identity. This ideal of “self” corresponds with the importance modern society places on the individual (Giddens 1991). It is also in keeping with the “me generation” label that is sometimes attributed to the participants’ age group,
although the literature often uses this term to explain planned childlessness as opposed to the timing of children (Weston and Qu 2001).

*People tend to want to do a lot more before they have kids…it’s selfishness in one sense but it’s not, you just want more for yourself first before you give up, well it’s not giving up but…I sort of sense with my mum she’d want to put me first for everything and I suppose we, our generation, is more inclined to want to get a bit for ourselves first and to travel and do things for ourselves before we’re ready to become selfless [laughs].* Teresa, age 29, wants kids in <2yrs

This “selfishness” delayed, and for many was continuing to delay, motherhood until they were confident enough in who they were to cushion or prevent a feeling of loss of self, or until they were “content to put kids first… and make [them] the number one priority”.

*Why I don’t want kids right now …It’s like, we don’t want our life to revolve around our kids and that’s all it is ‘cause we still want to travel more and develop our careers and everything first.* Laura, age 27, wants kids in 5+yrs

For some women an increase in their desire for children over time had reduced their perception of potential identity loss and made it seem insignificant in relation to the benefits of having children. Sonya felt that her positive feelings about having children, albeit in two to five years time, were due to “being happy in myself”.

*Feeling content with the things that I’ve achieved on my own. So feeling ready to be able to spread my wings into more of a family rather than being an individual. That’s probably had the most impact.* Sonya, age 27, wants kids in 2-5yrs

**7.2.6 Retaining a career**

Most commonly, participants spoke of creating a strong sense of self through establishing a career or “work” identity. This was of crucial importance, with decisions about childbearing closely tied to career paths and plans through the desire of the majority of the participants’ to combine the two. In positive terms, an education and a career were seen to provide practical readiness for motherhood in terms of security.
and stability, and emotional readiness in terms of self-fulfilment. This was the path to attaining the supermum ideal, and the hope that they could achieve all their life goals.

_I was always career orientated and… I wanted to make sure that I could actually finish my education and get a job and do that for myself so that I could have a break and have children and then have something else to come back to._

Sonya, age 27, wants kids in 2-5yrs

On the negative side, the difficulty of combining motherhood with higher education and/or a career was mentioned by many women (see also Bryson 2001; McDonald 2000b; Summers 2003a; Warner-Smith and Imbruglia 2001). The restrictions that children were seen to place on these areas of life meant that it was important to achieve fulfilment, along with a particular position or seniority, in their career prior to having a family to stand them in good stead on their return.

_Like if I’d … had children young and I was ready to go to work now without being in the workforce, I know that I’m starting right at the bottom._

Amy, age 30, wants kids in 2-5yrs

It was hoped that this approach would help to mitigate their expectation that they would not return to the workplace on the same terms as they had left, through their need to balance paid work with motherhood by being part-time or utilising other “family-friendly” practices.

The perceived requirement for financial security prior to motherhood and the anticipated need for women to stop or take a break from paid work, at least in the short term, after having children meant that both parents’ education must be completed and career established first. While the majority of the participants intended to retain their career once they were mothers the issue of one-income families was also discussed, including waiting until the partner’s wage was sufficient to support the family on its own.

In addition to their ideological and practical reasons for wanting to establish a career before becoming mothers, some participants believed they would be “wasting” their education and “throwing away” time spent in a career if they had a child too soon. Consequently, while most women felt there were two options available to them: ‘children then career’ or ‘career then children’, the latter was seen as by far the most viable and desirable choice.
The majority of the focus group participants and all of the interviewees were following the career-first model. This approach is not conducive to maintaining the fertility rate, as Australian (Franklin and Tueno 2004) and US (Martin 2000) research has shown. The more education a woman has, and this is a prerequisite to most career aspirations, the more likely she is to have fewer or no children in comparison to her counterparts with less education. This generally occurs as a result of delaying motherhood until after educational goals have been completed and a career established.

Achieving and negotiating a “family-friendly” career path was often time consuming. This was especially true for a couple of participants who described planning ahead for “the juggle”, to the extent that they had changed their career to one they felt would be better suited to combining with motherhood. This meant going back to the beginning of establishing a career, and a more protracted delay before having children.

I have recently chosen to leave full-time employment and return to study teaching. This was especially important as, although I am single currently, I would someday like to marry and raise a family and my previous job would have made that impossible. Survey 3, age 27

A few focus group participants were following the ‘children then career’ pattern, either by accident or design. Wendy, who had planned to be a young mother, explained that her career would happen after she had had her children, while Nicole, whose child was unplanned, exemplified the childless women’s concerns. She felt that older mothers had an advantage over her because they had had time to go to university and start a career before going on maternity leave to have children, while she was now aiming to balance higher education and a small child.

7.2.7 “The overseas trip” versus a sense of place
Travelling and living overseas continues to be a rite of passage for Australian youth (see, for example, West 2005). The literature refers to this phenomenon as negatively influencing reproductive decision-making, however, in this context “travel” is usually listed among a number of traits of individualism and is seldom explored in detail (Bean 2005; Cannold 2005; Macken 2005). Many of the participants described past or future travel as an important factor in deciding when to start having children, as indicated in
the quotes below. More than half of the interviewees had lived or travelled overseas for a month or more during adulthood.

Travel was something young women expect, and often feel they are expected, to do. Karen felt that society placed more emphasis on the goal of travel for women her age (29 years), alongside other ‘mind broadening’ activities such as attending university and finding a job, than on having a family. Susan valued her time overseas for the “life experience” and “maturity” it had given her, believing it had contributed to her current feeling of being “really ready to have children”.

These same young women, however, usually planned to return to Australia before having children. Indeed, no one spoke of travel and motherhood as being compatible. This was illustrated by the decision two focus group participants made to return to Australia to give birth and to bring up their unplanned children, who had been conceived while they were overseas. The common plan, therefore, was to delay motherhood until after travel plans had been completed. Yvette, who was otherwise “ready” for motherhood, explained in her interview that she was delaying childbearing in favour of a planned overseas trip that was almost two years away. Carol, aged 26, who introduced herself to the focus group as a “world traveller”, stated: “I want to travel a bit more so I probably won't have kids until I'm 30 or even older than that now probably…"

_ I am currently based overseas with my partner. We are employed full-time on a private motor yacht…Overall plan is to return to [Australia] and start a family…This is our third year in this industry. Survey 3, age 26_

The motherhood themes of responsibility and restriction were again evident. The participants felt that if they were already mothers they would have been prevented from travelling, or their travels would have been restricted and not as enjoyable as a consequence of having children with them. In addition, travel did not offer the security and stability perceived to be required by children. Therefore, it was necessary for participants, and their partners, to get travel “out of our system” prior to having children.
Travelling is just something that’s important in my life… I wanted to do it while I was single and on my own and certainly without children because ...you can’t sort of open your mind as much, I don’t think, with that responsibility and just do random things and go where ever you want to go. Sonya, age 27, wants kids in 2-5yrs

Conversely, overseas travel was also mentioned as an alternative lifestyle for those who did not or could not have children, for example, see quote by Allison above (p166).

For some women the significance of place when they had children was both an economic and emotional consideration, linked to having social support. Given that the majority planned to return to paid work after they had children, living close to family was seen to offer the potential for informal childcare. More often, however, participants spoke of not living near family, sometimes as a consequence of needing to be mobile for employment and career opportunities, and thus needing to be in the financial position to pay for childcare when the need arose. This highlights the extent to which the individual in modern society has become “disembedded” from family and community and experiences an increased need for self-sufficiency (Giddens 1991). For these women, a sense of place appeared to be associated more with establishing a home in Australia, referring back to the emotional as well as financial importance of home ownership in creating a stable and secure environment in which to have children.

The circumstances generally perceived as ideal, therefore, usually resulted in delayed childbearing. In this planning structure older motherhood was favoured over younger motherhood, often simply in relation to having the time to achieve all their desired goals prior to having children.

I would say it’s probably easier because you’re a lot older and you can cope with more stress and you’ve just had more life experience. And I suppose financially you’re probably a lot better off. And I suppose you’re more content in yourself with what you’ve achieved. Whereas if you’re younger and you have your kids, you (would) always wonder, “Oh what if I did this? What if I did that?” instead of having kids younger. Peta, age 30, wants kids in 2-5yrs

In relation to the childless status of the majority of the women in my study, it is significant that other Australian research has found that perceptions of financial security, relationship stability and career establishment were more influential in women
deciding whether or not to have a first child than those women who were choosing to have a subsequent child (Weston et al. 2004). This implies that the goal many women have of attaining the “ideal” circumstances impacts their delay of childbearing more than reducing their family size.

7.3 The right age: do women want to be older mothers?
When reproductive plans were investigated from the perspective of the participants’ desired maternal age a contrasting picture emerged that tended to support younger motherhood. In the focus groups and interviews the participants who wanted children were asked at what age they would like to become a mother. This included the ages they felt would be the youngest and oldest they would be happy to have (had) children. Their ideal age to have children was based on a number of factors, including their perceptions of what was “too old” and “too young” to have children and what they felt motherhood would be like at these two extremes; their observed experiences of mothers of different ages, including their own; their knowledge of age-related infertility and not wanting to leave it “too late”; and what they felt constituted “good” mothering. Interestingly, while the term “older” mother was usually used in a negative sense along with descriptions of being “too old” or “too young”, “younger” mother was applied more positively.

7.3.1 Younger motherhood: “cool and groovy”
“Younger” motherhood, defined as the earliest limit of each individual’s acceptable timeframe for children, was seen to offer health, in terms of physically conceiving and giving birth, energy, and the ability to relate well to their children.

I think definitely when you’re younger you’re more physically able to handle being pregnant and giving birth … I would have preferred to have them when I was a bit younger, in my mid to late 20s I suppose. Tamara, age 30, wants kids now

Examples were often given by participants who themselves had had “young” parents and the good relationship they had had with them. Georgina’s “cool” mother had had her when she was in her late 20s and was described as “good to hang around with”. Younger parents were also viewed as more adaptable than older parents, and not as set in their ways when it came to incorporating a child into their lives. In addition, the
participants felt the smaller generational age gap meant they would be more likely to have social support from their own parents while they were still young enough to be active grandparents.

While the interviewees and most of the focus group participants’ perceptions of age at motherhood were hypothetical, the first round of research did collect some vivid accounts of younger motherhood. It is interesting to note that there was a good fit between the actual experiences of young motherhood and the perceptions of childless women. Four of the five mothers in the focus groups had had their first child before turning 25 years old, falling into the “too young” category for many women. While two of these conceptions were accidental, two women, Ashley and Wendy, had planned their families to make sure that they would be young parents, realising the ideal of youthful motherhood shared by the participants as a whole.

*We had made a conscious decision to have children at an earlier age... I wanted to be… able to have the energy… to be playful enough and all of those things.* Group 4: Ashley, age 25

Although both women were married, neither Ashley nor Wendy had fulfilled all of the ideal precursors to having children identified above. This included financial security, with each stating it was difficult “some” or “all” of the time to manage on their available income. Ashley, who had one child, was building her career alongside her family. Having completed a university degree, she was currently in part-time paid work. On the other hand, Wendy, who had two children, had attained Year 12 qualifications, the completion of secondary schooling in New South Wales, and worked full-time in the home. She explained that she and her husband had decided “we’d worry about careers after we had kids”. Both Ashley and Wendy aspired to have another child and to be in the paid workforce by age 35.

Other younger mothers described their experiences less positively, attributing limitations on their lives to having had their children at a young age. This perspective was particularly noticeable among those who had not planned their children and often cited in relation to the incompatibility they were experiencing between motherhood and paid work.
In reference to my dissatisfaction with having my two children I am referring to the fact that I had them early. Since having them, I have realised how taxing it is on me and my relationship with my husband...If I could do it all again, I would, definitely choose to wait until my mid 30s so I could have my career, travel, buy expensive purchases, etc. Survey 3, age 28

The trend towards older motherhood was also described as isolating by a number of the younger mothers in the focus groups and comments. Often they were the youngest by far in their mothers’ group, and the only one of their friends with children.

It is hard in regards to friends as you don't fit with your school friends anymore. And most other mothers are years older and aren't all that accepting of young mothers. But I'm planning on going to university next year. So hopefully things will get better. Survey 1, age 23

These experiences corresponded with the reasoning of most childless participants for achieving a set of precursors to motherhood, and not having children when they were “too young”. Given the age of each participant group it was not possible to collect comparative experiences of older motherhood.

7.3.2 Older motherhood: “a risk”
Older motherhood was viewed primarily as a “risk” by the majority of the focus group and interview participants. This significantly influenced their beliefs about the ideal age at which to have children. The two main areas of concern were firstly, the potential for biological problems and, secondly, social issues. Indeed these were the counterarguments Ashley and Wendy, the focus group mothers who had planned their children, used when they were explaining their choice to become mothers at a young age: “the [foetal] DNA doesn't splice up right after you turn 30”.

The biological theme focussed on the belief that although older motherhood was possible there were significant risks involved with having children at a later age: problems conceiving and foetal abnormalities were the most commonly mentioned. These concerns are supported by the medical literature (Alonzo 2002; Bewley et al. 2005; Dunson et al. 2002). Older mothers' potential lack of energy was also a preoccupation, according to the participants’ views on what was needed to be a "good" mother.
Fundamental to reproductive decision-making is the basic fact of whether or not it is possible to conceive once a decision to have a child has been reached. Concerns about “diminished fertility” were expressed by many of the research participants, across all three research components. They articulated a general awareness of the potential for fertility problems, including the unknown of their own biological limitations.

Not everyone has a guaranteed reproductive lifespan that goes until their late 30s...maybe we don't all have lots of time to have babies like we think we do.

Group 6: Courtney, age not specified (between 18-30 years)

Almost all of the fifty interviewees (86%) believed that a woman’s fertility declined with age. When asked at what age they felt the decline began, the majority stated 30 years old, while a further quarter believed it happened around 35 years (See Table 7.2 below). Only a very few women thought the chance of becoming pregnant did not start to decline until women were in their late 30s or after the age of 40. A number of women, such as Danielle, were particularly well informed, giving almost text book responses supported by the medical literature (Bewley et al. 2005; Dunson et al. 2002).

Well I've heard that any time after the age of 27 your fertility starts declining and I think as you approach around 35 it gets more and more difficult. After 35 you don't have as much chance getting pregnant. Danielle, age 30, wants kids now

The commenters and focus group participants held similar views to the interviewees.

[I] am becoming concerned about infertility as a few friends have recently learned that they have fertility problems and must resort to IVF. As I don't want children until I'm 30 it worries me. Survey 2: age 27

Doing more and more research over the last couple of years I've realised that...your fertility kind of changes and things like that so it's kind of all down hill from 30. Group 1: Ellie, age 27

Given the desire of the majority to have children, a “fear of regret” and a “ticking biological clock” encouraged many of them to want to start trying to become a mother at an earlier age, that was perceived as safer. Sonya explained: “The reason why I think I should have children younger is because I don't want to risk not being able to.”
These concerns reflect recent research, as well as media and social commentary that focus on women who have left it “too late” (Chapman et al. 2006; Cannold 2005; Goward 2006; Haussegger 2005; Hewlett 2002; Kippen 2006; Macken 2005).

A small group across the three research components were less knowledgeable. They were unconcerned about their ability to conceive, seeing their fertility as ageless. It is possible some younger participants, particularly those commenters and focus group participants who were under 25 years of age, were so far removed from their childbearing plans that the possibility of age-related infertility was a foreign concept. However, some older participants also shared this view. Indeed the oldest focus group participant, Siobhan who was aged 31, was confident that she would not have problems conceiving. However, she was possibly influenced by the fact she had been pregnant twice before, each resulting in a termination, and had therefore ‘tested’ her fertility. Siobhan aimed to have her children in her late 30s or 40s, explaining: “I've heard about women in their 50s having babies and I mean…I wouldn't say no if it came to that”. Her “ideal” age bracket could also have been impacted by the fact she is older and still wants to have children, and that she was currently without a partner, by default placing her possible timeframe for children further into the future.

Interestingly, the same finite view of women’s fertility was not held about men’s fertility, with almost half of the interviewees believing that age-related infertility was not a concern for men (i=22). A further quarter (i=12) were unsure if age played a factor. The remaining quarter (i=13) felt that men’s fertility did fall with age, but felt that this happened at a later age than for women. Consequently, partner’s age was only mentioned by a few participants in relation to impacting their timing of children. This is an important point considering around 60% of interviewees had partners who were older than them, as is common in Australian society (ABS 2009b), some by as much as ten, fifteen or twenty years.

I believe that men can reproduce at any age and I just look to Rupert Murdoch [laughs] to see some 70 year old just having a baby. Brooke, age 30, wants kids in 2-5 years, partner aged 38

Older motherhood was also viewed as bearing increased health risks for both mother and child during both pregnancy and birth, if in fact pregnancy was able to occur at an older age. In half of the interviews and half of the focus groups the concept of older motherhood being “dangerous nature-wise” was introduced.
All I know is that it’s not as safe, like there can be complications during birth… something could be wrong with the baby when it’s born. I mean I don’t know the specifics…but I just know you’re just better off younger. Laura, age 27, wants kids in 5+yrs

Older motherhood was seen to increase the risk of foetal abnormalities, also referred to as chromosome “problems” or “defects”, with cerebral palsy, Down syndrome and spina bifida being mentioned by several participants (see Alonzo 2002).

Even if conception and gestation are successful and a healthy baby is born to a healthy older mother, many participants still held concerns about the ability of older mothers to fulfil their parenting responsibilities. Lack of physical energy was a major preoccupation, mentioned by half of the interviewees. A requirement of motherhood was being able to “run around [with] or pick up the child” and simply to have the physical stamina to cope.

You see people that have kids, that are older than 35, in to their 40s and you think about the child and how old the parents will be. I don’t want to be an old parent when my kids get to 15 or whatever. So that’s probably part of [it]…they’re starting to have kids later and I think you can’t really throw a ball around in the back yard with your kid if you’re not physically able to do that. Simone, age 31, wants kids in 2-5yrs

As discussed above in relation to the benefits of “younger” motherhood, social concerns about “older” motherhood included the potentially large age gap between parent and child if motherhood was delayed. Participants referred to potential difficulties with communication or a poor relationship between the two generations. There was also the fear of being mistaken for the grandparent, being the “oldest mother” at school, lack of social support from their own ageing parents, and maternal morbidity and mortality while the child was still young.

Waiting until later to have children was also seen to create problems in terms of disturbing the mother’s (and father’s) established lifestyle and career, which participants believed would have to be “given up”, or at least significantly changed, when children arrived. This was exacerbated by the belief that delayed childbearing
would mean that the children would be “hanging around” at home into their parents’ retirement years.

You’ve also become accustomed over a long period of time to a certain life style that doesn’t involve being woken up…three times a night. Kirsten, age 30, wants kids in 2-5yrs

Interestingly, although Kirsten and Brooke didn’t question their husband’s ability to father a child at an older age they were concerned about their being “older” fathers, considering whether they would be “young enough to do things with their children” and “how old will he be at our child’s 21st birthday”.

7.3.3 Ideal age at motherhood: an acceptable window of opportunity

Most of the interview and focus group participants mapped their childbearing plans within a general spectrum of “ideal” maternal age somewhere between the ages of 25 and 40 (see Table 7.2). This usually referred to the ages they wanted to be when they had their first and last child. The individual boundaries were created by what each participant perceived as too old and too young to have children, which usually formed a ten to fifteen year timeframe. A small number of women were more specific, allowing themselves a limited window of opportunity of around five years, often in their late 20s or early to mid 30s, in which to have all their children.

I would never, never consider having them before say 33…[and] if I got to 40 that’d be it. Penelope, age 27, wants kids in 5+yrs

The written ‘reproductive’ comments do not provide enough detail to generalise to this degree, although those who mentioned age discussed ideal motherhood as being within a similar age framework.
Table 7.2: The interviewees’ fertility beliefs and preferred age brackets for motherhood*

<table>
<thead>
<tr>
<th>Age &amp; circumstance not important</th>
<th>Youngest preferred age for motherhood</th>
<th>Oldest preferred age for motherhood</th>
<th>Believe ability to conceive starts to decrease for women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age not mentioned</td>
<td>20% (i**=10)</td>
<td>-</td>
<td>4% (i=2)</td>
</tr>
<tr>
<td>Change based on circumstance/ the individual not age</td>
<td>16% (i=8)</td>
<td>4% (i=2)</td>
<td>6% (i=3)</td>
</tr>
<tr>
<td>Age &amp; circumstance not important</td>
<td>2% (i=1)</td>
<td>-</td>
<td>2% (i=1)</td>
</tr>
<tr>
<td>Early 20s</td>
<td>6% (i=3)</td>
<td>-</td>
<td>2% (i=1)</td>
</tr>
<tr>
<td>Age 25</td>
<td>12% (i=6)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Late 20s</td>
<td>14% (i=7)</td>
<td>-</td>
<td>8% (i=4)</td>
</tr>
<tr>
<td>Age 30</td>
<td>16% (i=8)</td>
<td>2% (i=1)</td>
<td>36% (i=18)</td>
</tr>
<tr>
<td>Early 30s</td>
<td>8% (i=4)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age 35</td>
<td>-</td>
<td>28% (i=14)</td>
<td>28% (i=14)</td>
</tr>
<tr>
<td>Late 30s</td>
<td>-</td>
<td>18% (i=9)</td>
<td>4% (i=2)</td>
</tr>
<tr>
<td>Age 40</td>
<td>-</td>
<td>32% (i=16)</td>
<td>4% (i=2)</td>
</tr>
<tr>
<td>Over Age 40</td>
<td>-</td>
<td>10% (i=5)</td>
<td>-</td>
</tr>
</tbody>
</table>

* Excludes the three interviewees who intended to remain childless
**i= the number of interview participants and indicates the finding is based on interview narrative data, as opposed to the written survey data

Table 7.2 shows that half the interviewees wanted to have their first child after the age of 25. Having a child before this time was generally considered to be “too young”, although a handful would have been happy to have a child in their early 20s. For many, “youngest” age was associated with their perception of selfhood and expected circumstances at that time. Indeed eight participants did not have a “youngest” age. They referred purely to what they wanted to achieve, although generally this would have, and had, resulted in their being aged above 25 when they started their families. Ten interviewees were not asked and did not volunteer a youngest age for motherhood. It was more common for the focus group participants to view age 25 as the ideal start for their motherhood timeframe. This was possibly because they were generally younger than the interviewees, two-thirds being aged 25 or younger, while the interviewees were aged 27-32. The interviewees’ age also meant that motherhood at age 25 was a retrospective prospect, making it less easy to contemplate.
Thirty years old was a pivotal age for motherhood for the interviewees, as found in other aspirations research (ABS 2008; Berrington 2004; Weston et al. 2004). A third (i=17) referred to the prospect or reality of turning 30 as significant in their reproductive plans. Many of those yet to turn 30 viewed it as the age they planned to start having children: “It’s always been by the time I’m 30 I would like to have had a child or be ready for a child”. Some of the women who had already turned 30 found their desire for children had increased at that age.

Since I’ve turned 30 I’ve suddenly started thinking more seriously about children…I just feel that 30 changes things for me just because of reaching that milestone and because of… potential problems with reproduction later on.

Cherie, age 30, wants kids in 5+yrs

Others, such as Fiona who did not want to have children, were confused when this was not the case for them, having anticipated 30 to be the age they would become “clucky” and a mother. These women were usually ‘uncertain’ in their motherhood plans.

I always sort of thought once I hit 30 that was the time when you’d start to have children and it just seemed to be that lots of my friends were turning 30 and suddenly five minutes later they were all saying they were pregnant and I sort of thought “yes…that’s sort of a good age”… And then I turned 30 and didn’t get this big sort of drive to suddenly want to have babies, so I’ve actually been questioning myself quite a lot about is that normal and is that okay and the societal expectations… Fiona, age 30, wants no kids

These personal plans and expectations were reinforced by the belief many of the interviewees shared that society expected women to wait until age 30 to start having children. On the other hand, a number of women also felt that after the age of 30 a pressure was applied for those yet to have children. This created a very slim window of socially acceptable first-time motherhood-age, and implied additional pressure for those women aged in their 30s who did not want children yet or ever.

I actually think that society probably really encourages women not to have children before 30… Sonya, age 27, wants kids in 2-5yrs
I think that there is a general perception... that… if you haven’t had a child by the time you’re 30, there’s sort of maybe a big question mark put over the top of your head as if you’re not doing the right thing. Susan, age 30, wants kids now

These beliefs are supported by the fact that ten of the twelve interviewees who were trying to conceive were aged 30 or over, while the other two, Kym and Vanessa, were aged 27 and 29 years respectively. Their aspired age for motherhood also mostly fits within the participants’ possible fertile years, as defined by medical research (Bewley et al. 2005; Dunson et al. 2002). Other Australian research has found that childless women aspire to have their first child between the age of 26.7 and 29 years, with aspired age increasing with actual age and childlessness (Weston et al. 2004). National statistics indicate that the majority of women actually have their children within the participants’ acceptable motherhood window of 25-35 years old (Laws et al. 2010: 9). This is in keeping with the national median age of all mothers and first-time mothers in Australia calculated, respectively, at 30.6 years in 2009 (ABS 2010: 14) and 28.2 years in 2008 (Laws et al. 2010: 17), and the finding that it is women in their 30s who are contributing most to the Australian fertility rate (Heard 2010).

Given the trend towards delayed childbearing in Australia, and participant concerns surrounding age-related infertility, the age women perceive to be their “oldest” ideal is of equal, if not more, importance than their youngest ideal. The participants themselves also appeared to place more importance on their deadlines for motherhood. This was possibly due to many having already passed their youngest age, while being “too old” was becoming a more pressing issue the closer they got to their self-defined “crunch time”. While a few stated that their “oldest” age referred to having a first child, the majority indicated that it meant the age by which they wanted to have their last child, using terms such as “cut off” and “limit”; as Brooke explained: “I think I’d probably want to cap it at 38 really”.

All the interviewees and most of the focus group participants mentioned an age they felt was the oldest they would want to have children. Most described “older” mothers as those having children past the age of 35 or 40 years, with many clarifying that they were referring to women having their first child. The majority of the focus group participants considered 40 years old to be the end of the line. If they had not conceived by that age, they would not have children, although a few had no fixed upper limit.
I guess if I have problems [conceiving] and it took a while... I think once I hit 40 I would go “okay maybe it’s, you know, a no go”. Group 1: Melissa, age 27

The interviewees' “cut off” age spanned twenty years from the age of 30 to 50 (see Table 7.2). Around a third stated that 35 was their age limit, while the majority (50%) saw their late 30s or 40 as the oldest they would want to be having children. Only one interviewee and, as discussed above, Siobhan in the focus groups, went as high as a 50 year old limit. The majority therefore described an “oldest” age for having children that was beyond the age they believed a woman’s ability to conceive began to decline (see Table 7.2), and past the age the majority had indicated on their written survey that they intended to have all their children by, 35 years (n=29, 58%). The three women who did not want to have children held similar views on the ideal age of motherhood.

A small number of women from the focus groups and interviews did not attribute an age to their ideal timing. They based their plan entirely on the achievement of ideal circumstances, as outlined in the previous section, although, as stated above, in regard to “youngest” age this would result in their being at least 25 years old, and often older.

7.4 Negotiating the “right time”: a compromise

I don’t think it’s ever a right time...Like it wasn't the right time for me cause [my husband] and I had just got back from overseas and we had no money and we weren't established [in] any jobs or anything like that [laughs]… but I don't think any time would be the right time…it’ll just always be a little inconvenient. Even if you wait... Group 2: Jacqueline, age 28

A dual fear of “missing out” on “life” by having children when they were young or “missing out” on motherhood by leaving it “too late” created a conundrum of timing for the participants. When they combined their aspirations for lifestyle and the timing of motherhood there was often little or no room for manoeuvre. Personal and societal pressure made many participants aspire and expect to “have it all” (Arthur and Lee 2008; Bewley et al. 2005; Campo 2005; Haussegger 2005; Manne 2005; Pocock 2003; Summers 2003a). For most this resulted in the, perhaps unrealistic, expectation that they could combine the “white picket fence” traditional goals of marriage, a family home and motherhood, with the high modernity ideals of individualism, focussing on a
continued education, established career, world travel, and time to “be me” - all while they were still at a young age.

When these conflicting ideals are combined with the reflexive approach most women described applying to their lives (Giddens 1991), the problems, risks and need for compromise are highlighted. While some people adjusted their ideal age to fit their ideal circumstances, and a few vice versa, the majority of the women across the three research components spoke of the inconsistency between the two. Several women presented plans they appeared to be unaware would be unachievable, supporting Berrington’s (2004: 14) belief that the disparity between women’s intended and actual fertility can be partially explained by their lack of a “well thought out strategy”. Finding a “right time” was often seen to be impossible. How can they fit everything in?

I’m anxious…about motherhood. I’m not a mother yet and worry about being able to afford to have children at a young enough age after finishing my studies. The clock ticks… Survey 3: age 25

7.4.1 Fluidity of plans and ideologies

You don’t know what’s going to change…your business could go bankrupt and you could lose your house and have no money by the time [your children] go to uni or you could be rich and you could have ten investment properties. Like it’s hard to say when you decide to have a kid…what you’re going to be like financially in twenty years time. Group 6: Maria, age 22

For many women, the future was so uncertain that it was impossible to know when the right time would be. The conflict between ideal age and ideal circumstances, along with changes of mind and the potential for unexpected reproductive events, such as unplanned pregnancy and infertility, means that reproductive plans cannot be seen to be constant or fixed. Many women spoke of transitions during their life, some from choice and some from external circumstances, with children becoming more or less important or the intended timing being delayed or brought forward. This is in keeping with the literature which suggests aspirations for children change over time (Johnstone and Lee 2009).
A combination of a strong relationship, decreased attachment to their career and an increase in maternal or "clucky" feelings resulted in bringing the timing of children forward for some, although these women were in the minority. Reasons for delaying childbearing past perceived motherhood age limits were often linked to issues such as the complicated ordering of pre-motherhood goals that are outlined above.

Furthermore, despite the clear “ideal” age timeframes for children, many women were quick to state that their boundaries were elastic, often applying a ‘get out clause’, particularly to the oldest age they planned to have children. A number of interviewees conceded that they might push their oldest age limit for first-time motherhood higher, or had already done so, as a consequence of unconducive circumstances for motherhood, experiencing fertility problems or simply getting older. In many of these cases participants felt their desire for children would override their beliefs about ideal age.

I don’t want to be an older mother… I know that I want my first child to be before I was 30…But… it’s hard to say, if I couldn’t have children now I’d probably still be trying when I’m 40 [laughs]. I wouldn’t have an age where I would say “no I don’t want to be a mother”. Kym, age 27, wants kids now

The research findings make it clear that older motherhood was not appealing to the women in this study. However, regardless of age-related fertility concerns and a general “ideal age” framework for motherhood, participants tended to base the timing of childbearing on other life choices and aspirations which often delayed childbearing, making them older when they first tried to conceive. For some women the delay was more than they wanted or expected, resulting in their recognition of the need to compromise.

I could be forever waiting to have a child if I’ve got to make sure that my mortgage is paid off and get to make sure that I’ve got a business that can sustain itself while I’m not there for twelve months and I don’t think I’d ever get around to having children if I stayed as rigid as I think I once thought I had to be. Monique, age 28, wants kids in 2-5yrs
7.4.2 Contradictions: age versus planned timing

The interviewees' reproductive plans as they expressed them in their written survey often conflicted with the timing narrative recorded in their interview. Indeed many participants contradicted themselves within the narrative itself, as can be seen when the participants' age, plans prior to motherhood and ideal age at motherhood are considered. The interviewees' quantitative and qualitative data confirmed that the majority would like to have children and as none were pregnant or mothers, real timing could be discussed in terms of delaying children. Only twelve women (24%) were currently trying to become pregnant, all of whom were married and ten of whom were aged 30 or over.

Survey responses differed from interview responses in relation to number and timing of children. In the survey, many women wanted to have their “lifetime” number of children by the age of 35, which was between two and eight years away, but also wanted to be in full-time or part-time paid employment at age 35. In the interview, however, they often neither planned nor described the possibility of having that number of children by age 35. It is possible that in the survey they looked at each part of their life as individual entities - work, children, study, marriage - while in the interview they looked at the practicalities of the ‘big picture’. Nonetheless, many women still described planning to fit a lot of children in to a very short space of time and then be back in paid work by age 35, even in their interview narratives.

Table 7.3 shows data from the interviewees’ written surveys on their aspirations for children. A comparison between their aspirations for children “by age 35” and during their “lifetime” indicate that over a third (36% n=18) of the women interviewed expected to have at least one child after they were 35 years old. Two participants, Tara and Leonie, planned to have all of their children after the age of 35. Both women were aged 32 years at the time of the research suggesting that their aspirations could be more a consequence of realism than desired age.

An analysis of the interviewees’ interview narratives that explored when they stated that they expected or planned to have children grouped the women into five planning categories, as shown in Table 7.4: those trying now (‘Kids now’); those planning to have children in the next two years (‘Kids in <2 yrs’); those planning to have children in the next two to five years (‘Kids in 2-5 yrs’); those whose reproductive plans were more than five years away (‘Kids in 5+ yrs’); and those who planned not to have children (‘No
kids’). When conflicts occurred in the analysis, the lesser number of years was chosen so as not to over inflate the delay expected.

As the findings in Table 7.4 indicate, when the participant’s current age is compared with their intended reproductive timeframe it is clear that very few women expected or planned to have children before the age of 30. Having children appears to become more pressing as women neared and reached 30 years old. None of those women aged 32 perceived their childbearing plans to be more than five years away, however, many of this group still saw motherhood as being more than two years away. Consequently, many women were not planning to start having children until they were in their mid 30s. This was despite the concerns participants raised regarding the perceived biological limitations on their fertility and the physical and social problems of older mothers, and in contrast to their written survey data which suggested that all but two of the interviewees planned to already be mothers at the age of 35.

Deferment of childbearing has a ‘knock on’ effect on the number of children desired. For example, of the seven participants who wanted three or more children in their lifetime, six were aged under 30 years old while the seventh was aged 30. Interviewees aged 30 and over aspired to have one or two children. This reduction in family size ideals as women get older is reflected in the literature (Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004).

**Table 7.3: The interviewees’ aspired number of children by age 35 and ever**

<table>
<thead>
<tr>
<th>Number of children:</th>
<th>Interviewees (N=50) (aged 27-32 years)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>...by age 35</td>
<td>...in lifetime</td>
</tr>
<tr>
<td>No kids</td>
<td>10% (n=5)</td>
<td>6% (n=3)</td>
</tr>
<tr>
<td>1 kid</td>
<td>32% (n=16)</td>
<td>10% (n=5)</td>
</tr>
<tr>
<td>2 kids</td>
<td>54% (n=27)</td>
<td>70% (n=35)</td>
</tr>
<tr>
<td>3 or more kids</td>
<td>4% (n=2)</td>
<td>14% (n=7)</td>
</tr>
</tbody>
</table>

*“n” = the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives*
### Table 7.4: The interviewees’ age now compared with their planned timing of motherhood

<table>
<thead>
<tr>
<th>Age now</th>
<th>Timing of motherhood</th>
<th>Now (less than 2 years)</th>
<th>Soon (28-30 yrs)</th>
<th>In 2-5 years (30-33 yrs)</th>
<th>In 5 years+ or unclear (34 yrs+)</th>
<th>No kids</th>
</tr>
</thead>
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<td></td>
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<tr>
<td>27yrs</td>
<td>Aged 27yrs</td>
<td>-</td>
<td>Will be aged 29-32yrs</td>
<td>Will be aged 32yrs+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(n=5)</td>
<td>20% (i=1)</td>
<td></td>
<td>20% (i=1)</td>
<td>60% (i=3)</td>
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<tr>
<td>28yrs</td>
<td>Will be aged 28-30 yrs</td>
<td>11% (i=1)</td>
<td>Will be aged 30-33 yrs</td>
<td>Will be aged 33yrs+</td>
<td>11% (i=1)</td>
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<tr>
<td>(n=9)</td>
<td>12.5% (i=4)</td>
<td></td>
<td>55% (i=5)</td>
<td>22% (i=2)</td>
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<tr>
<td>29yrs</td>
<td>Aged 29yrs</td>
<td>Will be aged 29-31yrs</td>
<td>Will be aged 31-34yrs</td>
<td>Will be aged 34yrs+</td>
<td>-</td>
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<tr>
<td>(n=8)</td>
<td>12.5% (i=1)</td>
<td>50% (i=4)</td>
<td>25% (i=2)</td>
<td>12.5% (i=1)</td>
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<tr>
<td>30yrs</td>
<td>Aged 30yrs</td>
<td>Will be aged 30-32yrs</td>
<td>Will be aged 32-35yrs</td>
<td>Will be aged 35yrs+</td>
<td>7% (i=1)</td>
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<tr>
<td>(n=14)</td>
<td>29% (i=4)</td>
<td>7% (i=1)</td>
<td>43% (i=6)</td>
<td>14% (i=2)</td>
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<tr>
<td>31yrs</td>
<td>Aged 31yrs</td>
<td>Will be aged 31-33yrs</td>
<td>Will be aged 33-36yrs</td>
<td>Will be aged 36yrs+</td>
<td>11% (i=1)</td>
<td></td>
</tr>
<tr>
<td>(n=9)</td>
<td>55% (i=5)</td>
<td>11% (i=1)</td>
<td>11% (i=1)</td>
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<tr>
<td>32yrs</td>
<td>Aged 32 yrs</td>
<td>Will be aged 32-34yrs</td>
<td>Will be aged 34-37yrs</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>(n=5)</td>
<td>20% (i=1)</td>
<td>20% (i=1)</td>
<td>60% (i=3)</td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td>16% (i=8)</td>
<td>36% (i=18)</td>
<td>18% (i=9)</td>
<td>6% (i=3)</td>
</tr>
</tbody>
</table>

**n**= the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives

**i**= the number of interview participants and indicates the finding is based on interview narrative data, as opposed to the written survey data
7.4.3 Rationalising older motherhood

A theme of this chapter can be summed up as ‘not doing what you want – doing what you didn’t think you wanted to do’, meaning that the participants needed to reconcile themselves to how their lives were turning out. While few women wanted to be “older” mothers they felt it had become more of an option for them. The trend towards delayed childbearing in Australia encouraged the participants to view older motherhood as being increasingly socially acceptable. Many participants spoke of their observation that women around them were having children at later ages, and the majority felt that older motherhood was becoming more common. Older motherhood was also perceived to be more technically possible. The women in the study discussed both the use of contraception and pregnancy termination to delay childbearing, and the use of assisted reproductive technology (ART) to facilitate pregnancy in cases of age-related infertility. For the majority of the women these beliefs helped to legitimise and rationalise their own delayed childbearing and downplay their fears about the risks of older motherhood, overriding their belief in 25-35 years old as the ideal timeframe for having children. The participants’ perception of having options fits with the current generational zeitgeist of choice which includes making decisions about the body that had previously been governed only by “nature” (Giddens 1991).

Another way in which some of the women in the study rationalised the compromises they were making to their desired timing of childbearing, usually in the form of delay, was to view age at motherhood as being most important for their first child. This was despite the majority of their reservations about older motherhood being biologically based, which should have applied to age at all pregnancies. Some women articulated concerns about infertility past a certain age but still planned to have subsequent children after this time. One possible reason for this is that they may have felt that if they had been able to have a child, this would ‘test’ their fertility and older motherhood would be more possible for later children.

*I sort of look at it like around 35 the chance of becoming pregnant might start falling… and that’s why I’d like to have a first child before then to make sure it all works.* Natasha, age 28, wants kids in 5+yrs

This is more difficult to make sense of for those women who discussed their anxiety about foetal chromosomal abnormalities for mothers over age 35, yet also planned to have children after this time.
... when you get to 35 things start to be a bit more dangerous...like increased risk of Down syndrome for the child and that type of thing ... so I probably think that 35's [best] for your first child. 'cause I'm not going to fall pregnant straight away I would imagine so I would probably think by 33 we'd have started to try. Simone, age 31, wants kids in 2-5yrs, wants 1 child by 35 and 2 children ever

The importance of being younger with one’s first child is associated with wanting more than one child, as most of the participants did, meaning the younger they are with the first, the younger with the second, and so on. However, having subsequent children at older ages still contradicted their biological age-related concerns.

Despite their beliefs about support for older motherhood, and the priority they gave for maternal age for a first child, most women continued to express age-related concerns alongside their options discourse, and often put a “cap” on what they felt was “acceptable” older motherhood, usually limiting their plans to age 40.

I think just generally in society we see once you’re in your 40s having children is not really... not common in a sense. Not that it’s not acceptable. But I think having children probably in your 50s would be considered not acceptable.

Monique, age 28, wants kids in 2-5yrs

7.5 Conclusion

In conclusion the majority of the young Australian women in this study are delaying having children. The qualitative data discussed in this chapter reflect national statistics (ABS 2010; Kippen 2006; Laws et al. 2010), but more importantly this discussion shows that there is a list of precursors to motherhood that delay childbearing and override beliefs about the ideal age for motherhood. When to have children appear to pose a far more complex question than if for young women.

It is clear that most women do not aspire to be older mothers; they hold strong views on the optimum age to become a mother, usually between 30-35 years old, and express concerns about age-related infertility. However, the participants’ narratives demonstrated the need for this ideal age range to be reconciled with attaining the ideal circumstances for childbearing. This negotiation meant that only a quarter of the interviewees had started trying to conceive and many participants will delay having children until they are in their mid to late 30s.
The women’s perception of the mother construct was often the reasoning behind their reproductive planning narratives, primarily the widespread belief that motherhood necessitated the establishment of security and stability prior to having children, in order to fulfil the responsibilities of the role. They also felt they should complete any additional life goals first, due to the view that having children may restrict their future achievement. A common list of precursors to motherhood was created from both traditional and modern goals and values, focussing on financial security, relationship stability, self-fulfilment and career establishment. Although these factors usually resulted in delayed childbearing, their desire for children, the ultimate reward of motherhood, counterbalances the delay - as do beliefs about the impact of age on fertility and the ability to mother. Consequently, it is not a difficulty of desire but a difficulty of timing that delays childbearing, caused in part by negative perceptions of motherhood and the potential conflicts it will cause with other life goals.

This chapter highlights the conflicting beliefs many women hold in regard to the best time to have their children. Avoiding one risk usually means facing another head on, with women seldom able to find the perfect “right time”, although older rather than younger motherhood is favoured in the compromise. The problem of timing is compounded by the need to actively choose motherhood and the means by which to do so, as will be discussed in the next chapter.
Chapter 8: The design tools of reproduction: rationalising and realising older motherhood

I always thought I’d like to be finished having children by the time I’m 35. However, I’ve kind of changed my view on that just recently and… I don’t think there’s an age limit… If it didn’t happen the way I planned it to happen I wouldn’t rule out being pregnant at an older age… because my husband and I have been trying to have a baby and it’s not happening at the moment [laughs]. So… I’m open to the fact that it could take a while and it might not necessarily run as smoothly as I originally thought. Danielle, age 30, wants kids now

8.1 Introduction

This chapter focuses on the ‘design tools’ of reproduction, exploring the part reproductive technology plays in the choices women make about having children and how women use both technological and non-technological methods to engineer, enable and preserve their family planning intentions. The difficulty many participants described in finding a “right time” to have children, as identified in the previous chapter, meant that part of how women enacted their plans involved them rationalising the compromises that resulted from this goal, primarily the delay of childbearing and the increased likelihood of motherhood at an age that was older than they ideally wanted. Central to this reflexive process were the participants’ social constructions of motherhood, and the practical means they used to facilitate their plan, and, for many women, to postpone having children. The findings describe how women use, and plan to use, reproductive technology to balance the “risks” of both unplanned pregnancy and infertility, each of which were viewed as having the potential to dictate the timing of motherhood outside of the women’s planned ideal time frame. Consequently, issues of control and safety were prominent in the women’s narratives.

For the purpose of this investigation the broad term “reproductive technology”, which includes any technological intervention in the reproductive process, is restricted to those technologies deemed most pertinent to decision-making about whether and when to have children. These include: contraception, abortion, and assisted reproductive technologies (ART), such as in vitro fertilisation (IVF). Particular attention is paid to how these technologies impact on reproductive decisions that result in delayed childbearing and smaller families and how, in an age of self-management and perfectionism, women hope to manage the prospect of unplanned reproductive events.
Furthermore, the influence of cultural norms, “everyone is on the pill”, on decisions about the use of contraception or other reproductive technologies are examined, along with their beliefs and values about what is considered “safe” and “natural”. The themes of risk, choice and control, agency and fate, nature and intervention were found in relation to each reproductive technology and are explored in detail.

Qualitative and quantitative findings from all three research components are presented here in an integrated format, as the similarities in the technology narratives of the commenter, focus group and interview participants determined a chapter structure based on technology type as opposed to the chronology of data collection.

8.2 Fertility control

The availability of reproductive technologies was seen to facilitate older motherhood, being perceived to make it both more possible and “safer”. There was both an articulated trust in science and a belief that something new could destabilise what you thought was so. This exemplifies the heightened sense of uncertainty in contemporary societies, in which expert systems such as medicine have become disembedded from traditional certainties, such as biology (Giddens 1991). The technologies the participants discussed included contraception and abortion, which enable the delay of childbearing and mitigate unplanned pregnancies; assisted reproductive technology (ART), that provides the potential for motherhood in the face of infertility; and foetal screening tests which, when combined with the availability of abortion, offer choices in the event of foetal abnormalities which are more commonly experienced by older mothers (Alonzo 2002).

8.2.1 Contraception: “part of everyday life”

*I’ve definitely had choices and made a choice not to get pregnant.* Tamara, age 30, wants kids now.

Contraception was, unsurprisingly, reported as the most common tool used by the participants to shape their reproductive plans, delaying motherhood until they felt the time was “right” to have a child or, for a minority, to prevent childbearing altogether. For those commenters and the few focus group participants who were already mothers,
contraception was described as being used to control the spacing and number of subsequent children.

Contraception is defined as “the prevention of unwanted pregnancy…[by] drug, device or other means” (Anderson et al. 1999: 354). Therefore, for the purpose of this thesis, the term contraception incorporates: the oral contraceptive pill, subsequently referred to by its colloquial name ‘the pill’ as labelled by the participants in all three components; other hormone-based methods, including the contraceptive injection, contraceptive implant, and emergency contraceptive pill; barrier devices, such as the condom and the diaphragm; and finally, a group of techniques commonly referred to as “natural”, including coitus interruptus, referred to here as the ‘withdrawal’ method, and those, such as the Billings and ‘rhythm’ methods, that use temperature readings and mucus sensations to chart ovulation and determine the times when a woman is most and least fertile. These latter “natural” methods of contraception fall outside the category of reproductive technology per se and can, therefore, be viewed as alternatives to technology.

The participants felt that contraception provided them with choices and options. Motherhood itself was viewed as something to be actively chosen. By segregating sex from reproduction contraception literally offers fertility control and the ability to have reproductive plans as opposed to merely reproductive events. Indeed the very fact that reproductive plans and intentions can be discussed and researched at all is largely due to the existence of those technologies that have the potential to make motherhood a choice.

*How I feel about using contraception? I think it's fantastic to help women… be able to make a choice… to enable them to have a child if and when, and only when, they feel ready.* Yvette, age 29, wants kids in 2-5yrs

Andrea and Peta reflected this belief in their interview narratives by describing the choices contraception offered as “a great empowerment for women”. More often, however, this benefit was taken as an accepted part of being of their generation, as opposed to that of their mothers and grandmothers.
I think the big thing these days is contraception. You get that freedom of really choosing when you want them [children]... [My] grandmother said to me [laughs] “I envy you girls with the choice of contraception”. ‘Cause [then] you sort of had your kids when you fell pregnant and... you didn’t really have a choice and I suppose even [since] my mum’s era contraception has just come along so much further, and a lot more reliable. Vicki, age 30, wants kids in 2-5yrs

The association between contraception and autonomy, choice and control for women is a common topic in the literature (Albury 1999: 14; Bryson et al. 1999; Bryson 2001; Hakim 2003; McDonald 2000b; Wajcman 1991). It is in keeping with Giddens’ (1991: 8) assertion that, in late modernity, managing the body has become part of the reflexive process, with technology allowing “human action” to replace “nature” to a certain extent. The literature cites contraception as a primary reason behind the trends of delayed childbearing and lower fertility rates (ABS 2010; Bulatao 2001; Castles 2002; Hakim 2003; Lee and Gramotnev 2006a; Mackinnon 1997; Weston et al. 2004). In their fertility narratives, however, the participants themselves described contraception not as the cause of their plans but as a tool that enabled them to realise their plans.

Rachel, an interviewee, associated the potential for an unplanned pregnancy with the “consequences” of not using contraception. This view was shared by the majority of the participants, with unplanned pregnancy variously described as “a risk”, “a problem”, even “an evil” and contraceptive use described as the obvious proactive preventative solution. This language of risk is characteristic of modern society (Beck 1992; Giddens 1991). For many of the participants, when the “risk” of pregnancy was placed within their motherhood construct of responsibility, restriction and reward, and their somewhat reluctant coping strategy of delayed childbearing, contraception became “essential”, and “a necessity”. Consequently, while contraception was discussed positively as a “choice” for women, in actuality it appeared to be more a “given” part of the participants’ lives. The normalisation of contraceptive use was accommodated by the participants’ view that, in general, a variety of contraceptive methods were widely available, and held an accepted place in society.

This normalisation, and the high usage of contraception that the women reported, combined with the difficulty they described in finding a “right time” to start having children was exemplified by descriptions of the agonising decision many described in stopping using contraception and starting to try and conceive. Ellie, who was currently
pregnant, spoke of her decision to have children by explaining, “we made a conscious decision to stop not trying”, a euphemism for stopping using contraception. This reinforces the finding that motherhood is something that most women aimed actively to choose, highlighting a desire for autonomy and control and the carefully constructed plan to find the perfect time. In this instance the “risk” of pregnancy must be weighed against the “risk” of older motherhood.

8.2.2 Contraceptive practice: “safety” versus “the natural”

The participants’ contraceptive use was explored both qualitatively and quantitatively. This included direct and indirect qualitative questions asked of the focus group and interview participants about how they “managed their fertility” and their general childbearing plans. The topic of contraception was introduced by half of the interviewees themselves, while I instigated this discussion in the remaining interviews and in most of the focus group discussions. The latter were often less forthcoming than the interviewees, possibly due to the personal nature of discussing contraception in a group environment. A multiple choice survey question completed by the interviewees documented their “past” and “present” use of contraception, the findings of which are presented in Appendices 8.1, 8.2, and 4.3.6. A number of commenters also chose to write about their contraceptive use in response to the open ALSWH survey question “Do you have anything to add?” The contraceptive use data from the ALSWH 1973-78 cohort provided a useful comparison to the findings from this research.

All of the interviewees and most of the focus group and commenter participants reported having used one or more methods of contraception at some point in their lives [see Appendix 4.1.2, 4.3.6 and 8.1]. It was common for women to be combining two methods of contraception, as a fifth of the interviewees were [see Appendix 8.2]. The vast majority of the participants across the three components chose to use a technologically based contraceptive, a hormone-based or barrier method, with only a few relying on “natural” methods alone. ‘The pill’ and condoms were the most common methods used both “ever” and “now” across the research. Of the interviewees, all but one had “ever used” the pill (98% n=49), and a third used it “now” (34% n=17); while 94% (n=47) had “ever used” condoms, and a third used them “now” (32% n=16). Other methods were far less common. The ‘withdrawal’ method had been used by just under half of the interviewees (n=22), of whom eight (16%) were currently practicing it. A third had “ever used” (n=18) the emergency pill. None stated they were currently using it, presumably as this is a reactive measure. Only a few interviewees described having
used other hormonal (e.g. contraceptive implant or contraceptive injection) or natural (e.g. Billings or rhythm) contraceptive methods “now” or “ever”. The interviewees' contraceptive practices were in keeping with findings from the ALSWH 1973-78 cohort more generally (ALSWH 1997; 2002; 2005). Tables detailing the interviewees and ALSWH 1973-78 cohort contraceptive use can be found in Appendices 8.1 and 8.2.

The variable nature of contraceptive practice should be considered when these findings are interpreted. In the long term, life course changes such as relationship status or reproductive plans can impact usage (Foran 2003; Lee and Gramotnev 2006a). In the short term, each method is dependent on its consistent application. Several participants, including Nicole in focus group 2, mentioned the possibility or actuality of personal fallibility in remembering to take the pill every day. This was also true for other methods, such as remembering to use a condom every time you have intercourse or returning to the doctor to have the contraceptive implant replaced.

For most women, choosing which method of contraception to use was determined by a balance between their need for contraception, in relation to their openness to becoming pregnant; their perceptions about the reliability or safety of the method in comparison to that of pregnancy “risk”; and the perceived level of “intervention” or “intrusion” experienced in the methods use, often associated with beliefs about the “natural”, and actual or anticipated side effects (see Figure 8.1). This approach reflects the contraceptive continuum that is discussed in the literature (Foran 2003). The continuum positions those contraceptive methods viewed as being the most “effective”, the pill and other hormone-based options, at one end of the continuum. These methods were also usually believed to be the most “invasive”, with many participants cataloguing side effects, and discussing their dislike of taking “chemicals” and the monotony of taking a pill every day. Condoms and other barrier methods were positioned centrally on the continuum, “safe” and less invasive due to not being hormone-based, although some women described them as interrupting the “flow” of making love. At the other end of the continuum were “natural” methods. These included the withdrawal, Billings and rhythm methods which were seen by most women as not being “safe”, while others viewed them as a preferable non-invasive alternative for preventing pregnancy. Consequently, certain contraceptive methods were generally chosen for being “safer” or less “invasive” than others.
Figure 8.1: Choosing a method of contraception

most effective/
most invasive

The pill & other hormone-based methods

Condoms

“Natural” methods, such as withdrawal, Billings & rhythm

least effective/
least invasive

value placed on ‘safety’/reliability

value placed on ‘natural’/level of intervention

chosen method of contraception

openness to pregnancy
The participants’ overriding desire to plan the timing of childbearing, which for most meant continuing to delay having children, resulted in the majority of the women in the study prioritising the effectiveness of their contraceptive method over concerns about potential side effects and invasiveness. For over half of the interviewees (58%, i=29) this approach was unproblematic. These women were ‘routine’ users of contraception. They discussed contraceptive technology in a positive and matter-of-fact way, and typified the themes of choice, risk, and normalisation, viewing contraception as the obvious proactive answer to avoiding pregnancy until the time was right to have children. Stacey, for example, felt using contraception was “part of everyday life”. The most important classification was that ‘routine’ users were happy with the method of contraception they currently or usually used, regardless of negative experiences. Their assessment focussed on issues of safety, choosing a method for its perceived reliability. They were unconcerned about the level of “intervention” involved in its application. Many felt the pill was the “safest”, “easiest” and most “convenient” method of contraception available, with reliability seemingly associated with the use of hormones. Consequently, not including those women who were trying to conceive, three-quarters of the ‘routine’ user group were taking hormone-based contraceptives. The condom was also viewed as “safe”, though often not as safe as the pill. Other methods often met with mistrust, through lack of knowledge and/or a belief that they would not protect them from the “risk” of pregnancy as effectively as their chosen method; this was particularly the case for the withdrawal, Billings and rhythm methods.

*I’ve got friends who use the withdrawal method and…I just think…. if you don’t want to have children that’s not an acceptable method for me.* Erin, age 28, wants kids in <2yrs

For a quarter of the interviewees (26%, i=13), their desire to plan when they had children was so strong that they had ‘resigned’ themselves to using contraceptive methods they believed were “safer” than others in spite of their ambivalent or negative feelings towards that method. They reported currently, or usually, using a contraceptive method they were not happy with. Their unhappiness, which ranged from strong to ambivalent, was often associated with the level of “intervention” they perceived to be involved in the method, and almost always centred on experienced or anticipated concerns about the hormones involved in taking the pill, including headaches, “feeling fat”, high blood pressure, and fears that its prolonged use could affect their future fertility potential. This latter concern is exacerbated by delayed childbearing which usually increases the number of years a woman requires contraception, and therefore
their length of time on the pill. The negativity experienced towards certain methods by this group of women, however, was outweighed by the perceived “risk” of pregnancy, and the desire to control their reproductive lives, with contraception being seen as the lesser of the “two evils”. This was due to the value system the ‘resigned’ women shared with the ‘routine’ women which placed hormone-based contraceptives, and also often condoms, above other contraceptive methods in terms of their perceived ability to effectively protect them from pregnancy.

I’d rather take the pill and put up with the fact that I’m taking hormones every day which maybe I don’t really like but it’s worth taking that than having an unwanted pregnancy with no choice to make. Now we’re using condoms and they’re a bit of a pain ‘cause you’re sort of in the flow of things [laughs] and you’ve got to stop and remember… but again you just do it because the risk of getting pregnant is just not one I’m willing to undertake. Fiona, age 30, wants no kids.

Contradiction resulted from a desire to control their reproductive lives, a lack of trust in alternative methods, and the “ease” and “convenience” some viewed the pill as offering, regardless of their anti-technological stance. Therefore, it could be argued that while the ‘resigned’ users’ perception of pregnancy risk and the reliability of certain methods normalised their need for contraception, their concerns about their current or usual method suggested a need for alternative contraceptive options, and thus they did not express the same sense of having “choice” that other interviewees did. Consequently, despite their concerns, over half of the ‘resigned’ users were taking hormone-based contraceptives; including seven women who were on the pill, some of whom combined this with condoms or the withdrawal method, and one who was using the contraceptive implant.

In contrast to contraceptive technology as a “fact of life”, and possibly partly in response to this mindset, a small group of interviewees (16%, i=8) took a ‘natural’ approach to contraceptive use. They shared and acted upon the concerns voiced by the ‘resigned’ users by avoiding hormone-based methods due to the perceived impact they could have on their bodies. This appeared to be an informed stance as all but one of this group stated that they had used the pill in the past. Unlike the ‘resigned’ users, the ‘natural’ users chose to manage their fertility using a contraceptive method they were happy with, prioritising their anti-“interventionary” stance. These methods
included condoms (n=6), and the withdrawal, Billings or rhythm methods (n=2), all of which they considered less “intrusive” and more “natural” than hormone-based options.

_The major form of contraception that I use or that [my partner] uses is the withdrawal method… And also… natural fertility management which is a combination of the Billings method and temperature and mucus and ovulation charting… I would not take the pill or any medication to control my hormones… I just don’t want to put chemicals in to my body and suppress my natural rhythm._ Sonya, age 27, wants kids in 2-5yrs

8.2.3 Openness to pregnancy outside of “the plan”

Central to their assessment of each contraceptive method was the participant’s reproductive plan. Here the question of how certain they were about their desire, or lack of desire, to have children was joined by the issue of how ‘open’ they were to becoming pregnant outside of their carefully calculated plan, influenced by what point they were at in their childbearing timeline.

A comparison between the interviewees’ contraceptive _beliefs_ and their conviction about having children found that those who were using methods they were happy with, the women who held a ‘routine’ or ‘natural’ approach to contraception, were more likely to be ‘definite’ in their plans to have children, 72% (i=13) and 75% (i=6) respectively, than those who were ‘resigned’ to using contraception (58% i=7). This suggests that the ‘uncertainty’ towards having children experienced by the ‘resigned’ group encouraged them to prioritise methods they perceived to be “safer” at the expense of their beliefs about how “invasive” the method was, in order to ensure that they did not fall pregnant and waited to have children at the “right time”. Less clear results were found when the interviewees’ chosen contraceptive _method_ was compared with their level of conviction about having children and their desired timing of motherhood. The two most commonly used contraceptive methods, the pill (34%, n=17) and condoms (32%, n=16), were used across both the conviction spectrum and also the timing categories. The exceptions of course were those women who were actively trying to conceive, who were not using any contraception.

A micro analysis of the contraceptive methods that could be described as being at opposing ends of the participants’, and Foran’s (2003), effectiveness and side effect contraceptive continuum did find a relationship between method, conviction and timing; the numbers involved, however, were small. Karen and Anita, the two women who
used only the withdrawal method, a method seen to have potentially the biggest margin for error but also perceived as more “natural”, were both definite about having children and wanted their first child in the next two years. Karen’s quest to find the “right time” to have children prevented her from actively trying to conceive. However, she described her current contraceptive use, the withdrawal method, as “not being very careful” and “leaving a lot up to chance”, explaining:

*Up until, well I guess when we got married, we were always careful about not getting pregnant. And that was a conscious decision. But now I’m very open to it and in a way I would like it to happen by accident. Because then I don’t have to decide.* Karen, age 29, wants kids in <2yrs

Conversely, those interviewees who were using the contraceptive implant (n=3) or injection (n=1), methods it could be argued that were the most secure, due to their long-term application, but perceived by some to “mess up your system [with] chemicals”, were ‘likely’ or ‘uncertain’ in their desire for children, and wanted children in two to five years or five or more years. This included Laura who stated that while she wanted to have children she did *not* want to be pregnant, and was considering adoption.

These findings highlight an association between the contraceptive method’s place on the “safety” continuum and the user’s “openness” to pregnancy, in regard to how near their goal of childbearing is, although the small number of women involved in the analysis should be noted. Those methods seen to be “fraught with danger” by those *not* using them, were used when women were closer to their chosen timing of motherhood, perhaps suggesting that they too felt these methods were more fallible than others, as Karen intimated above. The relative permanency, and associated “safety”, of the injection and implant methods fit with a later reproductive plan.

Interestingly, the three interviewees, who aspired to have no children, Heather, Julie and Fiona, were using the pill (n=1) or condoms (n=2), methods viewed as “safe” but lacking the security of permanency offered by others. Heather, who was ‘certain’ in her desire to remain childless, and therefore ‘closed’ to pregnancy, had considered the possibility of being sterilised so as to remove the “worry” of an unplanned pregnancy. However, she explained that she would probably need to continue taking the pill anyway for medical reasons so “why would you go through surgery?”
The normalisation and continued high use of contraception, including a notable proportion of women who were using a method they were not happy with, highlights the emphasis women placed on effective “safe” contraception, in order to avoid the “risk” of pregnancy and fulfil their reproductive plans. This enabled delayed, and often older, motherhood.

8.3 The unplanned

*I can’t believe that there’s so much emphasis on planning it [having children] because to me I think that it is quite often something that just happens. There’s so many accidents... I used to think to myself I’d ideally like to plan it but if it happens it happens as well... in saying that if you are on the pill or something obviously you have to go off it so you would have to plan it in some kind of way. But then again you can still get pregnant on [the pill] as well. Group 6: Kathryn, 23 years*

The discussion thus far has shown that the participants in all three components articulated a desire to make active choices and decisions about their fertility and usually employed reproductive technology, in the form of contraception, to engineer their plan to have children at the “right time”. Women’s reproductive lives, however, do not always go as planned. This was substantiated by the finding that the participants’ motherhood aspirations were frequently discussed within a framework of biological chance, including the possibility or reality of unplanned pregnancies, miscarriages, and problems conceiving. These reproductive events often resulted in the use of reproductive technology, such as pregnancy termination or assisted reproductive technology (ART), and highlighted the complexity of the family planning question in regard to making active choices. Albury (1999: xii-xiii) stresses the importance of supporting women in the reproductive decisions they need to make “next” as a consequence of the unpredictability of biology. Unplanned reproductive events have the potential both to bring forward and to delay childbearing. Given that most of the women in this research are yet to have children, the latter consequence is explored in more detail here.

8.3.1 The “risk” of unplanned pregnancy realised

A small group of women from across the research chose to discuss their experience of having an unplanned pregnancy. This was often described as the consequence of
contraceptive failure. They also discussed their decision either to continue with or terminate the pregnancy.

_I have actually fallen pregnant before and chose to have a termination. So… my contraceptive [use] hasn't always been fool proof._ Group 7: Siobhan, age 31

As no direct questions about such “accidents” were asked of the participants it was not possible to ‘count’ their occurrence in this research. An exploration of the possible responses to unplanned pregnancy was conducted using the qualitative and quantitative data, including the place of pregnancy termination in their decision-making.

8.3.1.1 Terminating a pregnancy to delay motherhood

Those women who spoke of their decision to terminate their unplanned pregnancy frequently cited poor timing as their reason, usually linked to their age or circumstances. This included several commenters at each of the three surveys, two focus group participants, and four interviewees. Any interviewees who experienced an unplanned pregnancy would have to fall into this category due to their childless sampling criteria. In these instances abortion delayed childbearing until a perceived “right” or better time, as defined in the previous chapter. Financial instability, an underdeveloped career, and being “too young” were all mentioned. The prospect of single motherhood was not given as a reason by any participant, with many mentioning a partner in their descriptions of the decision to have an abortion.

_I recently had a termination, this was a decision that was made with my partner, due to financial reasons and also career development._ Survey 1, age 22

In her interview Melanie noted that she was “very grateful” she had had the abortion as she was only 16 years old at the time, and “too young” to become a mother. She planned to make a decision “one way or the other” about having children in three years time, when she would be aged 32, considerably older than her original prospect of motherhood. Vanessa’s story was more complex. The pregnancy had occurred at a time when she was “not ready”. She had been taking medication that could have affected the baby’s health. She was also having relationship problems and her husband had a gambling addiction. These circumstances threatened the ideals of being responsible and achieving financial and relationship stability prior to parenthood that Vanessa shared with most of the study participants. Having resolved these
concerns Vanessa and her husband were now trying to conceive. Both Melanie and Vanessa felt that delaying motherhood through their use of abortion had been the best outcome for them.

Abortion as a topic was introduced by participants in almost every focus group discussion in relation to their own or friends’ experiences, or issues such as pregnancy “risk”, or the foetal health problems they associated with older motherhood. The same was not true of the interviewees, with only eight out of fifty discussing pregnancy termination. Three referred to reproductive choices more generally or other people’s experiences, while five mentioned their own abortions. This was in spite of the fact that a fifth of the interviewees (20%, n=10) stated in their written survey that they had experienced one or more pregnancy termination, and a direct interview question which asked whether their reproductive lives had gone as they had expected. This discrepancy was possibly due to there being no direct pregnancy termination questions asked in the interviews, a belief that they had already provided the information in their written survey, or perhaps because they felt uncomfortable discussing the subject. The interviewees’ quantitative abortion data suggest that they were slightly more likely than the urban ALSWH 1973-78 cohort as a whole (Survey 3: 15%, approximately n=815) to have had one or more pregnancy termination (ALSWH 2005). The difference was possibly accounted for by the interviewees’ childlessness sampling criterion which meant that any interviewee who had chosen to continue with an unplanned pregnancy would not have been eligible to participate in the interview. As no direct question about pregnancy terminations was asked of the focus group participants it is not known how many of them had experienced an abortion.

8.3.1.2 Acceptance of earlier motherhood
An alternative response to an unplanned pregnancy resulted in women becoming mothers earlier than they had intended. Several commenters from each of the three ALSWH surveys and three of the five mothers from the focus group discussions reported this experience, describing their decision to continue with an unplanned pregnancy and have the child. None of the interviewees could fall into this category due to the sampling criterion. For Aletha, her son was “a little souvenir I got from travelling last year. I didn’t plan to have a baby” (group 7, age 20). Jacqueline explained that, “we hadn’t said ‘let’s have kids’. It just happened… I wanted it to happen in the next year anyway but we hadn’t started trying” (group 2, age 28). The finding of unplanned motherhood is supported by national and Victorian research which found that between
a third of men and women (Weston et al. 2004), and half of women (Maher et al. 2004), with children have had at least one child as the result of an unplanned pregnancy.

Given that all of the thesis participants were aged 32 years and under, these unplanned children frequently resulted in what the participants themselves defined as “young” motherhood, as discussed in the previous chapter. Having unplanned children appeared to compound the perceived difficulties associated with younger motherhood, such as not being financially and emotionally “ready” and the restrictions children can place on achieving education and career goals, see Chapters 5, 6 and 7.

I fell pregnant unexpectedly just after gaining a good job. We decided to go ahead with the pregnancy but feelings of...uncertainty plagued my pregnancy and the first year of [my daughter’s] life… The stress of being a new mum when I was on a well-planned career path has made motherhood extra tough. Survey 3: age 27

These feelings were in contrast to the two focus group participants, Ashley and Wendy, who had planned to be young mothers and, in recognition and acceptance of the potential limitations children could present, had had strategies for how they intended to fulfil their other life goals, such as delaying their career.

The number of participants who described the two possible outcomes of an unplanned pregnancy were small and it was not within the scope of this study to explore the differences between women who chose to continue with and women who chose to terminate unplanned pregnancies. The findings do, however, emphasise the divide in maternal age that often resulted from the two options.

8.3.1.3 Ready for an unplanned pregnancy?

The actual or hypothesised reaction to an unplanned pregnancy appeared to have the potential to change over time. Several women explained that as they grew older and had fulfilled more of their ideal circumstances, including a personal sense of readiness for the responsibility of motherhood, they were more open to the prospect of having a child outside of their plan and before they had actively begun trying to conceive. They explained that being more “ready” financially and emotionally to have children made the prospect of deciding to terminate an unplanned pregnancy more difficult “morally”, than they felt it was, or would have been at a younger age, when they were not “ready”.

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This belief maintained the goal of attaining the right circumstances before becoming a mother, and the resulting trend toward women having children at older ages.

I used to think I could [have an abortion] but…I couldn't ethically justify it to myself now because I couldn't financially justify it, I could financially support myself and a baby now. But prior to [that] I felt like I couldn't really get the help and support so then I could ethically do it. Group 1: Ellie, age 27

The prevalence and participant instigated discussion of unplanned pregnancy is at odds with both the participants' desire to plan when they have children and their extensive and normalised use of contraceptive technology. The participants' awareness of the possibility of the unplanned was illustrated by their preoccupation with pregnancy as a “risk” and the need to find a “safe” method of contraception to prevent the need to make the “difficult decision” between having a child earlier than planned or terminating the pregnancy. In her interview Tara referred to her previous unplanned pregnancies as being the consequence of using a contraceptive method other than the pill to explain her current ‘resigned’ use of the method.

I'm not particularly happy about using the pill, just in terms of messing up your system chemically. I would prefer not to but I see pregnancy as being the greater of the two evils [laughs] and my partner and I have tried not using the pill in the past and we're just not very successful at that and that did result in a pregnancy… so that's [taking the pill] what we need to do... Tara, age 32, wants kids in 5+yrs, survey states she has had two abortions

Overall, participants from across the research identified abortion as a real, if difficult and highly personal, choice for women in Australian society today. This view is largely supported in the literature (Betts 2004; 2009; Bryson 2001). The continuing debate over access to abortion, evidenced by variation in legislation governing the procedure across the different states and territories in Australia, and the impact this has both on women’s reproductive choices and on the stigma that remains associated with terminating a pregnancy, are also mentioned (Albury 1999; Baker 2008; Betts 2009). Those women who discussed experiencing increased “readiness” for an unplanned pregnancy as they got older exemplified the balance between the importance placed on creating the “right time” to become a mother and the common view that terminating a pregnancy was an emotionally, physically and morally difficult choice: a choice that
many women in the research considered themselves “very lucky” that they had not had to make.

8.3.2 Pregnancy termination for medical reasons

A very small number of participants described choosing to terminate their pregnancy as a result of discovering health problems with the foetus, regardless of whether or not the pregnancy had been planned. This was true for Amy, an interviewee, who explained that as well as her pregnancy being “unexpected”, tests revealed that the baby had cystic fibrosis, which was the reason given for the decision to have an abortion. At each of the first three ALSWH surveys several commenters noted that foetal abnormalities were the reason for their abortion (n=2, n=3, n=4 respectively). Some stressed that the pregnancy had been “wanted”. These comments prompted a wording change in the fourth survey of the ALSWH 1973-78 cohort, dividing a question about abortion prevalence between “termination for medical reasons (e.g. foetal abnormalities)” and “termination for other reasons”. At Survey 4 only 2% of the urban cohort had had one or more abortions for “medical reasons” while 15% had had one or more for “other reasons” (ALSWH 2007).

Despite the rare occurrence of “terminations for medical reasons”, the possibility of such an event was mentioned by participants in both the focus group discussions and interviews. This was specifically in relation to their own, and/or the national trend toward, delayed childbearing, and the increased risk of foetal abnormalities they perceived for older mothers. Their concerns are supported by medical research (Alonzo 2002). This finding exemplifies the advent of “new” moral dilemmas in the risk culture of late modernity (Giddens 1991), in this instance women’s awareness, often supported by media coverage, of the potential for negative repercussions of older motherhood.

While voicing their concerns about older motherhood, the participants in two of the focus group discussions as well as Tara, an interviewee, described their belief that reproductive technology in the form of foetal “screening techniques” meant that women can become a mother at older ages more “safely” than they have done in the past. The technology, such as amniocentesis, a pre-natal test for various chromosomal abnormalities, was seen to provide a potential, if difficult, safety net that could inform decisions about using further intervention in the form of a pregnancy termination, should a problem be detected.
I don’t think things like the increase in…genetic difficulties for children as you get older…would have that much of an impact [on] whether I’d have children later or not. Because I think just in terms of medical science and being able to detect those things early. Tara, age 32, wants kids in 2-5yrs

Group 1

Kelly: The issue of being too old, it seems you can be older now… It’s safer so you can be older (age 21)

RM: In what way do you think it’s safer to be an older mum?

Jodie: They’ve got those screening techniques now for deformities in children and I guess that’s the biggest risk that your children will have Down syndrome, things which obviously increase as you get older…But then you’ve got to make, you know, a decision… (age 27)

Heidi: There is a decision if there is a problem (age 26)

Jodie: But you’ve still got that choice…

The finding that some participants saw such tests as necessary, combined with their concern at the possibility of facing a “dilemma” should the tests find a problem with the foetus, and the general awareness that increased maternal age is linked to both a decline in fertility and an increase in the chance of foetal abnormalities, meant that while some participants felt that older motherhood was increasingly “safer” and more possible it was certainly not preferable.

8.3.3 Infertility as “risk”

I’ve been off the pill for seven months now and I reflect that for twelve years I have been desperate not to fall pregnant, and now my whole life is beginning to change because I’m trying to fall pregnant. Olivia, age 31, wants kids now

Another possible limitation to women’s reproductive plans is the inability to become pregnant. The “risk” of infertility was acknowledged by some of the commenters, many of the focus group participants and the majority of the interviewees. The topic was often instigated by the women themselves, who expressed varying levels of concern about
current or future problems. When they discussed conceiving a child within their chosen post-contraception timeframe some women spoke of it as a goal not a given, referring to “if it happens it happens”, while others confidently spoke of “when it happens it happens”.

Age-related infertility was the participants’ primary concern, and there was a general view that a woman’s ability to become pregnant declined with age (interviewees: “yes” i=43, 86%, “probably” i=4, “no” i= 1, not asked i=2), as discussed in the previous chapter. This belief has been confirmed by medical (Bewley et al. 2005; Chapman et al. 2006; Dunson et al. 2002) and empirical (Clarke 2008) research but was at odds with the consistent trend to delay childbearing among both the participants and in Australian society in general (ABS 2010).

*I am becoming concerned about infertility as a few friends have recently learned that they have fertility problems and must resort to IVF. As I don’t want children until I’m 30 it worries me. Survey 3, age 27*

Other perceived causes of infertility included medical conditions, such as polycystic ovarian syndrome, and the view some women held that prolonged use of the pill could impact their ability to conceive. Many of the interview and focus group participants illustrated their narratives with examples of friends or relations who had experienced fertility problems. This heightened their awareness of the existence of the problem, its potential, and the technology surrounding it.

Given that most of the participants were continuing to delay childbearing, their high level of awareness of the potential for fertility problems, characteristic of the risk culture in late modernity (Giddens 1991), contrasted with a low prevalence of actual experiences of infertility, as you would expect given their age and, for the majority, their untested fertility. The demographic markers for those experiencing problems were, therefore, similar to those who were trying to conceive: they were more likely to be married, to be aged 30 or over and to be more educated.

Among the interviewees, nine of the twelve women who were ‘currently’ trying to conceive, and therefore actively ‘testing’ their fertility, expressed some level of concern about their fertility. In response to a quantitative survey question six of these women stated that they had been trying to conceive unsuccessfully for twelve months or more. Four women had “sought help” and two had not. In their interview narratives, a further
three women expressed concern about the fact they had not yet become pregnant. All three had been trying to conceive for between six to twelve months. The remaining three interviewees who were trying to conceive had each been doing so for less than four months. This suggests that, while a medical definition of fertility problems is to try to conceive unsuccessfully for twelve months (Wang et al. 2009), women themselves may expect to become pregnant within the first six months of beginning to ‘try’. Two of the interviewees were using ART and three were undergoing fertility testing.

Only one focus group participant, Wendy, described experiencing problems conceiving. Her second child had taken longer than she would have liked to conceive and she was having the same experience while trying to conceive her third child. It should be noted that the majority of the women had not yet tried to become pregnant. A small number of the commenters chose to write about their fertility problems and resolutions in response to the open question: “Do you have anything to add?” Ten comments were found at Survey 1 (1996), and fifteen each at Surveys 2 (2000) and 3 (2003). A few women at each time point detailed their use of ART (c=2, c=4, c=7 respectively), of whom only a couple described successful outcomes. These comments exemplified the heartache which not being able to conceive can cause.

In the past three years I have been going through IVF. I have found that there was no real support for us. A lot of people don’t know the effects it has, to yourself as a person and your relationship. There is no awareness in the community which makes you feel very alone. Survey 3: age 28

The low prevalence of infertility among the women in my study was reflected by the findings of the urban ALSWH 1973-78 cohort as a whole who were asked the same infertility question as the interviewees. At Survey 3 when they were aged 25-30, only five percent reported problems conceiving (ALSWH 2005). Given the trend towards delayed childbearing and the possibility of age-related infertility, the occurrence of fertility problems could be expected to rise for the research participants as they get older and more women begin trying to conceive.

Three interviewees spoke of their experience of miscarriage, two of whom noted that the pregnancy had been planned. A fourth interviewee had had a stillborn child. These reproductive events, which were also mentioned by the commenters but not in the focus groups, were not included in the analysis of fertility problems as it was not within the capacity of this research to explore the reasons behind their occurrence.
8.3.3.1 Assisted Reproductive Technology: a safety net for delayed childbearing?

Despite the low prevalence of fertility problems among the participants, the technologies that assist with conception and women’s receptiveness to their use are important in the research for this thesis. Assisted Reproductive Technology (ART) is the collective term for fertility treatment and methods that have the potential to help a woman experiencing problems conceiving to become pregnant (Wang et al. 2009). There is an ever increasing array of technologies in this field which this thesis does not have the scope to cover; consequently, it was decided to focus on the participants’ views on three forms of ART: the technique of IVF; fertility hormones, such as Clomid, which are a part of IVF and other technical procedures, or can be used alone; and the use of donor sperm and donor eggs as part of ART. In addition to the ‘technological’ approach, “natural” fertility treatments were also discussed, such as the rhythm or Billings method. These methods use fertility knowledge to identify when a woman is most fertile and are utilised to both assist with and prevent conception. The latter application is discussed above in relation to contraception.

As discussed in previous chapters, regardless of concerns about age-related infertility, the association between older motherhood and foetal abnormalities, and the “ideal age” framework for motherhood, participants tended to base their timing of childbearing on other factors, namely achieving the “right” circumstances for motherhood. This pattern usually delayed childbearing, often resulting in their being older than they wished to be when they started, or planned to start, trying to conceive.

The trend toward delayed childbearing, evidenced by this and other research (ABS 2010; Berrington 2004; Cannold 2005; Maher et al. 2004; Weston et al. 2004), and the subsequent rise in age of first-time mothers (Kippen 2006; Laws et al. 2010), combined with the medical research which has found that a woman’s fertility declines with age (Bewley et al. 2005; Chapman et al. 2006; Dunson et al. 2002) has increased the possibility of fertility problems and the need for technology to assist in conception. In keeping with this, research has found that the use of ART has risen in recent years (Wang et al. 2009), although variables including technological development and access to treatment should also be taken into consideration. The question is whether women view ART as a real option in their reproductive decision-making, thus encouraging them to feel “safe” in delaying childbearing?
The interviewees’ response to actual or potential fertility problems were examined using both quantitative and qualitative methods. A multiple choice question in the written survey asked whether they had “heard of”, “ever used” or “would consider using” various technologies and techniques to assist conception, should the need arise. Closer exploration was possible during the interview process, and also in the focus group discussions, when the women were asked what they would do if they experienced problems becoming pregnant when they wanted to.

Given that most of the interviewees were continuing to delay childbearing, had not faced infertility as an experience and may never do so, the majority of women were discussing their theoretical response to a hypothetical problem, where infertility was a potential “risk”, a concern but not a reality. As a result, when they were asked directly about what they would do if they did experience difficulty becoming pregnant, many interviewees articulated the impossibility of knowing their true reaction to potential fertility problems, that may well never even eventuate, until they were in that situation. This included their own changes of mind, with a ‘get out clause’ following many participants’ planning narratives.

The prospect of infertility was more concrete for all those participants who were trying to conceive, and a real concern for those few with identified fertility problems. The element of the hypothetical and the unknown, however, remained for these women. Those using ART did not know if their next treatment would be successful, and if not, what they would do next. Those trying to conceive or in the process of undergoing fertility testing did not know why they had not yet fallen pregnant.

Analysis of the interviewees’ survey data found that the majority of the women were open to the use of ART in their reproductive plans (see Table 8.1). Eighty percent of the interviewees stated that they would consider using some form of ART to assist them in becoming pregnant if they were experiencing problems conceiving. All but one of these women would consider using IVF, the most famous of the technologies that is often a euphemism for ART in general (see Weston and Qu 2005). The outlier, Louise, would only consider fertility hormones and natural methods. In comparison to the popularity of IVF, only half of the sample would consider using fertility hormones or “natural” methods. Around a fifth would consider using donor gametes, with fewer women open to the possibility of egg donation than sperm donation.
A fifth of the interviewees would not consider using any ART. Of these women, Amy would only consider using “natural” methods; five would not consider ART or “natural” methods; and four women reported that they “could not imagine ever wanting to be pregnant”, and therefore would not need or want assistance to conceive. All but one of the interviewees who were trying to conceive discussed considering some form of ART in the face of infertility. Two were already doing so. It is possible that their current realised desire for children made the prospect of infertility more tangible and thus made these women more open to the use of ART. These findings are supported by other Australian research which found, among childless women aged 25-29, just over 80% may consider using IVF should they need to while just over 70% of 30-34 year olds felt this way (Weston and Qu 2005).

The interviewees’ attitude toward ART was generally found to be consistent in both their quantitative and qualitative data. The only discrepancies in terms of method acceptance related to two women who when discussing infertility in their narratives added donor gametes to the list of potential technologies they had stated they would consider in their written survey. This was associated with the theoretical nature of the problem and their uncertainty as to the lengths they would go to.

*If worst comes to worst and we would need to use donor eggs or donor sperm then I’d certainly consider that. I’d hope we wouldn’t have to go down that path.*

Anita, age 29, wants kids in <2yrs
Table 8.1: The interviewees’ potential use of ART and “natural” fertility methods

<table>
<thead>
<tr>
<th>Fertility treatment</th>
<th>Heard of</th>
<th>Would consider using</th>
</tr>
</thead>
<tbody>
<tr>
<td>In vitro fertilisation (IVF)</td>
<td>100% (N* = 50)</td>
<td>78% (n=39)</td>
</tr>
<tr>
<td>Donor sperm</td>
<td>98% (n=49)</td>
<td>22% (n=11)</td>
</tr>
<tr>
<td>Donor egg</td>
<td>96% (n=48)</td>
<td>18% (n=9)</td>
</tr>
<tr>
<td>Fertility hormones (e.g. Clomid)</td>
<td>76% (n=38)</td>
<td>50% (n=25)</td>
</tr>
<tr>
<td>Natural methods (e.g. Rhythm or Billings method)</td>
<td>80% (n=40)</td>
<td>56% (n=28) (Including 2%, n=1, Natural methods only)</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>10% (n=5)</td>
</tr>
<tr>
<td>I cannot imagine ever wanting to be pregnant</td>
<td></td>
<td>8% (n=4)</td>
</tr>
</tbody>
</table>

80% (n=40) would consider using some form of ART
20% (n=10) would not consider using any form of ART

*“n”= the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives

Table 8.2: The interviewees: how does desire for children impact on fertility treatment use?

<table>
<thead>
<tr>
<th>Fertility treatment “would consider”</th>
<th>Conviction about having children*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Certain (i*** = 35)</td>
</tr>
<tr>
<td>In vitro fertilisation (IVF)</td>
<td>n** = 39</td>
</tr>
<tr>
<td>Donor sperm</td>
<td>n = 11</td>
</tr>
<tr>
<td>Donor egg</td>
<td>n = 9</td>
</tr>
<tr>
<td>Fertility hormones</td>
<td>n = 25</td>
</tr>
<tr>
<td>Natural methods</td>
<td>n = 28</td>
</tr>
<tr>
<td>None</td>
<td>n = 3</td>
</tr>
</tbody>
</table>

*Excludes the three interviewees who intended to remain childless
**n”= the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives
***n”= the number of interview participants and indicates the finding is based on interview narrative data, as opposed to the written survey data
A spectrum of beliefs about and acceptance of ART and natural fertility methods were articulated in the interview narratives. The findings revealed an association between women’s certainty about having children and their potential use of fertility treatment, as shown in Table 8.2. Perceptions of ART were also found to be influenced by: their knowledge of the methods; an assessment of the costs, both financial and emotional, and success rates they associated with the different methods; and beliefs about “fate” and the “natural”, including the concept of “relatedness”. The latter term referred to the extent of the genetic and biological connection between the parents and the child.

Lack of knowledge was found to equate to lack of trust and acceptability, with only three of the nineteen interviewees who reported that they had not “heard of” a particular method considering using it. This meant that some women’s proposed use of ART was not necessarily logical. For example, of the thirty-nine interviewees who would consider using IVF, fifteen reported that they would not consider using fertility hormones, which are a necessary part of the IVF process, twelve of whom had not “heard of” fertility hormones. A similar pattern was found between knowledge of and considered use of “natural” fertility methods. This association explained the lower acceptance rate of these methods (see Table 8.1). Their lack of knowledge made some participants distance themselves from their responses, making more general statements, possibly for fear of showing their ignorance.

One perspective, shared by eight of the interviewees (16%) was to be matter-of-fact about the prospect of using ART, ‘willing’ to use the different technologies available, and to view them as a ‘solution’ to fertility problems. Their pro-ART stance appeared to be linked to their reproductive plans and conviction. They were all ‘certain’ about having children, and wanted to do so within the next five years; this included four women who were trying to conceive, two of whom were experiencing problems conceiving. Danielle, who had been trying to conceive for eleven months with no success, and had previously had a planned pregnancy end in a termination for medical reasons, explained “I don’t think I’d rule anything out at this stage. I’m sort of open to any options”.

Half of the interviewees (48%, n=24) expressed ‘reluctance’ and negativity toward some or all of the ARTs. This negativity was associated with factors such as their perceptions of the prohibitive financial costs, high emotional costs and physical impact involved in ART use; a dislike of the hormones involved or the “surgical” nature of the procedures; and concern about techniques involving donor gametes that severed the
genetic connection between parent and child. Their disinclination to use fertility hormones was an extension of the stance against using hormone-based contraceptive methods, discussed earlier in the chapter. A number of the commenters and focus group participants also expressed these concerns.

For the past three years I have been on different fertility treatments… I have spent up to $250 a month (at times) on these medications. I understand that this is by choice but it has put a lot of pressure on the family budget, and makes me feel a bit low when I have to tell a doctor I can't afford the best treatment available. Survey 3: age 28

For four interviewees their ‘certain’ desire for children outweighed their ‘reluctant’, hypothetical, use of ART.

I would try and avoid IVF at all costs. It would be my absolute last resort. I don’t like the idea of it but I also think that it’s fantastic that it’s an option… It’s interesting because my natural inclination is to say that I wouldn’t take like the IVF drugs and I would really prefer not to have donor sperm… then I thought about it and I thought well if I was 35 and I had tried to have children for the last seven years and I was reaching the end of my possible chances to have children. I think you can’t say you wouldn’t do any of those things until you were pushed to that limit… So I think that I would avoid [ART] at all costs if I could but I think if I was faced with not having children I’d probably try anything. Sonya, age 27, wants kids in 2-5yrs

It was more common, however, for the women who were ‘reluctant’ about using ART to limit their acceptance of different methods. For many of these women their reluctance to consider ART was specifically associated with beliefs about “relatedness” which usually meant that they were against the use of donor gametes. This concern was shared with other interviewees, as exemplified by the finding that only four of the ‘reluctant’ group, and around a fifth of the interviewees in general, would consider using donor sperm or donor egg. Kym spoke of her concern about the problems that could arise if only one parent was genetically related to the child: “One of you is going to be a real parent, the true parent, and the other one’s going to be at a disadvantage”. This notion of relatedness in association with fertility problems and treatment is supported in the literature (Franklin 1997; Franklin and McKinnon 2001). The importance this group of women placed on both partners being genetically related to the child combined with
their desire for children is highlighted by the finding that while none of these interviewees reported that they would consider using donor gametes, all of them would consider using IVF despite reservations about what the technique involved. Their reproductive plans and conviction were more mixed than those women who would consider using any method to help them conceive; most, but not all, were ‘certain’ about having children and most, but not all, wanted to have their children in the next five years.

The participants’ general acceptance of ART, in theory at least, suggests that the majority of women hoped to continue to control their fertility once they started to try to have children. Furthermore, desire for motherhood meant many stated they would probably ignore reservations about both technological intervention and older motherhood in their attempt to have a child. Problems conceiving were found to compound the issue of delayed childbearing. For those experiencing, or even hypothesising about, infertility their desire to have a child often resulted in the age at first-time motherhood getting pushed back and back with each month of trying. For example, Susan, Danielle, and Kym, all spoke of raising their age “limit” for motherhood or having no upper limit in light of their current problems conceiving, as discussed in the previous chapter.

If you had asked me this question maybe two years ago I would have said late 30s would have been probably too old [to have children]. But because of my changed circumstances I probably have a different perspective on that now. So I would say, if I was to give an upper age limit, sort of low 40s might be a little bit too old to be thinking about having children. But…if I keep having trouble falling pregnant…and I was really really desperate to have my own child then obviously that upper age limit would change. Susan, age 30, wants kids now

A few women took a different approach and spoke of ‘accepting’ their infertility as fate, should it happen, and stated they would not consider using any ART. Nadine, who had been trying to conceive unsuccessfully for about eighteen months stated that if she continued not being able to conceive she would not use any ART or “natural” methods and would accept her childless status. She explained her decision in relation to fate, saying: “If I can’t have children and there’s something wrong with me…that’s just the way it is. I was not meant to have children”. She put this in the perspective of the “traumatic” and laborious experience of a friend who had been going through IVF for seven years, saying: “I don’t know if I can go through all that heartache and the
pressure and the time…” However, like many, she added a get out clause, explaining that this was how she felt “at the moment”. She and her husband were also going to an infertility clinic to look into the problem, suggesting she could change her mind about using ART in the future. Like Nadine, Peta, who planned to start having children in two to five years, also spoke of not considering any ART if she had problems becoming pregnant, however, this was because she was equally open to adopting a child, possibly instead of conceiving.

*I’m really uncomfortable with [fertility treatment] to be honest… I think that if I found that I wasn’t successful in becoming pregnant on my own I’d certainly pursue adoptions. And to be honest I’m quite open to the idea of pursuing adoption in any case, whether I am capable of having a child myself or not.*

Peta, age 32, wants kids in 2-5yrs

Allison and Leah, who were both experiencing problems conceiving, also discussed the possibility of a life without children, however, they each planned to try using some form of ART before accepting this “fate”, and were also considering adoption. Consequently, the concept of “not meant to be” could occur at different stages of the participants’ hypothetical or real assisted technology decision-making journeys. This could be either before any intervention or, more often, after certain techniques had been tried, usually IVF and fertility hormones, and before others were attempted, namely the use of donor gametes. Nadine, Allison and Leah formed their own conviction category, discussed in Chapter 6, based on the premise that they could be ‘happy without’ children.

Similarly, for Carolyn, who had only been trying to conceive for a few months, the prospect of fertility problems that could delay motherhood past the age of 40 resulted in her intention to resume taking contraception at that age, preventing the option of having children for fear of the health problems associated with having a child as an older mother.

*After 40 I might actively look at contraception again… just to definitely prevent having kids… I think that jeopardising the health of myself and my [potential] child would be enough of a reason not to proceed [with motherhood].* Carolyn, age 32, wants kids now

As the other interviewees reach their desired “right time” to have children and begin trying to conceive, those who experience problems will get to choose from the options
demonstrated above: fate or ‘action’, and a spectrum of technologies. And, if they choose ‘action’, they will have to negotiate the unknown of whether or not the technology will be successful or whether they will have to keep pushing back their age “limit” for having children.

For the remaining interviewees, their theoretical use of ART in response to infertility was directly associated with their uncertainty about having children or their intention to remain childless. A quarter of the interviewees (i=12, 24%) were ‘undecided’ about what they would do if they faced fertility problems and held negative or ambivalent views about the technology involved in assisted conception. What differentiated these women from others who held negative perceptions of ART was their uncertainty about having children (‘certain’ i=4, ‘uncertain’ i=8). Many found it difficult to consider using ART as a consequence of their indecisiveness or disinterest about having children, rather than concerns about the technology. Three women reported that they would not consider using any of the technologies or “natural” methods if the need arose and none would consider using donor gametes. This was despite all of them stating that they planned to become mothers, usually in two to five years time. This group encompasses those women who felt that they should have children as opposed to wanting to have them as a consequence of desire. This finding is discussed in detail in Chapter 6.

Olivia represented the conundrums within this group. She had been trying to conceive for six months, yet was ‘uncertain’ about having children. She planned to use ART should she need to, which was a possibility due to having polycystic ovarian syndrome. However, in some respects she discussed the prospect of childlessness in a more positive light than the prospect of motherhood.

\[I \text{ haven't even got to that stage of what we'll do. I mean I guess it depends how desperate we get or whether we just count our losses and go ‘let's just be happy with the dog’}, I \text{ really can't answer that, I'm hoping it doesn't come to it...I mean I wouldn't rule it out, I'm not anti anything, I'm very pro whatever works do it.}\]

Olivia, age 31, wants kids now

These opposing reactions to actual or potential infertility illustrate the extent to which desire for children can influence women’s reproductive plans. As the results above attest, those who were ‘uncertain’ about having children were less likely to “consider” ART than those who were ‘certain’ (see Table 8.2 above). Epitomising this finding were the four interviewees who stated in the written survey that they “could not imagine ever
wanting to be pregnant”, and therefore would not use any ART or “natural” methods. This included the three participants who did not want to have children, Heather, Julie and Fiona, along with Laura, who explained in the interview that she did not want to become pregnant for cosmetic reasons regarding her post-pregnancy body, and planned to consider adoption instead.

8.3.3.2 The success of ART: a subconscious comfort

Even if the participants choose to utilise ART if they experience problems conceiving, as the majority suggest they will do, this will not necessarily result in a child, nor therefore improve the fertility rate. This is due to the continuing trend towards delayed childbearing that impacts the potential success of ART use. Research has found that for most ARTs, the chance of a successful conception, pregnancy and birth falls with maternal age (Wang et al. 2009). Furthermore, in 2007 the highest ART success rate was only 38%, and was experienced by women under the age of 30 (Wang et al. 2009: 10). Most of the participants in my study aspired to have children after this age, and expected to do so even later, particularly in relation to their desire to achieve the “right” circumstance before having children. Therefore, if these women do end up utilising ART they will be doing so at an older age that has less potential for a successful outcome. This is in keeping with the median age, 36 years, of the women who are accessing ART treatment in Australia and New Zealand using their own eggs (Wang et al. 2009: ix).

This thesis is not in a position to measure the success of ART given the minority of mothers in the study, therefore successful ART outcomes were limited to a handful of commenters: the three women at Survey 2 and two women at Survey 3 who chose to write about their experiences in their survey.

_I am currently fourteen weeks pregnant with my second child. This was made possible by taking fertility tablets “Clomid”. Survey 2: age 26_

What was possible was an assessment of the participants’ perception of the success of ART in order to investigate how this belief interacted with their hypothetical or, for the minority, actual, use of the technologies. Despite the participants’ high potential usage of ART, and specifically IVF, they held mixed views as to how successful they perceived the technologies to be. These perceptions were found to be loosely associated with their attitude towards, and potential usage of, ART.
Women who were ‘willing’ potential or actual users of ART were more likely to express confidence in the success of ART, as also found by Weston and Qu (2005). They spoke of the assisting technologies’ success as a given, providing them with “options” “if you got stuck and couldn’t have kids”. They felt that ART has “taken a lot of the guess work away” in regard to concerns about whether or not they will be able to conceive when they start trying, even if they delay childbearing.

*IVF... seems to assist people [to become pregnant] later on or earlier on or whenever they need it... You hear that if you’re going to fall pregnant naturally that it’s easier when you’re younger and everything bounces back much quicker but I guess with IVF it doesn’t really matter does it? As long as you’ve got that assistance.* Simone, age 31, wants kids in 2-5yrs

Even Cindy, whose fertility story is documented above, and who explained that IVF, which she was about to start using, had a success rate of “about thirty percent”, described expecting to be able to conceive using the technology. If her first cycle was unsuccessful: “I don’t know how many times it will take but I’ll try maybe until I have a baby because there’s no other way”. This plan says much about her ‘definite’ desire for children, her ‘willing’ use of ART and her self-described “positive” attitude, particularly when combined with her beliefs about the method’s low success rate and even an acknowledgement that it “may not be successful”.

Conversely, and more commonly, those women who were ‘reluctant’ to use ART should they need to, especially donor gametes, were more likely to express concerns about the success rate of the technologies.

*Maybe IVF won’t work for all of us, like ‘cause it does have failure rates.* Group 6: Courtney, age not specified (between 18-30 years)

A couple of women, such as Allison, even articulated the belief that the success of ART diminished with age: “I guess the older you get the harder it is”. The finding that they would still consider using the technology despite their negativity towards ART and their belief it would not necessarily work for them was strongly associated with their desire to have children. Kym, who had been trying to conceive for a year and had had a previous miscarriage of a planned pregnancy, explained:
[ARTs are] not something I really want to do but it’s a chance and if you can’t have children… but there’s a small chance you take it. I think IVF has only got a fifteen percent chance of working in each cycle but I’m willing to take a chance and try it out if I have to. Kym, age 27, wants kids now

Olivia’s description of having a “capability limit” for ART use exemplified the view of fertility treatment as being a potentially lengthy, emotionally draining experience that did not necessarily result in a baby. This was a situation that she was unwilling to submit herself to for years on end, should the treatment continue to be unsuccessful.

Thirty-seven is it [age limit for trying to have children]… that would be seven years of trying and I think after five I’d have to kind of think “well is it worth it?”… I mean god knows what I’ll go through in the next five years if I don’t have kids but I don’t think it’ll be an age limit. It’d be more a capability limit. Olivia, age 31, wants kids now

Samantha was unique in her forthright suggestion that women should be proactive and start trying to have children at a younger age. She discussed this specifically in spite of the existence of ART, highlighting her belief that the technology was not a safety net for delayed childbearing. Unlike Kym and Olivia, Samantha expressed her belief that ART would assist with conception. Her concern referred to her perception of the heightened risk of medical problems with the child that are associated with older motherhood, and the increased prevalence of such problems associated with technologies that assist women to conceive at older ages.

I think it’s great that they’re [ART] around and making sure that people get pregnant. I do think though perhaps if people did try to get pregnant at a younger age, when our bodies are probably more prepared for it then perhaps they wouldn’t be needed as much as they do seem to be these days…And I think sometimes, perhaps you can go a bit too far with intervening… also the other issue, as we do get older the risks of deformities and problems with the baby will increase and so if you’re sort of using a lot of fertility treatments to get pregnant when we’re older, I suppose the chances of problems happening are going to increase too. But I think it’s great that people get given chances to have a baby. Samantha, age 28, wants kids in <2yrs
It was more common for the participants to question the success rates of ART than view them as the given promise of a child, however, this did not prevent women from intending to utilise the technologies should they require them. Eighty percent of the interviewees stated they would consider the use of ART should they experience problems conceiving, and even those who said they would not often left room in their narrative for a change of mind. There appeared, however, to be a lack of knowledge about the different technologies available, the specific procedures involved, and their success rates. Furthermore, the majority of the participants did not comment on how successful they thought the different ARTs would be on a personal level, or in relation to older women, but made more general statements about ART offering choices that did not exist for previous generations. This broad viewpoint was encouraged by the hypothetical nature of the need, for most, and appeared to create an underlying feeling, among some, that infertility happened to other people and not them. Confidence also seemed to be bolstered by an expectation that they could control their fertility. This was exemplifed by Susan, who was having problems conceiving due to polycystic ovarian syndrome, who stated that she felt that her reproductive life had been “totally my choice”, although she conceded that “obviously my body isn’t working with me at the moment.”

The women’s delayed childbearing was therefore not found to be associated with a belief that technology can assist with conception if they leave it “too late” but rather with their aspiration to achieve the ideal circumstances before having children. This is consistent with the participants’ reasoning for using contraception to delay childbearing until they had achieved the “right time” to have children. However, while ART was not actively viewed as a safety net for delayed childbearing by the women in the study, it did, nevertheless, appear to be a subconscious comfort. The rational beliefs many women held about their age-related fertility limitations, and any knowledge they had about low ART success rates were often outweighed by their desire for children and their awareness that ART had the potential to enable conception at older ages.

8.3.3.3 A “natural” alternative to fertility technology
Wendy, a 27 year old mother of two from the focus group discussions, was the only participant who discussed her use of “natural” fertility methods to help her to become pregnant. She had planned both her children and was trying to conceive her third. The age gap between her first two children was six months more than she had intended due to the length of time it had taken her to conceive her second child, and she would...
have preferred to already be pregnant with her third child. Wendy was using “natural” fertility methods to identify her most fertile times to try to assist with conception, stating that she felt she was still “too young” to consider options like IVF, and believed her husband would not like to use that technology anyway.

Since I’ve had my first child I started finding out about natural family planning and the Billings method… The Billings method is just mucus… sensations that you can feel at the vulva and just record them… I’ve never actually used it for contraception. I’ve only used it to try and guess when I’m ovulating so I can fall pregnant again. Group 7: Wendy, age 27

Several participants in both the interviews and focus group discussions described their belief that stress had the potential to impact a woman’s ability to become pregnant, and described lifestyle changes, visiting naturopaths, and ensuring their personal health and wellbeing as possible solutions should they have problems conceiving.

It’s balance, trying to just work out my job and my life and… thinking about getting pregnant at the same time and worrying is my job… and my tiredness et cetera affecting my fertility. Kym, age 27, wants kids now

I think I probably would [try IVF] but I would exhaust all other methods first that I could think of… I’d do anything, any theory that anyone had like you know, eating pineapples [laughs]… and just have fun doing it because I realise that when you can’t fall pregnant, and you want to, a lot of the reason… [is] because you’re stressed out… Group 2: Brianna, age 25

8.3.3.4 Adoption: an alternative safety net?

Adopting or fostering a child was presented as an alternative to ART and an additional solution to fertility problems by half of the interviewees (i=24). This unanticipated topic was introduced by the women themselves, usually as part of their response to what they would do if they ever experienced problems conceiving. Seventeen women discussed adoption as something they would consider, while seven were unsure. Most explained that they would look to adoption only after they had “exhausted” the option of having their “own” child, having reached both their personal boundary of acceptability for both ART and “natural” methods and their “capacity” limit in terms of the number of treatment cycles and years they had been trying to conceive.
I wouldn’t say adoption would be a last resort either. I think it depends on what other treatments there are and how the success rate [is] and what you have to do… Brooke, age 30, wants kids in 2-5yrs

A few women spoke of preferring to adopt rather than use donor gametes as part of ART, the idealised genetic parent-child relationship replaced by a child that was neither genetically nor biologically related but whom they “could call our own so to speak.”

I wouldn’t be that keen on someone else’s sperm or someone else’s egg…I think I’d rather adopt in that situation. Bronwyn, age 27, wants kids in 5+yrs

Peta, Belinda, and Laura held a different perspective. Each stated that adoption was something they would pursue regardless of fertility problems, either instead or as well as having their “own” children. They spoke of altruistic reasons: Peta explained that her partner had been adopted from “pretty horrible circumstances”; Belinda worked in child protection and had had neighbouring children “accessing our house as a safe place”; while Laura had witnessed “children in need” on her travels overseas. Laura also spoke of having aesthetic reasons, her desire to adopt instead of giving birth an attempt to avoid “that horrible stretchy stomach” as well as “the pain of childbirth”.

Only two interviewees stated that adoption was not an option they would consider, including Melanie who explained that she wanted to have her “own” children and, therefore, would not consider donor gametes either. The remaining twenty-four interviewees did not comment on adoption and the question was not asked of them. No demographic differences were found between those who said they would consider adoption, those who would not, and those who did not mention it. A small number of commenters (Survey 1 c=4; Survey 2 c=1; Survey 3 c=3) and focus group participants also mentioned adoption as an option, again usually in relation to fertility problems.

While adoption was discussed in a number of the interviews it was only a significant part of the planning narratives of a few interviewees. The hypothetical possibility of choosing to adopt a child, usually after trying to conceive and attempting ART, meant that the process of adoption was seldom discussed in depth. Only a couple of women spoke knowledgeably about the process and possibility of adoption. Simone, who would consider adoption if she were unable to conceive, mentioned lengthy waiting lists, and “assume[d] there’s not that many children up for adoption”. Peta, who was
considering adoption regardless of having her own children, described having “looked into the various [adoption] legislations in [the] various different states and how much that differs and how difficult it is”. She noted that her de facto status and her age may require her and her partner to “get married… and relocate to a different state” should they finalise their decision to adopt, things she seemed prepared to do.

There was only one example of successful adoption in the research as a whole, although other commenters may just have chosen not to mention their adoptions.

_Twelve months ago we adopted a baby girl (six months old) from South Korea._

Survey 3, age 30

Consequently, although adoption was a consideration for many, the findings do not suggest that it is likely to affect the fertility rate, as it was usually only mentioned as a response to infertility and then only as a back up option should ART prove to be unsuccessful. However, problems could exist for those women who do consider adoption as an option for them, given the age they will be once they have started to try to conceive, discovered fertility problems and “exhausted” the ART option. The age limits applied to adoption applications highlighted by Peta meant that women who experience age-related infertility may again be limited in their motherhood options as a result of their age. This is compounded by research that documents the small number of children available for adoption in Australia (AIHW 2009). The report cites the declining fertility rate, increased availability of contraception, and both an increase in numbers and acceptability of children born outside of marriage as the reasons behind the decline in children available for adoption.

8.4 Conclusion

The overall finding from these analyses was that the women in the study felt that reproductive technology, especially contraceptive technology, provided them with choices and options about if and when to have children. The participants described making active choices about having children, and reported using, or considering the use of, reproductive technology in their plans to delay and accomplish the motherhood ideal, and reconcile any unplanned reproductive experiences. The women spoke of utilising “safe” contraception to avoid pregnancy, while attempting to align their perceptions of “ideal” circumstance and “ideal” age until they found the “right time” to
have children. The widespread use of contraception in contemporary society had normalised this practice for most women.

The relationship between pregnancy termination and choice, and ART and choice, were less straightforward. A fifth of the interviewees had had an abortion and the majority of women hypothesised that they would also choose to access ART in some form should they experience infertility. However, their use, or potential use, was often stigmatised by issues such as morality or the concept of “relatedness”. While there is no doubt that contraception and abortion enable the delay of childbearing, and subsequently often result in older motherhood, ART and foetal screening tests and any associated pregnancy terminations, were the technologies the participants described in regard to actually becoming older mothers. The hypothetical nature of ART for most women distanced them from the technology, however, creating juxtaposition between uncertainty through lack of knowledge, knowledge of low success rates, and an abstract notion that the technologies’ existence could be helpful. Consequently, ART was not discussed as a safety net for delayed childbearing as it was seen to offer potential but not definitive choices.

Despite the crucial part reproductive technology played in the participants’ delayed childbearing, therefore, in the young women’s narratives the technologies were described as providing the means to shape their reproductive lives, not being the reason for their shape. Ultimately personal need for technology, to enable the delay or conception of children, and fulfil their “plan” determined the women’s use of reproductive technology. This need questions the language of choice in regard to the use of the technology, particularly as it often transcended any ambivalent and negative beliefs many of the participants held about “unnatural” technological intervention in reproductive events, and even some negative physical experiences, such as side effects from contraceptive technologies. Unplanned reproductive events, including “accidental” pregnancy and infertility, further problematised the issue of choice, and added to the language of risk. These occurrences often provided women with a choice between two relatively unappealing options. One was additional use of reproductive technology, such as abortion and ART, methods which many women expressed some level of concern about; the other was a significant alteration to their reproductive plan, becoming a mother earlier than planned or childlessness. Consequently, the stories women told about their reproductive decision-making illustrated the technological fertility tightrope they walk, balancing years using the contraceptive pill with years of biological fertility.
In conclusion, decisions about the use of reproductive technology are influenced first and foremost by childbearing intentions, and the factors impacting on these plans. However, the extent to which participants normalise the use of reproductive technology in their lives, and their beliefs about intervening in nature, also have an effect on their decisions. Analyses suggest that women gloss over the part technology plays in their choreographed dance with motherhood. Indeed, in the case of contraception in particular, the technological dimension in the choice of motherhood has become an assumed part of everyday life for many young women; a pill to be taken every day to delay children until you have found that dream home in the suburbs.
Chapter 9: From plan to action: facilitating reproductive aspirations

I feel like I’ve suddenly found myself at 30, realised what’s happened and now realise that this child thing is going to be a problem [laughs], a wonderful problem, because I now have to try and rearrange my life in the next five years so I’m able to do it. Cherie, age 30, wants kids in 5+yrs

9.1 Introduction

The preceding chapters examine and explore reproductive decision-making from the perspective of planning to have children. Their findings focus on the desire for and timing of children, with particular emphasis on the reasons for and tools of delaying childbearing, along with the potential implications of this delay. This chapter questions how women move from planning to have children to making the active decision to start actually trying to conceive. The motivations behind this decision are examined: Why is now the right time for some women, and why, for the majority in this study, is it not?

The chapter begins by introducing four of the interviewees, Samantha, Vicki, Cherie and Carolyn, whose plans for children have been brought forward, pushed back or sustained. The context in which their fertility decisions were being made is then explored from a broad perspective. This situates reproductive choice by bringing together the multiple influences women face in relation to deciding whether and when to have children. The social and cultural environment is examined first. The ideology and perception of motherhood in late modernity, the practical influences of contraception and biology, and the conflicting and complex timing narratives that women hold are revisited. Women’s perceptions of choice are explored, including the degree of choice they feel they have in relation to childbearing and their intention to plan, or to rely on fate.

The second half of the chapter examines the political landscape in which women make choices about having children. This links individual women’s decision-making to a collective response to government policy. The participants’ perceptions of the recent, arguably pro-natalist, government approach were garnered, focusing specifically on the maternity payment that was introduced in 2004. The chapter concludes with a discussion of what the participants themselves felt should or could be done to enable women to have children if and when they want them, thus addressing both the question of reproductive choice and the fertility rate.
9.2 The choice narrative

9.2.1 Case studies

Vicki: “I suppose we’re a bit selfish. We want our time alone”

Vicki is 30 years old, married and has a diploma. She is in paid work. She plans to have two children in the next two to five years, which is later than she originally thought. She has been living with her partner for six years and has been married for six weeks. She feels it is “nicer” to be married before having children.

I always thought I’d have them a lot younger than what I am now but just circumstances haven’t led to that… My parents were young when they had us…[they’re] friends rather than just parents… Whereas now we’ve done a lot more travelling than probably what we could have done if we’d had kids a lot earlier.

Her timing is based on having achieved certain goals.

I’ve just finished some further study and financially we’re not too bad…we’ve now got our own house…you want to be a bit settled and we’ve actually been travelling around Australia and working out where we want to live.

She also does not want to leave it any later “age-wise” with uncertainty about whether she could physically cope with parenting in her late 30s. However, she explains that part of the delay to childbearing is due to the fact that she and her husband are:

still concentrating on what we want to do. I suppose we’re a bit selfish. We want our time alone.

Vicki states that she is “not a career person” and feels that her workplace is not family-friendly, viewing mothers as “not as capable… [and] not willing to work the longer hours”. However she feels she would “get too bored if I was home all the time” so plans to return to paid work when her child is 12 months old. She has mixed feelings about combining work and family.

You can still get part-time work but you just don’t get the satisfaction career-wise, but then you’ve probably got the satisfaction family-wise.

She feels she has had choice about if and when to have children, believing that there is less social expectation for women to have children in society today. The biggest facilitator of choice is perceived to be access to contraception, which, while she is “getting sick of putting it into [her] body”, has allowed her to achieve “so many things” in her life.

You get that freedom of really choosing when you want them.

She is unconcerned about Australia’s fertility rate and feels that the maternity payment:

Might have encouraged younger people to have children…[but ] I don’t think you should have a baby for financial gain. I think you should have them because you want them.
Carolyn: “I figure I can only do two things at once”

Carolyn is a 32 year old married professional who has been trying to conceive for four months. She is pursuing an intricate “have it all” plan for having two children, something she has been actively preventing with contraception up until now.

Carolyn believes she has had choices about having children, namely through her education, describing a dichotomy of “socio-economic status” between those women who have children straight out of school and those who go on to university. She feels that while her own professional mother faced “angst” in relation to combining motherhood with a career she “can just do what I like, take it or leave it”. The question her mother’s generation faced was “when” they would have children, while her generation is asking “if” they will have them.

While Carolyn feels that the “choice [to have children] has always been there…it’s the desire that has come to the fore at the moment”. This desire has been enhanced by her achievement of a catalogue of “right time” precursors to motherhood, which fit within the basic tenet of the research findings. This includes financial, career and relationship stability, along with being “ready”. She recently married her partner of six years, a precursor to having children that she says was important for her husband but not for her. She feels they will be “good” parents.

It’s an internal feeling of time is right. This is something I want to do. Something I can be good at.

Her timing is also based on being healthy and not wanting to be too old. She is 32 now and has a cut off age of 40 at which point she would consider starting to take contraception again, even if she has not yet had children, to prevent the “abnormalities and difficulties” she associates with motherhood after the age of 35.

Carolyn is confident that she and her husband are doing the “responsible” and “right thing” financially in deciding to have children now as they are both “eminently employable so we’ll always have enough”. However, she believes that if the government wants to increase the fertility rate, they need to “drop the tax rate”.

Carolyn is about to return to university and intends to fit her children within this plan. She feels that having a child while studying and on maternity leave from her current job makes sense financially.

As far as income loss goes having kids while I’m studying means that I spend less time out of the workforce… and keep my long service entitlement continuing.

She believes it is possible to combine being a mother with having a satisfying career. Her three-year goal is to be “at uni, juggling a kid”.

I’m looking forward to the physical and emotional challenge of [having kids] and I’m glad I’ll also have study to sort of balance it out. Obviously work will take a back seat while I’m studying with kids. I figure I can only do two things at once.
Cherie: “Right now it’s just too hard because I need to earn money and set myself up”

Cherie is 30 years old, tertiary educated, in paid employment and lives in a de facto relationship with her partner. She plans to have two children starting in about five years time.

Realistically I don’t imagine having more than two because of time constraints, financial constraints.

She describes postponing children until she is financially secure. She expects to take five years to purchase a house and “build up some equity... so that I can actually afford to be off work”. She also wants to be married prior to having children as it is “more socially acceptable”.

Having children has become important to her recently due to finally knowing someone with a child and in response to turning 30. Age is an important consideration in regard to “potential problems with reproduction later on, the older I get”. Despite this she holds one of the older “cut off” ages for motherhood in the study, of “45ish”. In three years time she anticipates motherhood to still be another two years away.

Cherie does not feel she has choices about having children and describes the timing of motherhood as a “problem”.

Because I haven’t planned my life around having a child. I’ve just done things spontaneously or as circumstances dictated... Now I’m realising it could have been kind of handy three years ago to start saving and planning and being in a better position by the time I was 30 so the children thing could happen a bit earlier.

She describes entertaining “the idea of falling pregnant accidentally” in response to the complexity of timing, although quickly disregards this as “irresponsible”.

In keeping with the financial focus of her narrative, Cherie believes it is the cost of living as opposed to choice that is impacting demographic changes, and delayed childbearing.

I think a lot of the older generations blame feminism for all these old mothers, losing the values and having a focus on careers but I think it’s actually [that] you need a double income... so it’s becoming harder financially for people to have children earlier.

She feels that the government does not make it “easy or financially viable for people to have children” and believes “there needs to be more financial incentive and relief to allow parents to make it affordable”. The maternity payment, however, would not “help that much” as it would only support her for about a month.

Cherie’s current focus is setting up her career, which she plans to retain after motherhood, although she is unsure whether she will try to combine paid work and motherhood initially, wanting to wait and see what her emotional response to the child is. This explains her requirement for financial security that would enable a one-income family.

I see myself as having a fulfilling career and having some involvement in meaningful employment my whole life. I don’t believe that my career and my interest in work will stop when I have a child... In the back of my mind I do sometimes think I need to get myself into some form of self-employment so that when I have a child I’ve got that flexibility to work from home.

She is “resentful” of people asking her whether she has children, feeling “I shouldn’t be defined by whether I have kids or not. I’m me. A person. An individual”.

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Samantha: “Previously I thought I’d have children a lot later, say in my late 30s”

Samantha is 28 years old, has a tertiary education, is in full-time paid employment and lives in a de facto relationship. She plans to have two children, “a nice even number”, having the first in the next two years. This is earlier than she anticipated wanting to have children. She believes a woman’s fertility declines after the age of 30. Her limit for motherhood is “40 definitely and personally I would like to have had children by 35, no later” both in terms of conceiving and having the energy to parent.

Samantha feels women should try to have children at a younger age, as a proactive solution to age-related infertility. She has ambivalent feelings about “intervening” in nature with ART though states it is “great that people get given chances to have a baby”. She is reluctantly using contraception to enact her plan.

Samantha holds a traditional set of security and stability precursors to motherhood, all of which she has fulfilled apart from marriage, which is important to her for religious reasons. She is getting married next year and then wants to start a family.

\[ I \text{ wanted to be financially secure [that] was probably the most important thing…} \]
\[ \text{In a fairly stable relationship as well… and career-wise being fairly happy in what I’m doing or what I’ve achieved work-wise so far.} \]

She believes that her childbearing plans have been brought forward as a result of a change in her priorities between career and motherhood, and exposure to both children and motherhood through her siblings’ experiences. The latter factor has positively changed her preconception of the mother-role. Overall Samantha felt that an increased hormonal desire for children had also contributed to her decision.

\[ \text{When I was younger I didn’t really see [having children] as being important, I thought maybe kids in the future and my career was more of an important thing to me, whereas now I wouldn’t mind not working for a while [laughs] and looking after children. Previously I didn’t think I would have that sort of mindset…} \]
\[ \text{Previously I thought perhaps being a mother at home might be not all that exciting but now that I’ve seen women with children I think perhaps I wouldn’t mind doing that.} \]

While Samantha feels it is possible for women to combine paid work and motherhood she believes it will be difficult.

\[ \text{I think it would be really hard to be a good mum and [have] a full-time very busy job or career. I know some women can, I think that personally I couldn’t.} \]

She intends to “take at least a year off to be a full-time mother” and would be part-time “if I was to return to work after having children”.

She feels she has had a “high level of choice” regarding her reproductive decisions but cannot verbalise why. When prompted she states that society’s attitude means women can have children at different ages now.

She is unconcerned about the fertility rate, “it’s not what’s important to me” and believes that financial incentives only encourage those women who were more likely to have children anyway.

\[ \text{A lot of people who are choosing not to have children probably are fine financially, they’re career minded people, [so] I don’t know that monetary incentives from the government would make a huge difference.} \]
9.2.2 Situating choice

The existence of reproductive choice remains a much debated and contentious issue in late modernity (Baker 2008; Cannold 2005; McDonald 2000b; Summers 2003a). The choice of if and when to have children is often grounded in circumstances, dictated, or at least influenced, by external factors. This is illustrated by the findings of the preceding chapters, exemplified by Samantha, Cherie, Vicki and Carolyn’s reproductive narratives, and supported in the literature (Berrington 2004; Johnstone and Lee 2009; Maher et al. 2004; Weston et al. 2004).

The four case studies above represent three planning outcomes among the interviewees. Carolyn was part of a small group who were fulfilling their plan and had not delayed childbearing. Samantha’s narrative signified the minority of women who were trying, or intended to try, to conceive earlier than they had originally planned. These women expressed surprise at their increased pressing desire for children that was often now gaining precedence over other life goals, such as career. Most women, including Vicki and Cherie, were delaying childbearing, either having passed or expecting to pass their ideal age before beginning to try and conceive, as the majority of the findings from this study highlight. This large group included those women whose reproductive plans were in conflict with their partners’, and more often in conflict with their social circumstances, along with those who held negative preconceptions of the mother-role, incorporating Cannold’s (2005) “thwarted mother” and “watcher and waiter” categories. The introspective decision-making process in late modernity (Giddens 1991) meant that most women were aware that they were delaying motherhood. While this concerned many of them, particularly in regard to age-related infertility, it was often seen as an inevitable outcome and was not something women expected to change unless the reason for the delay also changed, making motherhood possible.

Samantha, Cherie, Vicki and Carolyn each described a set of precursors to having children based on their preconceptions of motherhood and their life circumstances, namely in relation to finances but also often career planning and marriage, as discussed in Chapter 7. Carolyn was currently living in a situation that she felt was conducive to motherhood and was in the process of enacting her plan. Cherie and Samantha, on the other hand, were still to fulfil certain criteria: financial security and marriage respectively. While Vicki appeared largely ready from a practical perspective she was not yet ready to “give up” her time alone with her husband. The difference between the women’s ability to positively enact their childbearing plan was, therefore,
determined as much by whether or not they had achieved particular circumstances as it was on their relative agency and desire for children. These scenarios are characteristic of decision-making in late modernity where individualism has created an expectation for success and the option of bringing motherhood forward without achieving the individual’s chosen precursors becomes less acceptable.

The majority of the women in the study stressed that their choices about having children were made with their partner; a joint decision. This complicated ratifying the decision to start trying to conceive and to enact the reproductive plan, as both partners had to agree the time was “right”. The impact of this joint decision-making process was particularly evident in the narratives of five of the interviewees. Brooke, Amy, Denise, Andrea and Kylie explained that their plans for children were constrained totally or partially as a consequence of disagreement with their partner, who either wanted children later than they did or not at all. These women fit Cannold’s (2005) “thwarted mother” category and are discussed in Chapter 6 in relation to their partners’ wishes impacting their conviction about having children. This exemplifies the finding that delaying childbearing is not always a choice and that it is brought about by both women and men. While sampling criteria dictated that the women I interviewed had partners, lack of partner is a factor that contributes to the level of choice women have in reproductive decision-making, as illustrated by single commenters and focus group participants in this study, and in the literature (Cannold 2004; 2005; de Vaus 2002a; Qu et al. 2000; Weston and Qu 2001).

Any discussion of reproductive choice must acknowledge the occurrence of unplanned reproductive events. These unchosen events include accidental pregnancy, miscarriage, stillbirth and infertility, each discussed in the previous chapter, and represent the lack of choice or the restricted choices some people face in regard to having children as a result of biology.

9.2.3 A choice culture
The majority of the women in the study balanced a general recognition of the factors they felt were impacting their reproductive decisions with a strong belief in their own agency. Many women stated that they had had choices about having children, and celebrated the culture of opportunity that they felt was presented to their generation of women, characteristic of late modernity (Giddens 1991) and the feminist ideal (Albury 1999; Bryson 2001; Cannold 2005; Everingham 1994; Wajcman 1991). As articulated
by Samantha, Carolyn and Vicki, choice was believed to be offered by social attitudes and expectations, the practical assistance of contraception, the autonomy they had within their relationships, and who they were in themselves, in terms of knowing their own minds. This was in contrast to Cherie’s perceived lack of choice, based on what she described as her lack of “planning”, and therefore her current circumstances. Cherie’s stance reinforces the finding that “genuine choice” was seldom the only factor in women’s reproductive decision-making, despite an enthusiastic use of the choice rhetoric by other women in the study.

While few women would argue that reproductive choice is a bad thing, a number of women spoke of the choices surrounding the motherhood question as a mixed blessing. They described feeling overwhelmed by the multitude of choices and decisions facing young women today and believed they could present a stumbling block for ever finding the right time to have children. The reflexive process of decision-making that has become disembedded from tradition in late modernity, combined with a culture of risk and achievement, has made identifying and enacting the “right” choices a potentially stressful experience. In this context the perception of choice ironically gave several participants the contradictory feeling of loss of control, as opposed to one of empowerment. This finding is in keeping with research which has found that “unconstrained freedom leads to paralysis and a kind of self-defeating tyranny” (Schwartz 2000: 81).

Schwartz (2000) established that decisions are particularly difficult when the options a person has to choose between have little in common, making a “rational” ordering of the alternatives impossible: for example, choosing between becoming a mother or travelling. Consequently, some women articulated a belief that the choice of motherhood could easily be pushed into the background by the array of options available to women today, causing motherhood to be continually delayed.

*Once upon a time women knew what was expected of them (to get married, have kids, be a house wife). Today we just take every day as it comes not knowing what tomorrow has in store!! It can become quite stressful and depressing.* Survey 1, age 22
\[ I'd \] \text{like to have kids in the next couple of years and my theory is that if you think about it too much you won't do it [laughs] because there are too many things that would talk you out of it rather than you...just say[ing] “all right what the hell we'll just do it [have a child]”\]. Group 1: Melissa, age 27

One solution to the multitude of options available to women is represented by Carolyn who embraced the rhetoric of choice and planned to actively combine motherhood with studying and then career, and “have it all”. It was more common, however, for women to express concern at the “have it all” superwoman ideal expected of and aspired to by young women in Australia (Bryson 2001; Haussegger 2005; Summers 2003a), feeling that it further compounded the problem of finding the right time to have children. While Samantha, Vicki and Cherie also intended to combine paid work with motherhood, they felt it would be difficult and spoke of doing so in relation to financial necessity or a perception that they would be bored at home with a child.

\[ I \text{ feel there is a lot of pressure on women in their 20s to complete too much in too little time re. establish career, complete degree/study, travel, marriage, and start a family. It is impossible to complete all this leaving a lot of frustration, doubt, depression at not achieving all this. \} Survey 1, age 22

The tyranny of choice was further complicated for women who expressed uncertainty and confusion as to whether and when they actually wanted to have children.

9.2.4 Accident or design?
The most common reproductive plan exemplified by the young Australian women in this study, therefore, was to postpone childbearing through the use of contraception, as Samantha, Vicki and Cherie were all doing. Indeed the “problem” of fertility decision-making has been further compounded by the need to actively choose motherhood, as a consequence of the routine use of contraception in society as a precaution against having children, as discussed in the previous chapter. The shift from the controlled and planned environment of delay and contraceptive use to the uncertainty of conception and the unknown of motherhood was particularly daunting in a culture that guards against risk: When will it happen? Will it happen? Will I cope with motherhood?

A small group of women, however, including Samantha, expressed wistfulness at the prospect of not having to choose motherhood by having an unplanned pregnancy. This
unexpected finding was linked to an underlying theme of fate, “accidents” and the fluidity of choices that existed in the narratives of some women in the focus groups and interviews. The phrase “if it happens it happens” was used by these women to describe either conceiving a child at the “wrong time”, before they were planned, or not being able to conceive a child at the “right time”; an acknowledgement of the unpredictable nature of biology. This finding prompted the inclusion of a question that asked the interviewees whether they would prefer the timing of their children to be planned or “accidental”.

The majority of women advocated a strong desire to plan if and when they had children. This is in keeping with the carefully constructed timeframe for childbearing, support for choice and reluctance to start actively trying to conceive illustrated in the findings of this and the preceding chapters.

*I don’t think I’d like to leave it [when to have children] to chance unless I had the security that it didn’t matter what happened. Kylie, age 28, wants kids in 2-5yrs*

Several women spoke of being tempted by the concept of having an “accidental” pregnancy, believing that it could take the stress out of both trying to decide when to have a child and the actual pressure of trying to conceive. For these women internal battles between the planned and the unplanned were kept in check by the belief that planned pregnancy was “the wisest thing to do”, while their “idea of falling pregnant accidentally [was] just very very irresponsible”.

*I feel much more strongly about having children at this age than I expected… I even sometimes think about letting having accidents happen…. Just to let fate come into it so that I don’t plan it as much… When I think about being precise and planning it. I think that that is the wisest thing to do because I think that I would like to be at my optimum health like for having children…. But on the other hand… I think planning promotes anxiety…. My head says that I’d love to plan it but my heart says that it’d love to just be swept away with it. Sonya, age 27, wants kids in 2-5yrs*

Karen was the closest of all the interviewees to leaving the timing of motherhood to fate through her open attitude and contraceptive practices. She described finding it difficult to make that final decision to start trying to conceive and spoke of “not trying not to become pregnant”, explaining that since getting married she had been less “careful”.
She stated she was not taking the pill because she did not like taking it, and was using the withdrawal method. The fact she described not being “careful” suggests that she did not feel her chosen method was reliable.

*If it happens it happens. We’re leaving a lot up to chance… In a way I would like it to happen by accident. Because then I don’t have to decide. It’s a big decision… So in a way it would be nice to have it taken away from you… I think we’d probably all decide to keep putting it off. Karen, age 29, wants kids in <2yrs

Karen’s attitude was unusual. The majority of women consistently favoured self-management, with some expressing horror at the prospect of becoming pregnant outside of their plan. It was more common for accidental pregnancy to be viewed as a potential “risk” as opposed to fate, as discussed in the previous chapter.

*You wouldn’t want to fall pregnant accidentally [laughs]. I don’t think so. I think that’d be a nightmare… I’m a control freak… I think it’d be… better to… actually make that decision that you think the time might be right and then just see if things happen as they’re supposed to happen. Alexandra, age 28, wants kids in 2-5yrs

For most women, therefore, “fate” was only truly conceded to once they were actively trying to conceive or were preparing to try, having “made a conscious decision to stop not trying” as Ellie in the focus groups put it, a euphemism for having stopped using contraception. Thus, most participants would stay on what they perceived to be effective “low-risk” contraceptive methods until they were ready for “fate” to intervene. This created a carefully controlled environment in which “fate” was allowed to occur, and confirms the normalised part contraception plays in women’s everyday lives, suggesting that despite some women’s concerns about the reliability of their contraceptive methods, most women have confidence in their ability to control not becoming pregnant until they stop using contraception. Here, “if it happens it happens” referred to not knowing exactly when they were going to conceive within the contraceptive determined boundaries of their chosen timeframe, including some who discussed the possibility that it might happen more quickly than anticipated or recognised the potential for having problems conceiving, acknowledging the unpredictable nature of biology.
We’re going to plan in the sense, well obviously I’ve got to go off the pill… [and I] may not get pregnant for a couple of months in the sense of my body reregulating itself, but I mean if I accidentally got pregnant straightaway that would be fine as well…we do have a broad plan of next year, but how quickly next year it doesn’t really matter. Sharon, age 29, wants kids in <2yrs

9.3 Reproductive choice and government policy

9.3.1 Financial incentives: “it’s a bit cheap isn’t it?”

The controlled plans and lack of actual or imminent reproductive 'action' presented by the majority of the women I spoke to emphasised the finding that few factors actively encourage women to have children. Given that the previous liberal (conservative) Federal Government’s Intergenerational Report (Costello 2002a) and the, arguably pro-natalist, policy approach that followed (Heard 2006) were two of the main instigators for this thesis, it is salient to assess how government policy appeared to impact the reproductive decision-making of the women in this study. In a culture which values individuals and choice, finding a way to collectively encourage people to have (more) children is potentially problematic.

The interviewees and focus group participants were asked directly about their views on the government’s concerns about the fertility rate and what they felt would encourage people to have more children. The participants’ mainly ambivalent perspectives on the fertility rate are discussed in Chapter 5; however, these questions also elicited comment on government policy. This enabled an examination of whether women viewed government policy as having positively, negatively or negligibly influenced both their own choices and those of the wider society. In general neither the focus group nor interviewee participants felt current government policies encouraged people to redress the low fertility rate. This view has been found in other empirical and demographic research (Heard 2010; Maher 2008; Maher et al. 2004; Read et al. 2007). Of particular relevance to the women in my study was the finding that policy had more influence on women’s decision about whether to have more children as opposed to whether to have a first child (Maher 2008), confirming the suggestion that it would seem to be especially problematic to encourage childbearing among those women with no children. Most of the discussion focused on the maternity payment as this policy was introduced at the time of or just prior to when the data were collected. The initial maternity payment rate of $3,000 per birth was seen by all the women in the focus groups and most
interviewees, including Cherie, as simply not being enough money to affect their reproductive decision-making, in terms of either starting a family or encouraging them to plan to have bigger families than they originally intended. In the focus groups this possibility was usually met with laughter.

*I mean it's really not going to affect the decision because $3,000… doesn't actually give much, you might buy a stroller [laughs]. Which is nice to have a free stroller but…* Group 1: Ellie, age 27

The amount of money was seen as a major flaw, “it’s a bit cheap isn’t it”, particularly if the goal of the scheme was to encourage professional women to have children, as many of the participants believed. This was particularly the case given the perception of children as “expensive” and the desire to reach financial security prior to having children, as discussed in detail in Chapter 7.

*It's also weird… like that it's aimed at middle class women or whatever… so that they can get out of the workforce and stuff and have a baby… but it's not very much money for that either. So it's kind of a bit strange.* Group 6: Kathryn, age 23

*When you're talking about the sort of more wealthy part of society or the higher income people that amount of money is not really critical to their desire to have a child really. I think the actual flexibility toward women having children is actually far more important. You know paid maternity leave um things like that. I think would actually be a better way of encouraging women to have children.* Rachel, age 30, wants kids in 2-5yrs

Samantha felt that only those women who would have had children anyway would be influenced by the maternity payment. Her views were shared by a number of women from both the groups and the interviews who felt that other women, often young women and especially teenagers who they believed may not realise how expensive supporting a child is, might be encouraged to have a child in return for $3,000. This was often linked to discussion of who should and should not be having children: the “right” and the “wrong” people. A few women even voiced support for the stereotype of the “right” mothers being educated women, “role models” who were older but not “too old”, and thus potentially more financially comfortable when they had their children. This discourse grew from the belief that money should not be the reason behind people’s
choice to have children and that financial incentives could encourage the “wrong” women to have children for the “wrong” reasons.

RM: Do you think there’s anything that would encourage people to have more children or to have them earlier?

Kym: Not for the right reasons I don’t think. I think it has to be just a parent’s decision. Like I know with the money, or the $3,000 you get, I mean I don’t want to have a child because I get money and I don’t want other people to have children because of the money, like single parents because they can get a pension, ‘cause that’s not fair for the child. I can’t see a way that you could do it. Age 27, wants kids now

Indeed many of the interviewees, including Vicki, emphasised their view that having children is a personal decision and cannot and should not be “bought”. As well as views about who is having children, this stance emphasises the importance of free choice espoused by society today.

9.3.2 Enabling choice: a mother and childcare friendly culture

Given the finding that the majority of the women in the study were unconcerned about Australia’s fertility rate it is perhaps unsurprising that the ‘solutions’ they proposed for encouraging women to have children supported reproductive choice, as opposed to bolstering the fertility rate. This emphasised the general belief that reproductive decision-making was a personal choice, and highlighted the view that women need to be enabled to have the number of children they would like when they would like them. This echoes Cannold’s (2005) call for free unconstrained choice in childbearing. In light of this stance a number of women felt that people should not be encouraged to have children.

RM: Do you think there’s anything that would encourage people to have more children?

Bronwyn: No I don’t I think [so] it’s a very personal choice. And I think that we’re very lucky in Australia that it is a personal choice. Age 27, wants kids in 5+yrs
If policy were to influence women’s reproductive decision-making, the majority of the women in the focus groups and interviews felt that the government could establish much more effective policies than they had at present to encourage women to have children, to have bigger families, and to have them earlier, in terms of financial and practical support for mothers. Many emphasised the need for increased support for mothers in general, regardless of fertility rate manipulation. Carolyn and Cherie were among a number of women who advocated the need for general financial policies that made “life not so expensive”, such as a reduced rate of taxation. This would crucially improve individual financial stability, a key precursor to motherhood for many women.

The ability to assist women to achieve their precursors to children through policy as a way of enhancing the fertility rate was noted in the literature (Weston et al. 2004). Although it is also pointed out in the literature that policy could not assist with some criteria, such as finding a partner (de Vaus 2002a).

The majority of the women in the study intended to combine motherhood with paid work; consequently women often suggested policies that were seen specifically to aid working mothers. This fits with research that found that while individual policies were not influential in childbearing choices, the general “work-life” conflict that was perpetuated by policy was (Maher 2008; Baker 2008). Career women were also perceived both by the participants and in the literature (de Vaus 2002a; Franklin and Tueno 2004; Martin 2000; Mackinnon 1997; Quesnel-Vallée and Morgan 2003; Romeu Gordo 2009; Warner-Smith and Imbruglia 2001; Weston et al. 2004) to be the group of women in society who needed the most “encouragement” or enabling to have children. Desire for a national paid maternity leave scheme was often mentioned, along with improved flexible working arrangements.

For employers to be more willing to give people maternity leave, paid maternity leave, for longer periods of time, instead of, I’m not even sure what the rules are now… that would certainly make the decision easy to have kids… And then making sure that your position’s going to be available and you’re given the same sort of responsibility when you do actually come back to work and having the ability to go part-time as well without affecting your career and your status within your workplace. They’re all things I think which if they were improved in this country that there would be a lot more people having kids. Allison, age 31, wants kids now.
A few women, however, felt that a strong maternity leave policy could have negative repercussions for women of childbearing age, where employers discriminated against women when they applied for a job for fear of maternity leave payment losses should they become pregnant. This included Vanessa who had recently resigned due to being pregnant and having no maternity leave or flexible job options in her workplace.

_They're not going to… legislate something forcing companies to pay maternity leave. I mean a 30 year old woman who walks in for a job interview won't get the job._ Group 1: Melissa, age 27

During the lifetime of this thesis, there has been a change of Federal Government and two changes of prime minister, and some notable policy changes. Plans are now underway for a paid maternity leave scheme to be implemented, starting in 2011. At present the proposed policy will be government funded, alleviating some of the fears women expressed about the policy encouraging discrimination towards women of childbearing age, should the employer have to pay.

The individual narratives spoke with one voice to cite childcare “accessibility” and “affordability”, where a mother’s daily wage covered more than her childcare payments, as being the key to supporting women in their decision to have children. This policy area was the most common in the data.

_Childcare would be a big [encouragement]. ‘Cause to find a place. To be able to afford that place. It’s ridiculous._ Stacey, age 31, wants kids now

_Basically it’s like “oh okay go out and get an education, off you go and get a career because you need to support your country and um we’re not going to help you with childcare but can you sort of ‘do it all’.“ So my theory is that if they sorted out the childcare system babies would be coming out left, right and centre [laughs]._ Louise, age 31, wants kids in 5+yrs

_I had intended to resume working but have decided not to [because]… my husband and I earn too much to get childcare assistance, I would be working to basically pay for childcare and this defeats the whole purpose of working._ Survey 2, age 26
Laura and Nadine were unusual among the interviewees in explicitly articulating the need for society to have an attitudinal change toward motherhood as a way of facilitating or influencing women to have children. The lack of value the women in the study felt motherhood held in society, along with the gender inequity they saw in the workplace, were, however, common factors in their delayed childbearing. This suggests that a reevaluation of motherhood, as advocated in the literature (Hakim 2003; Maher et al. 2004; Manne 2005; McDonald 2006), would be beneficial in making childbearing more of a choice for women.

[There] needs to be a more social focus on how important it is to have children… and how valued it is... Being successful and making lots of money is valued and being a mother and having children is not valued. I think that’s the problem. Laura, age 27, wants kids in 5+yrs

Society… it’s not really encouraging women [to have children]… You see more women progressing their careers and things like that… Women want to be as equal with men and so it’s enforced in to them that you can’t have a baby and be as good as a man or work the same hours and have the same commitment. Nadine, age 31, wants kids now

A different social change was advocated by Denise, who expressed her belief that more people would be having children if they reduced the expectation of what they wanted and needed to achieve prior to childbearing.

If we could slow down what people expect to have by the time you’ve got a child, you know, you’ve got to have a five bedroom house built brand new out in the suburbs with a three car garage. If they could slow down that process by, I don’t know, manipulating interest rates or whatever they do. Denise, age 30, wants kids in 2-5yrs

Denise’s suggestion, which was not common in the data, was very relevant to the findings from this research of the valorisation of success and the view shared by the majority of the participants that certain precursors were necessary for motherhood. This approach is in keeping with the “affluenza” culture that is argued to be present in contemporary Australian society (Hamilton and Denniss 2005).
Cindy, an interviewee, was alone in suggesting that more government support for the financial costs of ART procedures could improve the fertility rate. While her infertility problems were not age-related, the tendency to delay childbearing among the women in the study, and more widely in society, suggest that this is a pertinent area for consideration. A potentially cheaper alternative would be an education campaign emphasising the negative association between age and fertility that could encourage childbearing at younger ages (see for example RCOG 2009; Bewley et al. 2009). However, the research findings for this thesis suggest that the majority of women are already well informed about the possibility of age-related infertility, often having younger “ideal” ages for motherhood as a result, and it is other factors, discussed above, that are limiting their decision to have children earlier in their lives.

The women in this study, therefore, emphasised the introduction of policies that would enable women to choose motherhood should they wish to, as opposed to encouraging them to have children they otherwise would not have had. By facilitating reproductive choice a woman may, therefore, choose not to have children. This was probably not the ‘solution’ the Treasurer Peter Costello originally envisaged in the Intergenerational Report (Costello 2002a). However, as the findings from this study, and the literature, have shown the majority of women do want to have children (see Berrington 2004; Johnstone and Lee 2009; Weston et al. 2004), and if an environment of choice was created it is possible women may have children earlier, have more children, and thus positively impact the TFR.

9.4 Conclusion
This chapter has shown that reproductive decision-making is a major preoccupation for many young Australian women today. What should be an empowering range of choices regarding whether and when to have children, provided on the one hand by technological intervention and on the other by increasing opportunity and equity for women, has instead resulted in growing indecision and uncertainty about the timing of motherhood. The findings highlight the importance of understanding how reproductive choices are made and in what circumstances, describing a social context in which choice is advocated, expected, but also often limited.

The factors found to influence women’s reproductive decision-making usually resulted in restricted choice and delayed childbearing. Aside from the achievement of the perceived “right” circumstances for motherhood few external factors were found to
encourage women to have children. This included current government incentives to procreate. While the government supports motherhood in theory (Costello 2002a), in practice many participants felt social and financial support for mothers was seriously lacking, preventing motherhood from becoming a rational choice for young women (Cannold 2005; McDonald 2000b). Therefore, the findings from this chapter join ongoing debate in arguing for policies, such as paid maternity leave and inexpensive childcare, which allow women to combine education, work and motherhood effectively and affordably (Bryson 2001; Castles 2002; McDonald 2001; Summers 2003a; Warner-Smith and Imbruglia 2001). Such policies would provide women with more choice about their timing of motherhood and may have the potential to increase the fertility rate by enabling women to have children at a younger age if they so wish. Thus, reducing the need women feel to continually delay motherhood has the potential to increase family sizes, for those who want to, and to decrease the number of women who are childless as a result of age-related infertility.
Chapter 10: Conclusion

I guess why I wanted to participate in this study was because [of] the whole issue of family versus career and when to do all these things. This is an area of my life which does cause me sort of internal conflict. When is the right time to do this? When are you leaving it too late? Not so much doing it too soon but as you’re get[ting] older you feel like your time’s ticking on and the questions of what happens if it doesn’t work?… Because those sort of questions run around inside my head so often… hopefully someone, somewhere down the track will make sense of it. Work out why women are so confused about things [laughs] and feel like you’ve got to succeed in both career and family. Monique, age 28, wants kids in 2-5yrs

10.1 The reproduction imperative in late modernity

In recent years young Australian women have faced questions about their desire for and planned timing of children in response to the demographic trends of declining and delayed childbearing. This thesis demonstrates that most young women would like to have children, in keeping with much of the literature as discussed in Chapter 2. The research concludes, therefore, that in order to augment the below replacement fertility rate in Australia, women do not need to be encouraged to have children; they need to be supported in their decision to choose motherhood and given the tools that will allow them to manipulate their circumstances to fit within their perceived “right” age to have children, an age that generally corresponds with their biological fertility. The main factors found to influence women’s reproductive decision-making were their perceptions of the value of motherhood and their ideal timing of childbearing.

Chapters 5 and 6 depict a competition between desire and doubt in regard to the question of having children as experienced by young Australian women in late modernity. The lack of concern the women demonstrated about the below replacement fertility rate in Australia was counterbalanced by their overall intention to have children. However, this was combined with a high level of ambivalence towards the mother-role. Perceptions of the responsibilities and restrictions of motherhood, and the low value ascribed to the role by society, and sometimes the women themselves, were often found to outweigh the perceived rewards of, and aspirations for, children. This contributed a degree of uncertainty to the decision-making process for the majority of women. Central to this uncertainty was the view many women shared that having
children could have a negative impact on their identity. The conflicting ideologies of wanting to be a “good” mum but not “just” a mum resulted in the goal of “having it all” for many women, which few felt they would be able to achieve. This belief was associated with concerns about combining their dual aspirations for motherhood and paid employment, and compounded by an awareness of continuing gender inequity in society, and most importantly the workplace.

Preconceptions of motherhood were found to be an important influence on women’s intended timing of motherhood, and particularly their tendency to delay childbearing. Chapter 7 offers a particular insight into the trend toward delayed motherhood through a detailed account of childless women’s planning narratives, based on their perceived, and often contradictory, “ideal” circumstances and “ideal” age for motherhood. The women’s precursors to motherhood centred on the goals of “security”, “stability” and being “ready”, and focussed on the areas of finance, career, relationship, and self-fulfilment. These factors contributed to the decision many participants in the study had made to postpone childbearing, as a consequence of the perceived restrictions which having children were seen to place on their achievements in other arenas. “Ideal” age, on the other hand, favoured younger motherhood, with the optimum age viewed as being between 30-35 years old. This timeframe was based on the concerns the majority of women expressed about the impact of older age on both their fertility and their ability to parent. The “right time” to have children was, therefore, often a compromise that usually upheld ideal circumstance over preferred age. Many women’s reproductive narratives, if fulfilled, indicated that they would be older than 35 when they began trying to conceive.

Regardless of their ambivalence about the mother-role, and their compromised timing of childbearing, women still intended to have children, meaning that when women want to have children is a more important question than if. The question of how women shape their reproductive lives from a practical perspective is answered in Chapter 8, which explores the relationship women have with the design tools of reproductive technology that are utilised to enact and preserve their reproductive plans. The findings demonstrate the normalised part that contraceptive technology has played in delaying childbearing for the women in this study until they identify the “right time” to have children, facilitating older motherhood. The connection the women had with technology that can assist with conception (ART), and thus potentially enable older motherhood, was less straightforward, due to the hypothetical nature of its use for most women in the study. Many women believed they would use ART should they face problems
conceiving in the future, although few expressed absolute confidence in its success rate. Despite the high actual or hypothetical use of reproductive technology, its existence was not found to be a cause behind women's delayed childbearing. While the participants perceived reproductive technology, both preventative and ‘assisting’, to offer them options and choices, this was discussed in terms of a need to control their fertility and shape their reproductive lives as a consequence of external factors, such as achieving the ideal circumstances.

The reproductive narratives of the women in my study exemplified many of the characteristics of Giddens’ (1991) discourse of late modernity, discussed in Chapter 3. Their plans were frequently described using a language of risk and often represented a desire for perfection. The goal of having children at the “right time” was created by their focus on life planning combined with a choice culture, their reflexive decision-making processes and the technological means to control fertility in late modernity. However, the majority of women also expressed an awareness of the difficulty of achieving their ideal childbearing plan. This included balancing the risk of pregnancy before they were “ready” with the risk of infertility should they leave it “too late”. These biological risks were in addition to the ideological risks to identity that motherhood was perceived to create in the current individualist climate. Many women, therefore, expressed anxiety about making choices that they saw to be both irrational and loaded with unknown risks.

The empirical chapters conclude with a discussion, in Chapter 9, of the difficulty women described in moving from planning to have children to actually trying to conceive and the impact, or lack of it, which government policy has on their decision-making processes. A complex choice rhetoric existed within the women’s planning narratives. Many women felt they had choices but often also described factors that limited their options, while some women simultaneously felt overwhelmed by the number of choices available to them. The women in the study advocated the implementation of enabling policies as opposed to the one-off financial incentives they saw offered by the government. The participants focussed predominantly on both specific and general policies and attitudes that would facilitate the combination of paid work and motherhood, including a national parental leave scheme, family-friendly workplace arrangements, and improved availability and cost of childcare. The persistently poor image of motherhood that was found in the data supported the reform of the ideology which values worker over mother in society. Culture change is more difficult to enact but could be enhanced by an improvement of the choices offered to
women in regard to balancing work and family. Overall, the findings indicate the need to support women in their reproductive choices.

10.2 Methodological considerations and limitations

The methodological approach applied to the research resulted in a richly contextualised exploration of young Australian women’s plans for children in late modernity that was strong in breadth and depth, see Chapter 4. An interpretive feminist perspective resulted in a pragmatic mixed method three-component design that combined qualitative and quantitative methods under a qualitative drive. This methodology facilitated an investigation of the research question through the experiences of the young women who were in the process of making choices that would impact Australia’s fertility rate. The detailed knowledge of the demographic background of each component sample that the mixed method approach allowed meant that the findings could be both situated within, and generalised to, a specific sector of the population. The sampling strategy prioritised those women who were living in an urban area, aged either side of 30, who were partnered, childless, tertiary educated, in paid employment, managing well on their available income, and healthy. The demographic make-up of the sample, particularly for component three, corresponded almost exactly with the characteristics the literature has found to be associated with an increased likelihood of delayed childbearing, smaller family size and childlessness. Therefore, in the context of below replacement fertility, the women whose voices are heard in this research represent an important group from which to gain an understanding of the processes women go through when they make decisions about having children.

If it had been within the capacity of the research, a parallel study investigating the reproductive choices of the young Australian women who were having larger families at younger ages would have provided an additional comparative element to the research, in order to further explicate the impact of social context on reproductive decision-making. Moreover, the potential to explore the childbearing choices of men, specifically the partners of the women I spoke to, would have provided a valuable insight into the negotiation processes surrounding the reproduction imperative within the home, in concert with that experienced within the public sphere. This would have been particularly illuminating in regard to the small group of women who described their reproductive lives as being dictated by an inconsistency between their own and their partners’ intentions for a family. This multifaceted approach to demographics was not, however, within the scope of the research.
10.3 The future for fertility and future directions for the research

As would be expected the social, reproductive and political worlds have continued to evolve throughout the duration of the research for this thesis. Changes to the Australian fertility rate have resulted in a rise and stabilisation since 2001, albeit just below replacement level in 2009, as noted in Chapters 1, 2 and 3. Analyses of these recent trends have associated them with a fall in the median maternal age (Heard 2010), adding credence to the exploration of women’s desired age at childbearing that was prioritised in the research for this thesis. The finding that it is educated women in their 30s of higher socio-economic status, characteristics shared by the participants in my research, who are contributing most to the fertility rate rise, combined with younger cohorts who are having children earlier (Heard 2010), suggest at least a brief correction of the conflict between “right” age and circumstance described by women in their reproductive narratives. These trends also imply that the maternal age debate, both in terms of observations of the experiences of other and older women and the coverage played out so prominently in the media, may have influenced younger generations. This is in keeping with the effect the women in my study felt the reproductive lives of their mothers and those around them had had on their choices. It can be argued, therefore, that the empirical findings presented in this thesis have charted the movement of fertility changes in recent years. The discord between ideal age and ideal circumstances that women expressed in their planning narratives, along with a general awareness of the biological limitations to their fertility, imply that the situation of delayed childbearing may be untenable.

The shift in median maternal age in Australia highlights the benefit that conducting a follow-up study with the women I interviewed would offer, along with analysis of subsequent waves of the ALSWH data, both quantitative and qualitative, that have been collected from the 1973-78 cohort. This would enable changing trends in young women’s reproductive decision-making behaviour to be explored empirically alongside the documented demographic transitions. This additional research would provide a continuation of the insight into women’s patterns of delayed childbearing by discovering how the reproductive lives of the women I spoke to have progressed and whether they have followed their anticipated course, or have had children earlier or later than planned, or not at all.
10.4 Concluding remarks

The findings from this thesis provide an explanation for both the delay in childbearing and decline in fertility that Australia has experienced and confirm the impact of social and ideological factors on women’s reproductive choices. The introspective and complex calculations women described making in relation to their decisions about if and when to have children focussed on a combination of desire, choice, cost-benefit ratio, risk, equity and ideological beliefs. Thus, their narratives often spoke to one or more of the perspectives the literature associates with fertility decision-making, of rationality, risk, gender inequity and preference, as discussed in Chapter 3.

Consequently, while a “preference” for or against having children was part of every woman’s reproductive story it was seldom, if ever, the only determining factor in her reproductive plan or actions.

The research confirms the need to support women in their reproductive choices. This is emphasised by the discrepancy between when women would like to have children in terms of age and when they expected to have children in terms of circumstances, and the resultant delay of childbearing for the majority. It also argues that by supporting reproductive choice, the fertility rate could also be supported. The research for this thesis concludes at a point of political upheaval for Australia. It is difficult to speculate as to the potential policy innovations and implications young women will face as they make decisions about having children in the coming years, but the implementation of a long awaited parental leave policy seems likely and its advent is supported by this research.

The findings of an overall desire for children and a younger “ideal” age for childbearing than many participants expected to achieve suggest that if real choices were made available for women, in relation to if and when to have children, many would have children earlier, which would in turn create the potential for them to have more. It is unlikely that the demographic implications of such an enabling environment would have negative repercussions for the revived social and government focus on a sustainable population. The majority of participants aspired to have two children which, if fulfilled, would keep the Australian fertility rate around replacement level. Thus, improving the life choices of women in general could potentially quell both the government economic
concern of a ‘greying’ population, and the disquiet expressed by the medical community in relation to older mothers and their babies. Most of all however, it would help to relieve the confusion and internal conflict reported by young women as they respond to the reproduction imperative in late modernity.
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McDonald, P. (2005) 'Has the Australian Fertility Rate Stopped Falling?' *People and Place* 13 (3): 1-5.


Appendices

Appendix 1.1: The Australian Longitudinal Study on Women’s Health (ALSWH) survey mailout schedule

<table>
<thead>
<tr>
<th>Cohort and Year</th>
<th>1996</th>
<th>‘98</th>
<th>‘99</th>
<th>‘00</th>
<th>‘01</th>
<th>‘02</th>
<th>‘03</th>
<th>‘04</th>
<th>‘05</th>
<th>‘06</th>
<th>‘07</th>
<th>‘08...</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973-78 cohort (14,247)</td>
<td>☑*</td>
<td>☑*</td>
<td>☑*</td>
<td>☑</td>
<td>☑</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1946-51 cohort (13,716)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1921-26 cohort (12,432)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey 1 | Survey 2 | Survey 3 | Survey 4 | Survey 5...

☑ indicates a survey mailout

*indicates surveys whose datasets were utilised for analyses in this thesis
Appendix 2.1: The Australian total fertility rate

2.1 TOTAL FERTILITY RATE(a), Australia—1929 to 2009

Source: (ABS 2010: 9)

Appendix 2.2: The median age of Australian parents

2.6 MEDIAN AGE OF PARENTS, Australia—1929 to 2009

Source: (ABS 2010: 14)
Appendix 4: Chapter 4 Appendices

Appendix 4.1.1 Component one: sample groups and coding structure from analysis of ALSWH written comments

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole ALSWH 1973-78 cohort</td>
<td>(N=14,247)</td>
<td>(N=9,688)</td>
<td>(N=9,081)</td>
</tr>
<tr>
<td>Participants who wrote comments</td>
<td>17% of cohort (C*=2,423)</td>
<td>20% of cohort (C=1,948)</td>
<td>25% of cohort (C=2,266)</td>
</tr>
<tr>
<td>Urban participants who wrote comments</td>
<td>64% of commenters (c=1550)</td>
<td>56% of commenters (c=1089)</td>
<td>58% of commenters (c=1315)</td>
</tr>
</tbody>
</table>

Coding structure

<table>
<thead>
<tr>
<th>Top level node (inductive and deductive)</th>
<th>Secondary level node</th>
<th>Lower level nodes</th>
<th>% of urban commenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments identified as ‘reproductive’</td>
<td>Includes all comments described below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reproductive decision-making comments</td>
<td>References to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Plans for children</td>
<td></td>
<td>12% (c=190)</td>
</tr>
<tr>
<td></td>
<td>□ Abortion</td>
<td></td>
<td>21% (c=224)</td>
</tr>
<tr>
<td></td>
<td>□ Adoption</td>
<td></td>
<td>28% (c=366)</td>
</tr>
<tr>
<td></td>
<td>□ Fertility impacting reproductive decisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Contraception use that impacts decisions eg. unplanned pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptive comments</td>
<td>Any mention of contraception</td>
<td></td>
<td>33% (c=62)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20% (c=45)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8% (c=29)</td>
</tr>
<tr>
<td>Motherhood comments</td>
<td>References to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Type of mother (single/step/first-time)</td>
<td></td>
<td>24% (c=46)</td>
</tr>
<tr>
<td></td>
<td>□ Experiences/expectations of motherhood/role/full-time motherhood/(paid) working mothers</td>
<td></td>
<td>29% (c=64)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>34% (c=124)</td>
</tr>
<tr>
<td>Reproductive experiences comments</td>
<td>References to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Pregnancy</td>
<td></td>
<td>41% (c=77)</td>
</tr>
<tr>
<td></td>
<td>□ Fertility problems</td>
<td></td>
<td>50% (c=113)</td>
</tr>
<tr>
<td></td>
<td>□ Reproductive health incidence/endometriosis</td>
<td></td>
<td>61% (c=222)</td>
</tr>
<tr>
<td></td>
<td>□ Miscarriage/stillbirth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Descriptive/demographic nodes</td>
<td>Numerous inc: Age; educational attainment; economic situation; number/spacing children; marriage/partner; social support; choice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* "c*= the number of written comments
Appendix 4.1.2 The demographic profile of component one: those women who wrote ‘reproductive’ comments compared with those who did not

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wrote ‘reproductive’ comments (urban) (C=190)</td>
<td>Did not write ‘reproductive’ comments (N=13,831)</td>
<td>X²</td>
</tr>
<tr>
<td>Married</td>
<td>No data</td>
<td>42%</td>
<td>23%</td>
</tr>
<tr>
<td>Live birth ever (37 weeks or more)</td>
<td>34%</td>
<td>9%</td>
<td>130.4**</td>
</tr>
<tr>
<td>Currently pregnant</td>
<td>14%</td>
<td>3%</td>
<td>95.4**</td>
</tr>
<tr>
<td>Attained tertiary education</td>
<td>12%</td>
<td>11%</td>
<td>10.8</td>
</tr>
<tr>
<td>Manage on income is easy</td>
<td>6%</td>
<td>13%</td>
<td>17.4*</td>
</tr>
<tr>
<td>Currently in paid work</td>
<td>40%</td>
<td>53%</td>
<td>62.8**</td>
</tr>
<tr>
<td>General health now: excellent/very good (Survey 2 = “good”)</td>
<td>44%</td>
<td>51%</td>
<td>7.8</td>
</tr>
<tr>
<td>Use contraception now</td>
<td>65%</td>
<td>72%</td>
<td>102.3**</td>
</tr>
<tr>
<td>Miscarriage ever</td>
<td>13%</td>
<td>4%</td>
<td>53.4**</td>
</tr>
<tr>
<td>Pregnancy termination ever</td>
<td>18%</td>
<td>7%</td>
<td>33.3**</td>
</tr>
<tr>
<td>Fertility problems ever</td>
<td>No data</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Aspire to have 3 or more children by age 35</td>
<td>36%</td>
<td>28%</td>
<td>5.1</td>
</tr>
</tbody>
</table>

*significance at p < .05 **significance at p < .0001
****c” = number of ALSWH 1973-78 cohort who did write reproductive comments ****n” = number of ALSWH 1973-78 cohort who did not write reproductive comments
## Appendix 4.2.1 Component two: focus group location demographic profile

<table>
<thead>
<tr>
<th>Focus groups conducted 2004</th>
<th>Groups 1, 2, 6 &amp; 7</th>
<th>Groups 3 &amp; 4</th>
<th>Group 5</th>
<th>No groups held</th>
<th>NSW average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Area 1</td>
<td>Area 2</td>
<td>Area 3</td>
<td>Area 4</td>
<td>Area 5</td>
</tr>
<tr>
<td></td>
<td>urban</td>
<td>urban</td>
<td>urban</td>
<td>rural</td>
<td>rural</td>
</tr>
<tr>
<td>RRMA classification (Rural remote &amp; metropolitan area)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of population in remoteness area (Census 2001)</td>
<td>Major cities</td>
<td>100.0%</td>
<td>99.8%</td>
<td>100.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Inner regional</td>
<td>-</td>
<td>0.2%</td>
<td>-</td>
<td>92.0%</td>
</tr>
<tr>
<td></td>
<td>Outer regional/ remote</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8.0%</td>
</tr>
<tr>
<td>Socio-economic status by postcode (Census 2001)</td>
<td>medium - high</td>
<td>medium</td>
<td>high</td>
<td>high</td>
<td>low</td>
</tr>
<tr>
<td>Average individual annual taxable income (2000-01)</td>
<td>$</td>
<td>$38,142</td>
<td>$35,581</td>
<td>$71,269</td>
<td>$34,767</td>
</tr>
<tr>
<td>Total population (all persons) at 30 June 2002</td>
<td>no.</td>
<td>143,103</td>
<td>150,489</td>
<td>59,226</td>
<td>24,780</td>
</tr>
<tr>
<td>5 year increase in population to 30 June 2002</td>
<td>%</td>
<td>3.6%</td>
<td>1.3%</td>
<td>4.3%</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Population density</td>
<td>persons/km²</td>
<td>783.7</td>
<td>482.0</td>
<td>5,642.2</td>
<td>5.9</td>
</tr>
<tr>
<td>Crude birth rate</td>
<td>rate</td>
<td>11.4</td>
<td>14.3</td>
<td>11.9</td>
<td>11.6</td>
</tr>
<tr>
<td>Unemployment rate (DEWR estimates June quarter 2002)</td>
<td>%</td>
<td>11.4%</td>
<td>9.9%</td>
<td>4.0%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Source: (ABS 2004b)
Appendix 4.2.2 Component two: focus group recruitment materials

4.2.2.1 Focus group participant recruitment: public advertisement poster text

The children question:
What do young women think about motherhood?

We are interested in young women’s thoughts about having children. We want to find out the reasons behind their plans and decisions, and listen to women’s different experiences.

Are you a woman aged between 18 and 30 years of age?

Would you like to talk about your reproductive decisions, experiences, plans and beliefs?

We would like to invite you to take part in a group discussion.

- The discussion will take around one and a half hours.
- If you take part in the focus group you will be reimbursed $25 to cover any travel or other expenses you may incur in order to take part.

If you are interested, and to receive more information, please call:

Rosie Brotherston

at the Research Centre for Gender and Health, University of Newcastle

1800 068 081

or email:
Rosie.Brotherston@newcastle.edu.au

These focus groups are being conducted by the Research Centre for Gender and Health, The University of Newcastle, during 2004. As the Research Centre studies how social factors, such as decisions about motherhood, impact on people’s health, no medical advice or help can be provided.

If you have any concerns about this project, and would prefer to discuss these with an independent person, you should feel free to contact the University of Newcastle’s Human Research Ethics Officer, Ms Sue O’Connor, on 0249 216 333, or write to her at The Research Office, The University of Newcastle, University Drive, Callaghan, NSW 2308.
4.2.2 Focus group participant recruitment: letter to chief executive officers

Research Centre for Gender and Health

Researchers: Dr Penny Warner-Smith1, Dr Ann Taylor2 & Rosie Brotherston1
1Research Centre for Gender and Health & 2School of Social Sciences
The University of Newcastle
Callaghan NSW 2308
Email: Rosie.Brotherston@newcastle.edu.au
Telephone: 1800 068 081
Fax: 02 4923 6888

To whom it may concern

Information Statement for organisations recruiting employees:
Reproductive decision-making among young Australian women

The Research Centre for Gender and Health at the University of Newcastle are conducting focus groups looking at reproductive decision-making among young Australian women. The research is being conducted by Rosie Brotherston as part of her Masters degree, under the supervision of Dr Penny Warner-Smith from the Research Centre for Gender and Health and Dr Ann Taylor from the School of Social Sciences, all of the researchers are located at the University of Newcastle.

It is important to address these issues, so that policymakers can be more fully informed about what young women want in regard to how they manage their fertility. This is a very important topic, particularly as Australia's birth rate continues to fall, with people having smaller families and an increasing number of women choosing not to have children at all.

In order to find women to take part in the focus group discussions, we are requesting CEOs of organisations such as yours, to assist us in finding participants for our study from among interested employees in your organisation. Please refer to the attached Information Statement and Consent Form for further information. The research team will not initiate contact with any of your organisation's employees. Interested participants will contact the researchers for more information, using our freecall number or email. Your participation as CEO in recruitment for this study is voluntary and you can withdraw at any time without having to provide a reason.

What we are asking you to do:

- Circulate the attached flyer to employees from your organisation via email lists or mailouts, which include relevant staff members - women aged between 18 and 30 years
- Display the attached flyers on staff notice boards
- Display the attached flyers on notice boards in your shop for the general public

What we are asking participants to do:

- Take part in a group discussion (about one and a half hours)
- Fill out a brief anonymous survey (10 minutes)

If you decide to assist us with recruitment we hope that you will be able to display this material as soon as possible. Someone from the research project may phone you in a week or two to discuss how recruitment is going or to discuss any concerns you may have.

Further information
Further information about this research, including hard copy versions of the flyers and Information Sheet, can be obtained by contacting Rosie Brotherston at the Research Centre for Gender and Health on 1800 068 081 or by emailing her at Rosie.Brotherston@newcastle.edu.au

Yours sincerely,

Dr Penny Warner-Smith  Dr Ann Taylor  Rosie Brotherston
Deputy Director    Lecturer   Research Centre for Gender and Health
Research Centre for Gender and Health School of Social Sciences

Complaints about this research:
This research has been approved by the University's Human Research Ethics Committee, Approval number: H-792-0304. Should you have concerns about this project, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, you should feel free to contact the University of Newcastle’s Human Research Ethics Officer, Ms Sue O’Connor, on (02) 4921 6333, or write to her at The Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308 or Email: Human-Ethics@newcastle.edu.au
4.2.2.3 **Focus group participant recruitment: community newspaper advertisement template**

**The children question: What do young women think about motherhood?**

Are you a woman aged between 18 and 30 years of age? Would you like to talk about your reproductive decisions, experiences, plans and beliefs?

We would like to invite you to take part in a group discussion. Groups will be held in [Area] on [Date].

The discussion will last around two hours, and if you participate you will be reimbursed $25 to cover any travel or other expenses you may incur in order to take part.

For more information contact Rosie Brotherston at the Research Centre for Gender and Health, the University of Newcastle on 1800 068 081 or email: Rosie.Brotherston@newcastle.edu.au
Appendix 4.2.3 Component two: focus group information statement

Research Centre for Gender and Health

Researchers: Dr Penny Warner-Smith\(^1\), Dr Ann Taylor\(^2\) & Rosie Brotherston\(^1\)
\(^1\)Research Centre for Gender and Health & \(^2\)School of Social Sciences
The University of Newcastle
Callaghan NSW 2308
Email: Rosie.Brotherston@newcastle.edu.au
Telephone: 1800 068 081
Fax: 02 4923 6888

Information Statement for the Research Project:
Reproductive decision-making among young Australian women

You are invited to take part in the project identified above, which is being conducted by Rosie Brotherston as part of her Masters degree under the supervision of Dr Penny Warner-Smith from the Research Centre for Gender and Health and Dr Ann Taylor from the School of Social Sciences, all of whom are located at the University of Newcastle.

We are interested in young women’s thoughts about having children. We want to find out the reasons behind their plans and decisions, and listen to women’s different experiences.

It is important to address these issues, so that policymakers can be more fully informed about what young women want in regard to how they manage their fertility. This is a very important topic, particularly as Australia’s birth rate continues to fall, with people having smaller families and an increasing number of women choosing not to have children at all.

We would like you to take part if you are a woman aged between 18 and 30 years of age and would like to talk about your reproductive decisions, experiences, plans and beliefs.

If you agree to participate, you will be asked to take part in a focus group discussion, which will last about an hour and a half, the discussion will be led by the research student, Rosie Brotherston.

As a member of the group, you would talk about the things you feel are important about decisions you make regarding your reproductive health.

For example, you might be asked about whether or not you have, or intend to have, children, and to discuss the reasons behind your decisions, or for your views on Australia’s falling birth rate.

We would also ask you to fill in a short survey. This will ask about your age, postcode, and so forth, and will take about ten minutes to complete. Your name will not be included on the survey. For this reason, it will not be possible to withdraw your survey, once it has been collected by the researchers.

The focus group discussion will be audiottaped and transcribed by the research student. No identifying information will be included in the typed transcript and the tapes will be wiped after they have been written up. You will be able to review the recording and/or transcript to edit or erase your contribution. Participants will be requested not to discuss the specific content of the focus group discussion with people outside the group.

The total amount of time we expect the focus groups to take is about two hours. If you take part you will be reimbursed $25 to cover the costs of taking part in the research (e.g. to cover transport or childcare costs). This money will be posted to you in the form of a cheque after the focus group.
We do not expect that any one will wish to discuss illegal behaviour. However, we are obliged to
tell you that if someone taking part in the focus groups were to give specific details about an
illegal incident (eg. date, place, perpetrators), then the researchers might be required to report
the information to the police.

It is possible that some women may become upset when discussing their reproductive
experiences. If this happens, you can stop taking part, or take a break. The researchers will
provide reassurance and refer you to a suitable support and counselling service, such as
Lifeline. Their telephone number is 131 114.

Participation in the project is entirely your choice. Only those people who give their informed
consent will be included in the project. Whether or not you decide to participate, your decision
will not disadvantage you in any way. If you decide to participate, you may withdraw from the
project at any time without giving a reason.

We encourage you to take part in this research because it offers you the opportunity to share
your experiences in an important forum. The results of the research will be used to prepare a
research thesis to be submitted for Rosie’s Masters degree, and to prepare papers for
publication in professional journals and/or for presentation at conferences. Individual
participants will not be identified in any reports arising from this project. If you choose to take
part in this project, you will be able to obtain a summary report of the research findings by

Your name will only appear on the consent form. All information will be securely stored and only
accessible to researchers connected with the project. All data will be stored for five years.

To participate, please read this Information Statement and be sure you understand its contents
before you consent to participate. If there is anything you do not understand, or you have
questions, please call or email (details below), or ask Rosie when you attend the focus group
session.

If you know of any of your friends who might also be interested in participating in the discussion,
please let them know about the focus groups.

Thank you for considering this invitation.

Dr Penny Warner-Smith
Deputy Director
Research Centre for Gender and Health

Dr Ann Taylor
Lecturer
School of Social Sciences

Rosie Brotherston
Research Centre for Gender and Health
Telephone: 1800 068 081
Email: Rosie.Brotherston@newcastle.edu.au

Complaints about this research:
This research has been approved by the University’s Human Research Ethics Committee, Approval
number: H-792-0304. Should you have concerns about this project, or you have a complaint about the
manner in which the research is conducted, it may be given to the researcher, or, if an independent person
is preferred, you should feel free to contact the University of Newcastle’s Human Research Ethics Officer,
Ms Sue O’Connor, on (02) 4921 6333, or write to her at The Research Office, The Chancellery, The
University of Newcastle, University Drive, Callaghan NSW 2308 or Email: Human-
Ethics@newcastle.edu.au
Appendix 4.2.4 Component two: focus group discussion schedule

Prior to audiotaping

- Researchers introduce themselves & project (what/why/how used) & discussion (no right or wrong answers, interested in all experiences) & thank participants & offer refreshments
- Reiterate that participation is voluntary & you may cease taking part at any stage, don’t have to answer questions, note need to report illegal acts if mentioned
- Request that people not discuss the content of the focus group with people outside the group for confidentiality reasons
- Ask for permission for the discussion to be tape-recorded
- Any questions?
- If you wish to participate please read and sign the consent form and complete the written survey

Tape recorder switched on [Participants informed]

- Participants asked to briefly say a little about themselves and what motivated you to take part in the group.

Reproductive decisions/Family planning

- How many, if any, children would you like to have? Why? Is this something you have thought about?
- Do you already have children?
- How do you manage your fertility? And what has influenced your decisions?
- Are you following a plan about when/if to have children? Explain
- Do you feel that you have options and choices about whether and when to have children?
- What do you think gives you options/control?
- Do you feel lucky to be in the position that you are in now, where you do have these choices, or do you ever have a secret thought it might have been nicer when it was easier and you had less control?
- What influences do you feel have the most impact on your reproductive decision-making?
- Has your reproductive life so far passed as you expected it would? Why? Other peoples expectations?
- Do you feel that society has any particular expectations for women your age?

Ideal age for people to become parents:

- When do you want to have children? Age? Why?
- If you have not yet thought about having children at what age do you think this might become an important issue for you? Why?
- What do you think of the ideas of being too old/young to have children/fall pregnant?
- Is there a point at which you go okay I’m not going to have children?
- Roughly at what age do you think women’s chances of becoming pregnant start declining? Roughly at what age do you think a man’s fertility starts to decline?

Reproductive experiences

- Are there any particular reproductive experiences you have had or have heard about that you would like to discuss today?
The future for the Australian birth rate

- The government is concerned about the fact that Australia’s birth rate is falling. Do you think it is a problem?
- Why do you think the birth rate is falling?
- Do you think people should be encouraged to have more children? Why? How?

Reproductive experiences continued:
Participants will be prompted with the following questions only if the particular topic is raised by a participant during the discussion:

- Problems falling pregnant: How did that make you feel? Did you seek help? Where from? Did you find the advice helpful? Did you follow the advice? Did you then become pregnant/have a child?
- Assisted Reproductive Technology, such as In Vitro Fertilisation, Donor Insemination, Egg Donation: If you had trouble falling pregnant which, if any, of these techniques would you try? Why/not? Who do you think should use these technologies? Who do you think should pay for the cost of the treatment? How successful do you think these technologies are? What do you know about IVF treatment?
- Technology used during childbirth: What technologies were used? Did the birth proceed as you expected it to? How did you feel about your experience?
- Abortion: Age when had abortion? Reason? Thoughts on foetal testing (e.g. amniocentesis) for disabilities such as Down syndrome or for particular health problems such as heart defects.
- Contraception: What methods of birth control do/have you used? Which do you prefer?
- Sterilisation/Vasectomy: Would you consider sterilisation if you either decided you did not want any children or had the number of children you wanted?
- Adoption: Would you consider adopting children? In what circumstances?
- Surrogacy: Would you consider finding a surrogate mother if you discovered you could not carry a baby? Would you consider being a surrogate for somebody else? In what circumstances?

Mother as an identity?

- What do the terms ‘mother’ ‘father’ and ‘family’ mean to you? Why? Definitions
- Who do you consider you are related to? Do you feel more related to certain people? Why?

Case study scenario [taken from ALSWH 1973-78 written comments]

- What do you think about the idea of being sterilised in your 20s because you want to adopt children as opposed to conceiving your own children?

Closing questions

- Women will be asked if there is anything they would like to add/any questions?

Tape recorder switched off [participants informed]

- Complete the written survey if not already done so
### Appendix 4.2.5 Component two: coding structure from analysis of focus group discussions

<table>
<thead>
<tr>
<th>Top level node*</th>
<th>Secondary/lower level node*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual participant node</strong></td>
<td>Group no. &amp; ID no. (to explore individual speaker’s narratives)</td>
</tr>
<tr>
<td><strong>Demographic variables</strong> (as described during discussion)</td>
<td>Inc: motherhood status; children’s ages; partner status; currently pregnant?; paid employment?</td>
</tr>
<tr>
<td><strong>Focus group question</strong></td>
<td>Numerous as relevant [see Appendix 4.2.4: Focus group discussion schedule]</td>
</tr>
<tr>
<td><strong>Kids?</strong></td>
<td>Whether to have (more) children?</td>
</tr>
<tr>
<td></td>
<td>How many children want/ have?</td>
</tr>
<tr>
<td></td>
<td>Adoption</td>
</tr>
<tr>
<td><strong>When?</strong> (Timing of kids)</td>
<td>Plan? Inc: unplanned pregnancies/children</td>
</tr>
<tr>
<td></td>
<td>Age?</td>
</tr>
<tr>
<td></td>
<td>Influences on: Inc: travel, finances; health; career; marriage/ partner; biological clock</td>
</tr>
<tr>
<td><strong>Motherhood</strong></td>
<td>Perceptions of</td>
</tr>
<tr>
<td></td>
<td>‘Meaning’ of</td>
</tr>
<tr>
<td></td>
<td>Experiences of</td>
</tr>
<tr>
<td></td>
<td>Support for</td>
</tr>
<tr>
<td></td>
<td>Fatherhood</td>
</tr>
<tr>
<td><strong>Work</strong></td>
<td>Attachment to work; current employment</td>
</tr>
<tr>
<td></td>
<td>Maternity leave</td>
</tr>
<tr>
<td></td>
<td>“Stay-at-home” mothers</td>
</tr>
<tr>
<td></td>
<td>(paid) “working” mothers</td>
</tr>
<tr>
<td><strong>Contraception</strong></td>
<td>Use of; methods; positive; negative; as a given; options of; trust</td>
</tr>
<tr>
<td><strong>Reproductive events</strong></td>
<td>Abortion; miscarriage; pregnancy; childbirth; conceiving; fertility problems; fertility treatment</td>
</tr>
<tr>
<td><strong>Choice</strong></td>
<td>Control?</td>
</tr>
<tr>
<td><strong>Society</strong></td>
<td>Expectations; generational differences; not wanting to judge</td>
</tr>
<tr>
<td><strong>Government policy</strong></td>
<td>Inc: childcare; maternity payment; maternity leave</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Fertility rate debate; over population; who is having children in Australia?</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>Of: fertility; motherhood; childbirth; contraception</td>
</tr>
</tbody>
</table>

*Nodes both inductive and deductive
Appendix 4.2.6 Component two: focus group written survey

Reproductive decision-making among young Australian women

Researchers: Dr Penny Warner-Smith¹, Dr Ann Taylor² & Ms Rosie Brotherston¹

Thank you for taking part in the focus group discussion. This survey will help us to ensure we have spoken with women from a diverse range of backgrounds.

Please try and answer every question. Either tick the appropriate box or write your answer on the line provided. If you have any questions about the survey, please ask.

There is no need to put your name on this survey.

1 How old are you? __________

2 What is your residential postcode? __________

3 Do you have children? (tick the appropriate box)

No ☐
Yes ☐

If no, go to Q5

4 How old are your children? (please write their age/s in the box/s)

5 Are you currently pregnant?

Yes ☐
No ☐
Don’t know ☐
6 Do you usually speak a language other than English at home?
   No, I speak English at home □
   Yes, other (please specify on line) □ ___________________________

7 Are you of Aboriginal or Torres Strait Islander origin?
   (tick all that apply)
   No □
   Yes, Aboriginal □
   Yes, Torres Strait Islander □

8 What is your PRESENT marital status?
   (tick one only)
   Never married □
   Married □
   De facto (opposite sex) □
   De facto (same sex) □
   Separated □
   Divorced □
   Widowed □

9 What is the HIGHEST qualification you have completed?
   (tick one only)
   No formal qualifications □
   Year 10 or equivalent (eg School Certificate) □
   Year 12 or equivalent (eg Higher School Certificate) □
   Trade/apprenticeship (eg hairdresser, chef) □
   Certificate/diploma (eg child care, technician) □
   University degree □
   Higher university degree (eg Grad Dip, Masters, PhD) □
10. Are you currently a student?
   - No □
   - Yes (part-time) □
   - Yes (full-time) □

11. Are you currently in paid employment?
   (tick one only)
   - Yes
     - I am on paid maternity leave
     - I am on unpaid maternity leave □
   - No □

12. Is your paid employment:
   (If you are on maternity leave please answer for the job you are currently on leave from)
   - Full-time □
   - Part-time □
   - Casual □
   [If no, go to Q13]

13. How do you manage on the income you have available?
   (tick one only)
   - It is impossible □
   - It is difficult all the time □
   - It is difficult some of the time □
   - It is not too bad □
   - It is easy □
14 When you are 35, would you like to be in:
(tick one only)

- Full-time paid employment [ ]
- Part-time paid employment [ ]
- Full-time unpaid work in the home [ ]
- Self-employed/own business [ ]

15 When you are 35, would you like to be:
(tick one only)

- Married [ ]
- In a stable relationship but not married [ ]
- Single (not in a stable relationship) [ ]

16 When you are 35, would you like to have:
(tick one only)

- No children [ ]
- 1 child [ ]
- 2 children [ ]
- 3 or more children [ ]

17 When you are 35, would you like to have more educational qualifications than you have now:
(tick one only)

- Yes [ ]
- No [ ]
- Not sure [ ]

Thank you for your participation

Research Centre for Gender and Health

The University of Newcastle Australia

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## Appendix 4.2.7 Components two and three: derivation of variables for the focus group and telephone interview written surveys

<table>
<thead>
<tr>
<th>Focus group survey question</th>
<th>Interview survey question</th>
<th>Question wording</th>
<th>Question response options</th>
<th>ALSWH source questions/modifications to questions (1973-78 cohort surveys)</th>
<th>Original Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>-</td>
<td>How old are you?</td>
<td>‘Please write on line’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q3</td>
<td>-</td>
<td>Do you have any children? (circle one only)</td>
<td>‘No’; ‘Yes’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q4</td>
<td>-</td>
<td>How old are your children? (circle one only)</td>
<td>‘No’; ‘Yes’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q5</td>
<td>Q2</td>
<td>Are you currently pregnant?</td>
<td>‘No’; ‘Yes’; ‘Don’t know’</td>
<td>Exact as at: Survey 1 Q21 Survey 2 Q34 Survey 3 Q34</td>
<td>Australian Longitudinal Study on Women’s Health (ALSWH)</td>
</tr>
<tr>
<td>Q7</td>
<td>-</td>
<td>Are you of Aboriginal or Torres Strait Islander origin?</td>
<td>‘No’; ‘Yes, Aboriginal’; ‘Yes, Torres Strait Islander’</td>
<td>Exact as at: Survey 1 Q79</td>
<td>ABS (1993) 1996 Census of population and housing: Nature and content of the census (ABS cat. no. 2008.0). Canberra: ABS.</td>
</tr>
<tr>
<td>Q10</td>
<td>-</td>
<td>Are you currently a student?</td>
<td>‘No’; ‘Yes (part-time)’; ‘Yes (full-time)’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q11</td>
<td>-</td>
<td>Are you currently in paid employment?</td>
<td>‘Yes’; ‘I am on paid maternity leave’; ‘I am on unpaid maternity leave’; ‘No’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q12</td>
<td>-</td>
<td>Is your paid employment:</td>
<td>Full-time; ‘Part-time’; ‘Casual’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q4</td>
<td>-</td>
<td>How long have you been in your current relationship?</td>
<td>‘Please write in the boxes’ : ‘years’; ‘months’</td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>Q2</td>
<td>Q5</td>
<td>What is your residential postcode? (where you live)</td>
<td>‘Please write number in boxes’</td>
<td>Exact as: Survey 3 Q107a (See also: Survey 1 Q88; Survey 2 Q93)</td>
<td>ALSWH</td>
</tr>
<tr>
<td>Focus group survey question</td>
<td>Interview survey question</td>
<td>Question wording</td>
<td>Question response options</td>
<td>ALSWH source questions/ modifications to questions (1973-78 cohort surveys)</td>
<td>Original Source</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------</td>
<td>------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>-</td>
<td>Q7</td>
<td>In general, would you say your health is:</td>
<td>'Excellent'; 'Very good'; 'Good'; 'Fair'; 'Poor'</td>
<td>Exact as at: Survey 1 Q1 Survey 2 Q14 Survey 3 Q14</td>
<td>Ware, J.E., and C.D. Sherbourne (1992) The MOS 36-item Short-Form Health Survey (SF-36): 1. Conceptual Framework and Item Selection, <em>Medical Care</em> 30 (6): 473-483.</td>
</tr>
<tr>
<td>Q14</td>
<td>Q8</td>
<td>When you are 35, would you like to be in:</td>
<td>'Full-time paid employment'; 'Part-time paid employment'; 'Full-time unpaid work in the home'; 'Self-employed' own business</td>
<td>Exact as at: Survey 2 Q101 Survey 3 Q111 (See also: Survey 1 Q89)</td>
<td>Modified from: Hakim, C. (1991) Grateful Slaves and Self-Made Women: In Women’s Work Orientations, <em>European Sociological Review</em> 7 (2): 101-121.</td>
</tr>
<tr>
<td>Q15</td>
<td>Q9</td>
<td>When you are 35, would you like to be:</td>
<td>'Married'; 'In a stable relationship but not married'; 'Single (not in a stable relationship)'</td>
<td>Exact as at: Survey 2 Q103 Survey 3 Q112 (See also: Survey 1 Q93)</td>
<td></td>
</tr>
<tr>
<td>Q17</td>
<td>Q10</td>
<td>When you are 35, would you like to have more educational qualifications than you have now?</td>
<td>'Yes'; 'No'; 'Not sure'</td>
<td>Exact as at: Survey 1 Q93 Survey 2 Q105 Survey 3 Q114</td>
<td></td>
</tr>
<tr>
<td>Q16</td>
<td>Q11</td>
<td>When you are 35, would you like to have:</td>
<td>'No children'; '1 child'; '2 children'; '3 children'; '4 or more children'</td>
<td>Focus group - exact as at: Survey 2 Q104 Survey 3 Q113 * '4 or more' option added</td>
<td>Interview – modified from: Survey 1 Q92 Survey 2 Q104 Survey 3 Q113</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Focus group survey question</th>
<th>Interview survey question</th>
<th>Question wording</th>
<th>Question response options</th>
<th>ALSWH source questions/modifications to questions (1973-78 cohort surveys)</th>
<th>Original Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Q12</td>
<td>In your lifetime, would you like to have: (circle one only)</td>
<td>&quot;No children&quot;; &quot;1 child&quot;; &quot;2 children&quot;; &quot;3 children&quot;; &quot;4 or more children&quot;</td>
<td>Modified from: Survey 1 Q92; Survey 2 Q104; Survey 3 Q113</td>
<td>Modified from: Hakim, C. (1991) Grateful Slaves and Self-Made Women: In Women's Work Orientations, <em>European Sociological Review</em> 7 (2): 101-121.</td>
</tr>
<tr>
<td>-</td>
<td>Q13</td>
<td>Circle all forms of contraception you have: (circle all that apply)</td>
<td>&quot;Oral contraceptive pill&quot;; &quot;Condoms (male)&quot;; &quot;Femidoms (female condom)&quot;; &quot;Contraceptive implant (e.g. Implanon)&quot;; &quot;Contraceptive injection (e.g. Depro-Provera)&quot;; &quot;IUD (Intrauterine device)&quot;; &quot;Diaphragm&quot;; &quot;Withdrawal method&quot;; &quot;Natural family planning (e.g. Rhythm or Billings method)&quot;; &quot;Emergency contraception (e.g. Morning after pill)&quot;; &quot;Other (please write on line)&quot;</td>
<td>Modified from: Survey 1 Q23; Survey 2 Q32; Survey 3 Q30 (these questions refer to contraceptive 'use now' not 'heard of' or 'ever used') Added options: 'Withdrawal method'; 'other'; 'I have never used any form of contraception'; 'I am not currently using any form of contraception'</td>
<td>ALSWH</td>
</tr>
<tr>
<td>QA a-k</td>
<td>Heard of:</td>
<td>QBa-k-k &quot;I have never used any form of contraception&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QB a-m</td>
<td>Ever used:</td>
<td>QC a-m &quot;I am not currently using any form of contraception&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QC a-m</td>
<td>Use now:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Q14 a-h</td>
<td>Which of these best described why you are not using contraception now? (circle all that apply)</td>
<td>&quot;I am trying to become pregnant&quot;; &quot;I have had a tubal ligation&quot;; &quot;I have had a hysterectomy&quot;; &quot;My partner has had a vasectomy&quot;; &quot;I have found out that I cannot have children&quot;; &quot;I have found out that my partner cannot have children&quot;; &quot;I have no male sexual partners now&quot;; &quot;Other (write on line)&quot;</td>
<td>Modified from: Survey 3 Q31 Options removed: ‘now pregnant/just had a baby’ (See also: Survey 1 Q23; Survey 2 Q32)</td>
<td>ALSWH</td>
</tr>
<tr>
<td>Focus group survey question</td>
<td>Interview survey question</td>
<td>Question wording</td>
<td>Question response options</td>
<td>ALSWH source questions/ modifications to questions (1973-78 cohort surveys)</td>
<td>Original Source</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>-</td>
<td>Q15 a-e</td>
<td>How many times have you had each of the following: (Circle one on each line)</td>
<td><em>Never</em>; <em>Once</em>; <em>Twice</em>; <em>Three times</em>; <em>Four or more</em>; <em>No answer</em></td>
<td>Modified from: Survey 1 Q22</td>
<td>ALSWH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Survey 2 Q35</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Survey 3 Q35</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>‘Abortion’ option divided into two categories: ‘medical reasons’; ‘other reasons’</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Options removed: ‘live birth’; ‘live premature birth’;</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>Stillbirth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Miscarriage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Termination (abortion) for medical reasons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Termination (abortion) for other reasons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Ectopic pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Q16</td>
<td>Which of the following fertility treatments: (circle all that apply)</td>
<td><em>In Vitro Fertilisation (IVF)</em>; <em>Donor sperm</em>; <em>Donor egg</em>; <em>Fertility hormones (e.g. Clomid)</em>; <em>Natural methods (e.g. Rhythm or Billings method)</em>; <em>Other treatment: please write on line provided</em></td>
<td>None</td>
<td>R. Mooney (author)</td>
</tr>
<tr>
<td>QA a-f</td>
<td>have you heard of?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QB a-h</td>
<td>would you consider using if you had problems becoming pregnant?</td>
<td></td>
<td>QBg ‘I would not use any fertility treatments to become pregnant’</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>QBh ‘I cannot imagine ever wanting to become pregnant’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Q17</td>
<td>Have you and your partner (current or previous) ever had problems with fertility – that is, tried unsuccessfully to get pregnant for 12 months or more? (circle one only)</td>
<td><em>No, never tried to get pregnant</em>; <em>No, had no problem with fertility</em>; <em>Yes, but have not sought help/treatment</em>; <em>Yes, and have sought help/treatment</em></td>
<td>Exact as at: Survey 3 Q39 (see also: Survey 2 Q38)</td>
<td>ALSWH</td>
</tr>
<tr>
<td>-</td>
<td>Q18</td>
<td>Have you lived overseas for a month or more in any year between 1996 and 2005? (circle one only)</td>
<td><em>Yes</em>; <em>No [skip Q19]</em></td>
<td>Exact as at: Survey 4 (pilot) Q101</td>
<td>ALSWH</td>
</tr>
<tr>
<td>-</td>
<td>Q19</td>
<td>How many months have you been overseas in each of the following years: 1996-2005</td>
<td><em>No time overseas</em>; <em>One-three months</em>; <em>Four-nine months</em>; <em>Ten-twelve months</em></td>
<td>Exact as at: Survey 4 (pilot) Q102</td>
<td>ALSWH</td>
</tr>
<tr>
<td>Q13</td>
<td>Q20</td>
<td>How do you manage on the income you have available? (circle one only)</td>
<td><em>It is impossible</em>; <em>It is difficult all the time</em>; <em>It is difficult some of the time</em>; <em>It is not too bad</em>; <em>It is easy</em></td>
<td>Exact as at: Survey 1 Q85 Survey 3 Q110</td>
<td>ALSWH</td>
</tr>
<tr>
<td>Focus group survey question</td>
<td>Interview survey question</td>
<td>Question wording</td>
<td>Question response options</td>
<td>ALSWH source questions/ modifications to questions (1973-78 cohort surveys)</td>
<td>Original Source</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Question wording</td>
<td>Question response options</td>
<td>ALSWH source questions/ modifications to questions (1973-78 cohort surveys)</td>
<td>Original Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9</td>
<td>Q21</td>
<td>What is the highest qualification you have completed? (circle one only)</td>
<td>'No formal qualifications';  'Year 10 or equivalent (e.g. School Certificate)';  'Year 12 or equivalent (e.g. Higher School Certificate)';  'Trade/apprenticeship';  'Certificate/diploma (e.g. child care, technician)';  'University degree';  'Higher university degree (e.g. Grad Dip, Masters, PhD)'</td>
<td>Exact as at: Survey 2 Q94 Survey 3 Q104 (see also: Survey 1 Q78)</td>
<td>Modified from: ABS (1993) 1996 Census of population and housing: Nature and content of the census (ABS cat. no. 2008.0). Canberra: ABS.</td>
</tr>
<tr>
<td>Q22A</td>
<td>These questions are about how you feel about different areas of your life: In general, how satisfied are you with what you have achieved in each of the following areas of your life? (circle one on each line)</td>
<td>'Very satisfied'; 'Satisfied'; 'Dissatisfied'; 'Very dissatisfied'</td>
<td>Modified from: Survey 1 Q94 Survey 2 Q106 Survey 3 Q115 Option removed: 'not applicable' option from motherhood</td>
<td>ALSWH</td>
<td></td>
</tr>
<tr>
<td>Focus group survey question</td>
<td>Interview survey question</td>
<td>Question wording</td>
<td>Question response options</td>
<td>ALSWH source questions/ modifications to questions (1973-78 cohort surveys)</td>
<td>Original Source</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| -                           | Q22B                      | Please rate the following areas of life in order of their importance to you: | 'Number from 1 to 8
1= most important
8 = least important' | None | R. Mooney (author) |
|                             |                           | a Work | | | |
|                             |                           | b Career | | | |
|                             |                           | c Study | | | |
|                             |                           | d Family relationships | | | |
|                             |                           | e Partner/ closest personal relationship | | | |
|                             |                           | f Friendship | | | |
|                             |                           | g Social activities | | | |
|                             |                           | h Motherhood/children | | | |
| -                           | Q23                       | In a usual week, how much time in total do you spend doing the following things? (circle one on each line) | 'I don't do this activity'; ‘1-15 hours'; ‘16-24 hours'; ‘25-34 hours'; ‘35-40 hours'; ‘41-48 hours'; ‘49 hours or more' | Modified from:
Survey 2 Q75
Survey 3 Q87
Options c-e expand ‘paid work' | Modified from: ABS (1993) Time Use Survey, Australia, 1992:
|                             |                           | a Active leisure (e.g. walking, exercise, sport) | | | |
|                             |                           | b Passive leisure (e.g. TV, music, reading, relaxing) | | | |
|                             |                           | c Full-time permanent paid work | | | |
|                             |                           | d Part-time permanent paid work | | | |
|                             |                           | e Casual paid work (no paid holiday or sick leave) | | | |
|                             |                           | f Work without pay (e.g. family business) | | | |
|                             |                           | g Studying | | | |
|                             |                           | h Unpaid voluntary work | | | |
|                             |                           | i Home duties (own/ family home) | | | |
| -                           | Q24                       | Have we missed anything? | 'Please write on the lines below' | Modified from final page:
Survey 1
Survey 2
Survey 3 | ALSWH |

(see ALSWH 1997; 2002; 2005; 2007)
Appendix 4.2.8 Component two: focus group consent form

Research Centre for Gender and Health

Dr Penny Warner-Smith¹, Dr Ann Taylor² & Rosie Brotherston¹
¹Research Centre for Gender and Health & ²School of Social Sciences
The University of Newcastle
Callaghan NSW 2308
Email: Rosie.Brotherston@newcastle.edu.au
Telephone: 1800 068 081
Fax: 02 4923 6888

Consent form for the research project:
Reproductive decision-making among young Australian women

Researchers: Dr Penny Warner-Smith, Dr Ann Taylor & Rosie Brotherston

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand that I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to participate in a focus group discussion about my reproductive decision-making, experiences and beliefs and to complete an anonymous demographics survey.

I understand that my personal information will remain confidential to the researchers.

I have had the opportunity to have questions answered to my satisfaction.

Print name: ____________________________________________

Signature: ___________________________ Date:___________

Address: ___________________________________________

(For the purpose of mailing the reimbursement cheque)
### Appendix 4.2.9 Component two: focus group demographic profile

<table>
<thead>
<tr>
<th>Survey variable</th>
<th>Focus group survey data (2004) urban, 18-30 years (N=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>63%</td>
</tr>
<tr>
<td>Married</td>
<td>21%</td>
</tr>
<tr>
<td>De facto</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Motherhood status</strong></td>
<td></td>
</tr>
<tr>
<td>Has children</td>
<td>21%</td>
</tr>
<tr>
<td>Has no children</td>
<td>79%</td>
</tr>
<tr>
<td><strong>Currently pregnant</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4%</td>
</tr>
<tr>
<td>No</td>
<td>96%</td>
</tr>
<tr>
<td><strong>Highest qualification</strong></td>
<td></td>
</tr>
<tr>
<td>Year 12 or equivalent</td>
<td>29%</td>
</tr>
<tr>
<td>Trade/ apprenticeship</td>
<td>8%</td>
</tr>
<tr>
<td>Certificate/ diploma</td>
<td>13%</td>
</tr>
<tr>
<td>University degree</td>
<td>46%</td>
</tr>
<tr>
<td>Higher degree</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Able to manage on income available</strong></td>
<td></td>
</tr>
<tr>
<td>It is difficult all of the time/ impossible</td>
<td>13%</td>
</tr>
<tr>
<td>It is difficult some of the time</td>
<td>25%</td>
</tr>
<tr>
<td>It is not too bad</td>
<td>46%</td>
</tr>
<tr>
<td>It is easy</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Language spoken at home</strong></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>96%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Work status</strong></td>
<td></td>
</tr>
<tr>
<td>Full-time paid work</td>
<td>29%</td>
</tr>
<tr>
<td>Part-time paid work</td>
<td>29%</td>
</tr>
<tr>
<td>Casual paid work</td>
<td>17%</td>
</tr>
<tr>
<td>No paid employment</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Student status</strong></td>
<td></td>
</tr>
<tr>
<td>Studying full-time</td>
<td>13%</td>
</tr>
<tr>
<td>Studying part-time</td>
<td>25%</td>
</tr>
<tr>
<td>Not currently studying</td>
<td>63%</td>
</tr>
<tr>
<td><strong>Aspired marital status at age 35</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>83%</td>
</tr>
<tr>
<td>In a stable relationship but not married</td>
<td>13%</td>
</tr>
<tr>
<td>Single</td>
<td>-</td>
</tr>
<tr>
<td>Survey variable</td>
<td>Focus group survey data</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td>(2004)</td>
</tr>
<tr>
<td></td>
<td>urban, 18-30 years</td>
</tr>
<tr>
<td></td>
<td>(N=24)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspired number of children at age 35</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>No children</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 child</td>
<td>21%</td>
<td>(n=5)</td>
</tr>
<tr>
<td>2 children</td>
<td>63%</td>
<td>(n=15)</td>
</tr>
<tr>
<td>3 or more children</td>
<td>17%</td>
<td>(n=4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspire more educational qualifications at age 35</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>missing data 4% (n=1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>79%</td>
<td>(n=19)</td>
</tr>
<tr>
<td>No</td>
<td>17%</td>
<td>(n=4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspired type of employment at age 35</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>missing data 4% (n=1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time paid employment</td>
<td>50%</td>
<td>(n=12)</td>
</tr>
<tr>
<td>Part-time paid employment</td>
<td>29%</td>
<td>(n=7)</td>
</tr>
<tr>
<td>Full-time unpaid work in the home</td>
<td>4%</td>
<td>(n=1)</td>
</tr>
<tr>
<td>Self-employed/ own business</td>
<td>13%</td>
<td>(n=3)</td>
</tr>
</tbody>
</table>

* *n* = the number of focus group participants and indicates the finding is based on written survey data, as opposed to the focus group transcripts
Appendix 4.3.1 Component three: telephone interview invitation letter and information sheet

[Participant name]
[Participant address]
[Participant address]
[Participant address]

Dear [Participant name]

Thank you for your continued participation in the Women’s Health Australia (WHA) project. We appreciate how many demands there are on your time, and are grateful for your continued involvement.

When you agreed to take part in the Women’s Health Australia project, we mentioned that you might be invited to participate in projects on a range of health issues between the main surveys. One important issue for young women is the question of if and when to have children, particularly as an increasing number of women are delaying motherhood. We would like to invite you to complete the enclosed survey and to participate in a telephone interview at a later date on this topic. For this project, we are collaborating with Rosie Mooney from the University of Newcastle. There is more information about Rosie on the back of this letter.

The invitation to participate is for women who are married or in a de facto relationship, have not already had children and are not currently pregnant, as these are factors that could influence women’s feelings about having children. If you have received this invitation and do not fall into this category we would be grateful if you would take the time to indicate this on the first page of the enclosed survey and return it to us in the reply paid envelope provided.

If you would like to take part in this research, please complete the enclosed survey, sign the consent form and return it to us in the reply paid envelope. Rosie will then call you in the next few weeks to arrange a suitable time to complete the telephone interview. If you don’t wish to take part in this research or would like more information, you may call us on Freecall 1800 068 081.

Any information you give us will remain confidential, and will only be available to the researchers. The results of the research will only be published in a form that does not identify you.

Participation in this research is voluntary and you can change your consent to take part at any time, without giving a reason for doing so. Please be assured that this will not affect your continuing participation in the Women’s Health Australia project.

Thank you for considering our invitation. The choices young women make about having children is an important issue in Australia today, and we are interested in your experiences and opinions.

Yours sincerely

Penny Warner-Smith
Project Manager
Participant information statement

Reproductive decision-making among young Australian women

This project is part of research being conducted by Women’s Health Australia, which is situated at the Research Centre for Gender and Health, the University of Newcastle and at the University of Queensland.

The research is being conducted by Rosie Mooney, a research student at the School of Social Sciences, Newcastle University, in collaboration with Women’s Health Australia. The research will form the basis of Rosie’s thesis. Rosie’s supervisors are Dr Penny Warner-Smith, the manager of the Women’s Health Australia project, who may be contacted on (02) 4923 6872, and Dr Ann Taylor from the School of Social Science, who may be contacted on (02) 4921 6834. All the researchers are located at the University of Newcastle.

For general inquiries or to get further information about the project from Rosie, please use our Freecall number 1800 068 081.

As outlined in our invitation, taking part in this research involves completing and returning the enclosed survey and undertaking a telephone interview at a time arranged to suit you. To save you from re-answering some questions that you have already answered in the main surveys, we may link what you say in the interview and survey with your answers from previous surveys.

The survey will take about 10 minutes to complete and includes questions about your reproductive experiences, and current circumstances, such as your marital and employment status.

It is anticipated that the phone interview will take approximately 45 minutes. You will be asked questions about your reproductive plans and experiences, such as whether you intend to have children and the age you believe would be ideal for a woman to have her first child. The interview will be tape recorded and typed up. No identifying information will be included in the typed copy. If you choose you may use a pseudonym (a different name) during the interview. You may also ask to review, edit or erase the tape recording of your interview, or request a transcript to edit the interview.

Your name will only appear on the consent form, which will be kept separately from your responses to the survey and interview. All information will be securely stored and will only be accessible to the researchers connected with the project. All data will be stored for five years.

This project has the approval of the University of Newcastle Human Research Ethics Committee, Approval No. H-792-0304.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, you may contact the Human Research Ethics Officer, Ms Sue O’Connor, on (02) 4921 6333, or write to her at The Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308 or Email Human-Ethics@newcastle.edu.au.
Appendix 4.3.2 Component three: telephone interview written survey and consent form

Additional survey for young women
[Version 1, 22 August 2005]
August 2005

Your experiences are important to us!

Thank you for considering our invitation to complete this survey and to participate in a telephone interview about your reproductive decisions, experiences, plans and beliefs.

Your responses to the questions in this survey will provide background information about your health and lifestyle, including your contraceptive and reproductive experiences. Some of the questions are the same as those asked in previous surveys, this takes account of the changes in your life experiences since the last survey and gives an up-to-date picture of your life now.

Please answer every question you can. There are no right or wrong answers, we are interested in your experiences. If you are unsure about how to answer a question, circle the response for the closest answer to how you feel.

Please read the instructions above each question carefully. Some require you to only answer those options which are applicable to you. Other questions require you to circle one answer on each line.

If you would like to make further comments about anything in this survey, please use the space provided on page 8.

When you have completed the survey, please sign the consent form on page 2 and return the survey to us in the reply paid envelope provided.

If you need help to answer these questions, please ring us on 1800 068 081 (This is a FREECALL number)

If you are concerned about any of your health experiences and would like some help, please contact:
• Your nearest Women’s Health Centre or Community Health Centre;
• Your general practitioner for advice about who would be the best person in your community for you to talk to.
If you feel distressed NOW and would like someone to talk to, you could ring Lifeline on 131114 (local call).
Consent Form for the Research Project:  
Reproductive decision-making among young Australian women  
[Version 1, 16 August 2005]

Researchers: Dr Penny Warner-Smith, Dr Ann Taylor & Ms Rosie Mooney

I agree to participate in the above research project and give my consent freely.

I acknowledge receipt of the letter from Women's Health Australia outlining details of the above project, a copy of which I have retained.

I consent to complete this written survey and to participate in a telephone interview about my reproductive decisions, experiences, plans and beliefs. I give permission for the interview to be tape recorded and typed up.

I understand that completing this survey is voluntary. If I do not complete this survey, I understand that this will not affect my continuing participation in the Women's Health Australia project.

I understand that my personal information will remain confidential to the researchers.

I agree that information gathered from the project may be published, provided that I will not be identified.

I understand this project is part of Women's Health Australia and that my responses may be linked to information I have already provided to Women's Health Australia.

I have had the opportunity to have questions answered to my satisfaction.

Signature: _______________________

Date: ____________

What is your date of birth?  
(Please write date in boxes)  
19

If you need help to answer any of the questions, you can contact us by telephoning  
1800 068 081  
(FREECALL)
1. Have you ever given birth to a child who is still living with you?  
(Circle one only)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
</tr>
</tbody>
</table>

If yes, you do not need to answer any more questions. Please return the survey to us. Thank you for your time.

2. Are you currently pregnant?  
(Circle one only)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t know</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
</tr>
</tbody>
</table>

If yes, you do not need to answer any more questions. Please return the survey to us. Thank you for your time.

3. What is your present marital status?  
(Circle one only)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>De facto (opposite sex)</td>
<td>2</td>
</tr>
<tr>
<td>De facto (same sex)</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
</tr>
<tr>
<td>Never married</td>
<td>7</td>
</tr>
</tbody>
</table>

If you are not living in a registered marriage or in a de facto relationship, you do not need to answer any more questions. Please return the survey to us. Thank you for your time.

4. How long have you been in your current relationship?  
(Please write in the boxes)

<table>
<thead>
<tr>
<th>Years</th>
<th>Months</th>
</tr>
</thead>
</table>

5. What is your residential postcode?  
(where you live)

6. Who lives with you?  
(Circle all that apply)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a  No one, I live alone</td>
<td>1</td>
</tr>
<tr>
<td>b  Partner/spouse</td>
<td>1</td>
</tr>
<tr>
<td>c  Your step children</td>
<td>1</td>
</tr>
<tr>
<td>d  Your fostered/adopted children</td>
<td>1</td>
</tr>
<tr>
<td>e  Someone else’s children</td>
<td>1</td>
</tr>
<tr>
<td>f  Parents</td>
<td>1</td>
</tr>
<tr>
<td>g  Other adults</td>
<td>1</td>
</tr>
</tbody>
</table>

307
7. **In general, would you say your health is:**

   (Circle one only)

<table>
<thead>
<tr>
<th>Health Level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>1</td>
</tr>
<tr>
<td>Very good</td>
<td>2</td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
</tr>
<tr>
<td>Fair</td>
<td>4</td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
</tr>
</tbody>
</table>

8. **When you are 35, would you like to be in:**

   (Circle one only)

<table>
<thead>
<tr>
<th>Employment Type</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time paid employment</td>
<td>1</td>
</tr>
<tr>
<td>Part-time paid employment</td>
<td>2</td>
</tr>
<tr>
<td>Full-time unpaid work in the home</td>
<td>3</td>
</tr>
<tr>
<td>Self-employed/own business</td>
<td>4</td>
</tr>
</tbody>
</table>

9. **When you are 35, would you like to be:**

   (Circle one only)

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>In a stable relationship but not married</td>
<td>2</td>
</tr>
<tr>
<td>Single (not in a stable relationship)</td>
<td>3</td>
</tr>
</tbody>
</table>

10. **When you are 35, would you like to have more educational qualifications than you have now?**

    (Circle one only)

    | Qualifications Desired | Code |
    |------------------------|------|
    | Yes                    | 1    |
    | No                     | 2    |
    | Not sure               | 3    |

11. **When you are 35, would you like to have:**

    (Circle one only)

    | Number of Children | Code |
    |--------------------|------|
    | No children        | 0    |
    | 1 child            | 1    |
    | 2 children         | 2    |
    | 3 children         | 3    |
    | 4 or more children | 4    |

12. **In your lifetime, would you like to have:**

    (Circle one only)

    | Number of Children | Code |
    |--------------------|------|
    | No children        | 0    |
    | 1 child            | 1    |
    | 2 children         | 2    |
    | 3 children         | 3    |
    | 4 or more children | 4    |
13 Below is a list of different contraceptive methods, in each column please circle all methods you have: A) heard of, B) ever used and C) use now.
(Circle all that apply)

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>you have heard of</td>
<td>you have ever used</td>
<td>you use now</td>
</tr>
<tr>
<td>a</td>
<td>Oral contraceptive pill</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>Condoms (male)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>c</td>
<td>Femidoms (female condoms)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>d</td>
<td>Contraceptive implant (eg Implanon)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>e</td>
<td>Contraceptive injection (eg Depro-Provera)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>f</td>
<td>IUD (Intrauterine Device)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>g</td>
<td>Diaphragm</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>h</td>
<td>Withdrawal method</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>i</td>
<td>Natural family planning (eg Rhythm or Billings method)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>j</td>
<td>Emergency contraception (eg morning after pill)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Another method of contraception (write on the line provided)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>f</td>
<td>I have never used any form of contraception</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>I am currently using any form of contraception</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

If yes to using any contraception now go to Q15

If not using any contraception now go to Q14

14 Which of these best describes why you are not using contraception now?
(Circle all that apply)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am trying to become pregnant</td>
<td>1</td>
</tr>
<tr>
<td>I have had a tubal ligation</td>
<td>2</td>
</tr>
<tr>
<td>I have had a hysterectomy</td>
<td>3</td>
</tr>
<tr>
<td>My partner has had a vasectomy</td>
<td>4</td>
</tr>
<tr>
<td>I have found out that I cannot have children</td>
<td>5</td>
</tr>
<tr>
<td>I have found out that my partner cannot have children</td>
<td>6</td>
</tr>
<tr>
<td>I have no male sexual partners now</td>
<td>7</td>
</tr>
<tr>
<td>Other (please describe on the line provided)</td>
<td>8</td>
</tr>
</tbody>
</table>
15 How many times have you had each of the following:  
(Circle one on each line)

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

16 Which of the following fertility treatments:  
(Circle all that apply)

<table>
<thead>
<tr>
<th></th>
<th>A Have you heard of?</th>
<th>B Would you consider using if you had problems becoming pregnant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>In Vitro Fertilisation (IVF)</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>Donor sperm</td>
<td>1</td>
</tr>
<tr>
<td>c</td>
<td>Donor Egg</td>
<td>1</td>
</tr>
<tr>
<td>d</td>
<td>Fertility hormones (eg Clomid)</td>
<td>1</td>
</tr>
<tr>
<td>e</td>
<td>Natural methods (eg Rhythm or Billings method)</td>
<td>1</td>
</tr>
<tr>
<td>f</td>
<td>Other treatment: please write on line provided</td>
<td>1</td>
</tr>
<tr>
<td>g</td>
<td>I would not use any fertility treatments to become pregnant</td>
<td>1</td>
</tr>
<tr>
<td>h</td>
<td>I cannot imagine ever wanting to become pregnant</td>
<td>1</td>
</tr>
</tbody>
</table>

17 Have you and your partner (current or previous) ever had problems with fertility - that is, tried unsuccessfully to get pregnant for 12 months or more?  
(Circle one only)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>c</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
20. **How do you manage on the income you have available?**

(Circle one only)

<table>
<thead>
<tr>
<th>Option</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is impossible</td>
<td>1</td>
</tr>
<tr>
<td>It is difficult all the time</td>
<td>2</td>
</tr>
<tr>
<td>It is difficult some of the time</td>
<td>3</td>
</tr>
<tr>
<td>It is not too bad</td>
<td>4</td>
</tr>
<tr>
<td>It is easy</td>
<td>5</td>
</tr>
</tbody>
</table>

21. **What is the highest qualification you have completed?**

(Circle one only)

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qualifications</td>
<td>1</td>
</tr>
<tr>
<td>Year 10 or equivalent (e.g., School Certificate)</td>
<td>2</td>
</tr>
<tr>
<td>Year 12 or equivalent (e.g., Higher School Certificate)</td>
<td>3</td>
</tr>
<tr>
<td>Trade/apprenticeship (e.g., hairdresser, chef)</td>
<td>4</td>
</tr>
<tr>
<td>Certificate/diploma (e.g., child care, technician)</td>
<td>5</td>
</tr>
<tr>
<td>University degree</td>
<td>6</td>
</tr>
<tr>
<td>Higher university degree (e.g., Grad Dip, Masters, PhD)</td>
<td>7</td>
</tr>
</tbody>
</table>

22. **These questions are about how you feel about different areas of your life:**

Please answer for each life situation even if you do not do that activity or have that relationship.

A. **In general, how satisfied are you with what you have achieved in each of the following areas of your life?**

(Circle one on each line)

<table>
<thead>
<tr>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>g</th>
<th>h</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>Career</td>
<td>Study</td>
<td>Family relationships</td>
<td>Partner/desire personal relationship</td>
<td>Friendships</td>
<td>Social activities</td>
<td>Motherhood/children</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>Satisfied</td>
<td>Dissatisfied</td>
<td>Very dissatisfied</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. **Please rate the following areas of life in order of their importance to you.**

Number from 1 to 8

1 = most important
8 = least important

7
23 In a usual week, how much time in total do you spend doing the following things? (Circle one on each line)

<table>
<thead>
<tr>
<th></th>
<th>I don't do this activity</th>
<th>1-15 hours</th>
<th>16-24 hours</th>
<th>25-34 hours</th>
<th>35-49 hours</th>
<th>41-48 hours</th>
<th>49 hours or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Active leisure (e.g. walking, exercise, sport)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b</td>
<td>Passive leisure (e.g. TV, music, reading, relaxing)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c</td>
<td>Full-time permanent paid work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d</td>
<td>Part-time permanent paid work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e</td>
<td>Casual paid work (no paid holiday or sick leave)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f</td>
<td>Work without pay (e.g. family business)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g</td>
<td>Studying</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>h</td>
<td>Unpaid voluntary work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>i</td>
<td>Home duties (own/family home)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Have we missed anything?
If there is anything else you would like to tell us, especially relating to your reproductive experiences, plans or beliefs, please write on the lines below.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Thank you for taking the time to complete this survey.
Please sign the consent form on page 2 and send the survey back to us as soon as possible.
We will detach the consent form and store it in a separate locked room.

Women's Health Australia
Reply Paid 70
Hunter Region MC 2310

If you have any questions you can contact us by telephoning 1800 068 081 (freecall)

Australian Longitudinal Study on Women's Health
The University of Newcastle, Callaghan NSW 2308
Phone: 02 4923 6872 Fax: 02 4923 6888 Email: whasec@newcastle.edu.au
Web: http://www.newcastle.edu.au/centre/wha
Appendix 4.3.3 Component three: telephone interview invitation package follow up telephone call script

Telephone script

Hello my name is Rosie Mooney

I am calling from the Women’s Health Australia project at the University of Newcastle.

Please can I speak to ----------- (name of participant)

Participants who have returned the completed survey
Recently you completed a short written survey which asked about your reproductive plans and experiences. Thank you for taking the time to complete the survey. I am a research student who is working with Women’s Health Australia on this project. My supervisors are Dr Penny Warner-Smith and Dr Ann Taylor who are also from Newcastle University.

I wondered if I could arrange a time for you to complete the telephone interview part of this research with me. The interview will take approximately 45 minutes and will be tape recorded and typed up. No identifying information will be included in the typed transcript and you may use a pseudonym (a different name) during the interview if you wish. You may ask to review, edit or erase the tape recording of your interview, or request a transcript to edit the interview.

We are interested in talking with women about their reproductive decisions and experiences, in relation to both past choices and future plans about motherhood. For example, you might be asked whether you intend to have children, and to discuss the reasons behind your decisions, or to describe the age you feel is ideal for women to have their first child.

Participation in the telephone interview is voluntary. You can stop the interview at any time if you do not wish to continue, without giving a reason. This will not in any way affect your participation in the ongoing Women’s Health Australia project.

Do you have any questions about the project?

Are you interested in taking part in a telephone interview?

Consenting participant: When do you think would be the most suitable time to have this interview, bearing in mind you may want some privacy to answer the questions?

Would you also like to give an alternative time, in case you have to go out or you are busy? [Confirm telephone number for interview and record time and date of interview appointments].
Give 1800 068 081 number in case they wish to change time/date.

Thank you for your time and your participation in the Women’s Health Australia project

Non-consenting participant: Thank you for talking the time to complete the written survey. Your non-participation in this interview does not in any way affect your involvement with the Women’s Health Australia surveys.
We really appreciate all the time you spend on the surveys. You will receive a newsletter from us in the next couple of months to let you know what’s been happening at Women’s Health Australia, and will receive your next main survey around Easter time next year.

Participants who have not returned the survey
Have you recently received a letter and survey from us about young women’s motherhood plans?

Yes, survey received:
[Check eligibility]: As you will have read we are interested in talking with women who have not already had children, are not currently pregnant, and who are currently married or living in a de facto relationship.

[Check interest]: There are two parts to the research, completing the survey you have there and completing a phone interview.

If you would like to take part you can either complete the survey and post it back to us or I can complete the survey with you by phone before you do the interview.

[Organise interview: as appropriate]

No, survey not received:
There are two parts to the research, completing a short written survey and taking part in a phone interview about your reproductive plans and experiences.

[Check eligibility]: We are interested in talking with women who have not already had children, are not currently pregnant, and who are currently married or living in a de facto relationship.

[Provide information: - offer to post the invitation letter and survey to them and state that the researcher will call them back in a week once they have received the information letter to find out whether they are interested in participating]

Non-consenting participant: Thank you for your time. Your non-participation in this research does not in any way affect your involvement with the Women’s Health Australia surveys.

Ineligible participant: [If the participant indicates that they do not fulfil this criteria]
Thank you, but we need to interview women who have not already had children/are not currently pregnant/are currently married or living in a de facto relationship, as that is a factor that could influence your feelings about having children.

Thank you for your participation in the Women’s Health Australia project. We really appreciate all the time you spend on the project. You will receive a newsletter from us in the next couple of months to let you know what’s been happening at Women’s Health Australia, and will receive your next main survey around Easter time next year.
Appendix 4.3.4 Component three: telephone interview schedule

Interview schedule

Hello my name is Rosie Mooney.

I am calling from the Women’s Health Australia project at the University of Newcastle.

Please can I speak to ******* (name of participant)

**Introduction:** [Tape recorder off]

Is it still convenient for you to do the interview about your reproductive decision-making now? It will take no more than 45 minutes. Just let me know if you need to stop at any point while we are talking.

With your permission, the interview will be tape recorded and typed up. No identifying information will be included in the typed transcript and you may use a pseudonym (a different name) during the interview if you wish. After the interview you may ask to review, edit or erase the tape recording, or request a transcript to edit the interview.

We are interested in finding out what women in your age group are thinking about if and when to have children. There are no right or wrong answers to any of the questions – we are interested in your thoughts and experiences.

The results of the research will be used to prepare a research thesis to be submitted for my Doctoral degree. The results will also be used to write papers for journals and for presentation at conferences. Individual participants will not be identified in any reports arising from this project. All information will be securely stored and only researchers connected with the project will have access to the data. Data will be held for five years. In July 2006 you will be able to obtain a summary of the results by contacting the researchers.

It is very unlikely that you will want to discuss illegal behaviour during the interview. However, I am obliged to tell you that if you give specific details about an illegal incident, such as time and place, then the researchers might be required to report the information to the police.

We do not expect that this research will cause any distress, but sometimes people become upset when talking about their reproductive experiences. If this happens you can stop the interview, or take a break. I can also give you the contact number of the counselling service, Lifeline: 131 114

Do you have any questions you would like to ask before the tape is turned on?

I am switching the tape on now.
**Verbal consent for telephone interview:** [Tape recorder on]

The tape recorder is now running. Before we begin I need to ask you some questions about your willingness to take part in this interview, your response to these questions provide your verbal consent to complete the interview, if you agree to take part.

Just answer ‘yes’ or ‘no’.

- Do you acknowledge that you have read and kept a copy of the letter which invited you to take part in this research? Do you understand why this research is being conducted, and have you had all of your questions about the research answered?

- Do you consent to participate in a telephone interview about your reproductive decisions, experiences, plans and beliefs, and to complete a short written survey?

- Do you understand that the interview is being tape recorded, and that information on this tape-recording will be used for research which may be published, provided that you will not be identified in the research or publications?

- Do you understand that your personal information will remain confidential to the researchers?

- Do you understand that you can stop the interview at any time if you do not wish to continue, or would like to take a break, and that you do not have to give any reason for doing this?

- Do you understand that if you do not complete the interview, this does not affect your continuing participation in the Women’s Health Australia project?

- Do you understand that this study is part of Women’s Health Australia and that your responses may be linked to information you have already provided to Women’s Health Australia?

Do you have any questions before we begin the interview?
Ask questions as appropriate based on participant survey responses to:
desire for children/currently trying to conceive/contraceptive use/fertility
problems/sterilisation/hysterectomy/sexuality.

**Schedule A: ask those who want children or are undecided**

**Plans and aspirations:** The first set of questions is about any thoughts you might have about having or not having children:

You indicated on the survey that you would like to have children?
- Had you thought about whether or not you wanted to have children before you completed the survey?
- Have you always wanted children? Why? What stage in your life/age did/might this become important to you? Is there anything that you think could change your mind about wanting children in the future? Eg circumstances.
- Do you want to be in a particular situation in your life when you have children? If so what criteria do you want to fulfil before having children?
- [If currently trying to become pregnant]: Why did you decide that now was the best time to start a family? How long have you been trying...

You wrote in the survey that you would like to have X children.
- Had you thought about how many children you might like to have before you did the survey? Why that number? Ideal number? Number expect to have?
- How important is being a mother at some point in your life to you?
- Have you ever thought that you might not have children? Do you think it is more or less likely that you will become a mother at some point?

**Age and motherhood:** One interesting thing about motherhood is the age at which women would like to have children:

- When do you want to have children? At what age?
- Is or was there a youngest age when you thought you definitely didn’t want kids before that? What about the oldest age you would want to become a mother? Why?
- What age do you expect to have children? Why?
- Do you think you might reach a point where you’re like “okay I’ve missed the boat now, I’m going to go on and do other things and not worry about having children”? When? How do you feel about that?

- What is the oldest/youngest age you think women should have children? Too young? Too old to have children? Why?
- Do you think there are differences between younger and older mothers? What are they? Good and bad.
- Do you think women are tending to become mothers later in life? Why? Do you think it is easier or more difficult to have children later in life?
- Do you think the chance of becoming pregnant changes as a woman gets older? Roughly at what age do you think this might happen?
- Do you think the chance of becoming a father changes as a man gets older? Roughly at what age do you think this might happen?
Schedule A continued: ask those who want children or are undecided

Work and children:
- Do you think there is a switch over age when you’re supposed to finish, say the career part of your life and start having kids, or finish having kids and start working or do you not see it like that?
- In general do you think it is possible for women to combine being a mother with a satisfying job/career? Would you? Childcare?
- Paid work? Do/would you have options for maternity leave or flexible working hours in your current job?

Experiences/Expectations about having children:
- What level of choice do you feel you have had about whether or not to have children and when to have children?
- Do you feel that you have options and choices? Why not? What do you feel has given you these choices? Do you think these options will continue to be there for you?
- Do you expect you will be able to follow your plan to have children? Have this number of children? Have children at the age you would like?
- What do you think might affect your plans/wishes about having children?
- Generations: Do you think options and choices women have today in relation to if and when to have children have changed in comparison with your mother’s generation? For better or worse? In what way..?

- What influences do you feel have had the most impact on your reproductive decisions/choices/experiences/plans?
- How much does money and your economic circumstances affect the choices you have made, and will make, about having children?
- How would having kids fit into your life now? Could you imagine having kids now?
- What priority do you give to having a child at some point in your life?
- Has your life gone as you expected it would in relation to having children? Why?
- How about other people’s expectations of your life, your partner/parents/family/friends? Do you feel society has any particular expectations for women your age?

Marriage views
- Is being married before you have children important to you? Why?
- [As appropriate] How long have you been married?

Partner’s views
- Is having children something you have talked about with your partner? Do they feel the same as you do?
- Age of partner.
Schedule B: ask those who do not want children

Plans and aspirations: The first set of questions is about any thoughts you might have about having or not having children:

You indicated on the survey that you do not want to have children?

- Had you thought about whether or not you wanted to have children before you completed the survey?
- Have you always not wanted children? Why? What stage in your life did you decide this? Is there anything that you think could change your mind about wanting children in the future? Eg circumstances.
- If previously did want children – what has changed?
- Have you ever thought that you might have children in the future? Number of children? Do you think it is more or less likely that you will become a mother at some point?

Age and motherhood: One interesting thing about motherhood is the age at which women would like to have children:

- What is the oldest/youngest age you think women should have children? Too young? Too old to have children? Why?
- Do you think there are differences between younger and older mothers? What are they? Good and bad.
- Do you think women are tending to become mothers later in life? Why? Do you think it is easier or more difficult to have children later in life?
- Do you think the chance of becoming pregnant changes as a woman gets older? Roughly at what age do you think this might happen?
- Do you think the chance of becoming a father changes as a man gets older? Roughly at what age do you think this might happen?

Work and children

- Do you think there is a switch over age when women are supposed to finish, say the career part of their life and start having kids, or finish having kids and start working or do you not see it like that?
- In general do you think it is possible for women to combine being a mother with a satisfying job/career? Would you? Childcare?
- Paid work? Do/would you have options for maternity leave or flexible working hours in your current job?
Schedule B continued: ask those who do not want children

Experiences/Expectations about having children
- What level of choice do you feel you have had about whether or not to have children and when to have children?
- Do you feel that you have options and choices? Why not? What do you feel has given you these choices? Do you think these options will continue to be there for you?
- Do you expect you will be able to follow your plan not to have children?
- What do you think might affect your plans/wishes about not having children?
- Generations: Do you think options and choices women have today in relation to if and when to have children have changed in comparison with your mother’s generation? For better or worse?
- What influences do you feel have had the most impact on your reproductive decisions/choices/experiences/plans?
- How much does money and your economic circumstances affect the choices you have made, and will make, about having children?
- How would having kids fit into your life now? Could you imagine having kids now?
- What priority do you give to having a child at some point in your life?
- Has your life gone as you expected it would in relation to not having children? Why?
- How about other people’s expectations of your life, your partner/ parents/ family/ friends? Do you feel society has any particular expectations for women your age?

Marriage views
- Do you think women should be married before they have children? Why?
- [As appropriate] How long have you been married?

Partner’s views
- Is having children something you have talked about with your partner? Do they feel the same as you do?
- Age of partner.
Ask in both schedules A and B: those who want/ do not want children

Contraceptive use: I'd now like to ask you some questions about how you manage your fertility.

(1) Not currently trying to become pregnant and using contraception
From what you have told me, you do not want to become pregnant at this point in time, and in your survey you have noted that you are using contraception to manage your fertility.

(2) Not currently trying to become pregnant and NOT using contraception
   - From what you have told me, you do not want to become pregnant at this point in time, do you mind my asking how you are managing your fertility? (making your plan work)
   - Are you using contraception?

(3) Trying to become pregnant
From what you have told me you are trying to become pregnant at the moment:
   - Before you started to try to have children were you using contraception?

Ask all contraceptive status groups
   - How do you feel about using contraception? Have you always used these method/s? Do you feel the same about all methods of contraception? Are there some you prefer? Do you feel like it offers you choices?

Infertility views: I'd now like to change tack a bit and talk about becoming pregnant.

No known fertility problems
   - If you had trouble becoming pregnant when you wanted to, what would you do? What other options would you look at?
   - Have you thought much about this before?

(4) Fertility problems (self/partner): You mentioned in the survey that you have had problems becoming pregnant:
   - When did you first try to become pregnant?
   - How long did you try/have you been trying for?
   - Have you ever sought any help/treatment for this?
     Yes – help sought
     - Who did you go to for help? What did you use to help you? Expectations?
     No – help not sought
     - Have you ever thought of using any fertility treatments to help you?

Ask both those with/without known fertility problems
In your survey you noted that you would not use any/consider using [ART method] but not use [ART method] if you experienced problems becoming pregnant (and changed your mind about not having children):
   - Why do you think you would try some fertility treatments but not others?
   - I don’t know very much about [ART method] have you heard much about it?
   - What do you think about all the fertility treatments on offer these days? Is that something that you think is out there for people to find out about?
   - Procedures/costs/success rates?
   - How long would/will/did you (should someone) wait before seeking help/talking to someone?
Ask all participants

Information:
- Do you feel quite informed/you know much about pregnancy/childbirth/motherhood?

The Australian birth rate: The government is concerned about the fact that Australia’s birth rate is falling/Australia is not producing enough children.
- How do you feel about that? Do you think it is a problem?
- Why do you think the birth rate is falling?
- What do you think would encourage people to have more children?

Final questions
- What does being a mother/the role of a mother mean to you? Why do you want to have children?
- Plan or no plan: Do you think you’ll plan when to have children or would you almost prefer to fall pregnant accidentally? Why? [omit for those who state are infertile/do not want children]
- Are there any particular reproductive experiences you have had or have heard about that you would like to mention/talk about? Anything you would like to add? Any questions?
- What is your main focus/goal in your life at the moment? Short/long term.
- What do you think your life will be like/you will be doing in three years time?

Additional questions: only ask if the topic is initiated by the participant

Sterilisation:
- Would you ever consider sterilisation of either yourself or your partner once you had the number of children you wanted, or had made the final decision not to have any children?

Abortion:
- Age when had the abortion? Reason?
- Thoughts on fetal testing (e.g. amniocentesis) for disabilities such as Down syndrome or for particular health problems.
- If you became pregnant accidentally/unintentionally do you think you would have a termination? Why? Do you think this has changed as you have got older?
- Do you think abortion is a real option for women in Australia today?

Adoption:
- Would you consider adopting or fostering children? In what circumstances?

Surrogacy:
- Would you consider using a surrogate mother if you discovered you could not carry the baby yourself? Would you consider being a surrogate for somebody else? In what circumstances?
**Additional questions: ask as appropriate re. individual circumstances**

You mentioned in your survey that you have had a hysterectomy/tubal ligation/your partner has had a vasectomy:
- How old were you (and your partner) when you/he had the operation?
- If you don’t mind my asking why did you/he have the operation?
- Had your partner already had the vasectomy when you met him?
- [If they want to have children (also ask if in same sex relationship)]:
  - Have you thought about how you plan to do this?
    (Surrogacy/foster/adoption)
  - Have you thought much about this before?

**Conclude interview**

I am now turning the tape off.
[Tape recorder switched off]

Thank you so much for taking part in the interview and completing the survey. It has been really interesting to hear your points of view on all these issues, they are very important to our research.

[If survey completed by phone] Please remember to sign the consent form and return it in the prepaid envelope.

We really appreciate the time you spend on all the Women’s Health Australia surveys. You will receive a newsletter from us in the next couple of months to let you know what’s been happening at Women’s Health Australia, and will receive your next main survey around Easter time next year.
Appendix 4.3.5 Component three: telephone interview response rate

<table>
<thead>
<tr>
<th>Participant status</th>
<th>%</th>
<th>Status description</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineligible</td>
<td>54%</td>
<td><em>Currently pregnant and/or has child/ren</em></td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>(n=107)</td>
<td><em>Not currently living in a marriage or de facto relationship</em></td>
<td>(n=89)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Unknown</em></td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(reason for ineligibility not given)</em></td>
<td>(n=13)</td>
</tr>
<tr>
<td>Not attempted</td>
<td>4%</td>
<td><em>Overseas</em></td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>(n=7)</td>
<td><em>Long term travel in Australia</em></td>
<td>(n=5)</td>
</tr>
<tr>
<td>Intention to treat sample</td>
<td>43%</td>
<td><em>Non-contactable</em></td>
<td>5%</td>
</tr>
<tr>
<td>(Eligible/non-contactable)</td>
<td>(n=86)</td>
<td><em>Not this time</em></td>
<td>(n=10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(eligible, declined invitation)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Completed survey only</em></td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(eligible, non-contactable for interview)</em></td>
<td>(n=10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Final interviewee sample</em></td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(completed both survey &amp; interview)</em></td>
<td>(n=16)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total invited sample</td>
<td>100%</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>(N=200)</td>
<td></td>
<td>(n=50)</td>
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<td></td>
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</tbody>
</table>

58% of intention to treat sample (n=86)
### Appendix 4.3.6 The demographic profile of component three: telephone interviewees compared with whole ALSWH 1973-78 cohort

<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole ALSWH 1973-78 cohort</th>
<th>Fulfil substudy criteria</th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>(N=9,081)</td>
<td>Not selected</td>
<td>Selected/ invited sample</td>
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<tr>
<td>Marital status</td>
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<tr>
<td>Married</td>
<td>41% (n=3,722)</td>
<td>57% (n=982)</td>
<td>50% (n=100)</td>
<td>30% (n=15)</td>
<td>64% (n=32)</td>
<td></td>
</tr>
<tr>
<td>De facto</td>
<td>20% (n=1,827)</td>
<td>43% (n=738)</td>
<td>50% (n=100)</td>
<td>70% (n=35)</td>
<td>36% (n=18)</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>35% (n=3,157)</td>
<td></td>
<td></td>
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<tr>
<td>Motherhood status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No children</td>
<td>67% (n=5,977)</td>
<td>100% (N=1,720)</td>
<td>100% (N=200)</td>
<td>100% (N=50)</td>
<td>100% (N=50)</td>
<td></td>
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<tr>
<td>One or more children</td>
<td>33% (n=2,906)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently pregnant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8% (n=694)</td>
<td>9% (n=160)</td>
<td>11% (n=22)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No</td>
<td>90% (n=8,179)</td>
<td>88% (n=1,510)</td>
<td>89% (n=177)</td>
<td>100% (N=50)</td>
<td>94% (n=47)</td>
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<tr>
<td>Don't know</td>
<td>2% (n=174)</td>
<td>3% (n=45)</td>
<td>1% (n=1)</td>
<td></td>
<td></td>
<td>6% (n=3)</td>
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<tr>
<td>Residential location</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>60% (n=5,330)</td>
<td>100% (N=1,720)</td>
<td>100% (N=200)</td>
<td>100% (N=50)</td>
<td>100% (N=50)</td>
<td></td>
</tr>
<tr>
<td>Rural/remote</td>
<td>40% (n=3,523)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 years old</td>
<td>18% (n=1,591)</td>
<td>18% (n=305)</td>
<td>17% (n=34)</td>
<td>14% (n=7)</td>
<td></td>
<td>Not asked</td>
</tr>
<tr>
<td>26 years old</td>
<td>19% (n=1,755)</td>
<td>20% (n=349)</td>
<td>21% (n=42)</td>
<td>24% (n=12)</td>
<td></td>
<td></td>
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<tr>
<td>27 years old</td>
<td>20% (n=1,816)</td>
<td>21% (n=356)</td>
<td>17% (n=33)</td>
<td>14% (n=7)</td>
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<tr>
<td>28 years old</td>
<td>21% (n=1,890)</td>
<td>21% (n=358)</td>
<td>25% (n=50)</td>
<td>26% (n=13)</td>
<td></td>
<td></td>
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<tr>
<td>29 years old</td>
<td>20% (n=1,789)</td>
<td>18% (n=303)</td>
<td>19% (n=37)</td>
<td>18% (n=9)</td>
<td></td>
<td></td>
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<tr>
<td>30 years old</td>
<td>3% (n=237)</td>
<td>3% (n=49)</td>
<td>2% (n=4)</td>
<td>4% (n=2)</td>
<td></td>
<td></td>
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<tr>
<td>--------------------------</td>
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<td>------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not selected</td>
<td>Selected/ invited sample</td>
<td>ALSWH 1973-78 cohort: (N=1,720)</td>
<td>Invited substudy sample: (N=200)</td>
<td>Interviewee sample: (N=50)</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Highest qualification</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>No formal qualifications/Year 10</td>
<td>11% (n=934)</td>
<td>4% (n=61)</td>
<td>4% (n=8)</td>
<td>2% (n=1)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Year 12 or equivalent</td>
<td>19% (n=1,728)</td>
<td>14% (n=236)</td>
<td>16% (n=32)</td>
<td>10% (n=5)</td>
<td>14% (n=7)</td>
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<tr>
<td>Trade/apprenticeship</td>
<td>3% (n=280)</td>
<td>2% (n=38)</td>
<td>1% (n=2)</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Certificate/diploma</td>
<td>22% (n=1,994)</td>
<td>20% (n=344)</td>
<td>18% (n=36)</td>
<td>10% (n=5)</td>
<td>10% (n=5)</td>
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<tr>
<td>University degree</td>
<td>34% (n=2,997)</td>
<td>44% (n=738)</td>
<td>46% (n=91)</td>
<td>52% (n=25)</td>
<td>50% (n=25)</td>
<td></td>
</tr>
<tr>
<td>Higher university degree</td>
<td>11% (n=934)</td>
<td>16% (n=278)</td>
<td>14% (n=28)</td>
<td>25% (n=12)</td>
<td>26% (n=13)</td>
<td></td>
</tr>
<tr>
<td>Able to manage on income available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is difficult all the time/impossible</td>
<td>12% (n=1,082)</td>
<td>4% (n=73)</td>
<td>7% (n=15)</td>
<td>4% (n=2)</td>
<td>6% (n=3)</td>
<td></td>
</tr>
<tr>
<td>It is difficult some of the time</td>
<td>30% (n=2,720)</td>
<td>20% (n=347)</td>
<td>19% (n=37)</td>
<td>24% (n=12)</td>
<td>22% (n=11)</td>
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<tr>
<td>It is not too bad</td>
<td>38% (n=3,468)</td>
<td>46% (n=798)</td>
<td>46% (n=91)</td>
<td>42% (n=21)</td>
<td>34% (n=17)</td>
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<tr>
<td>It is easy</td>
<td>20% (n=1,764)</td>
<td>29% (n=500)</td>
<td>29% (n=57)</td>
<td>30% (n=15)</td>
<td>38% (n=19)</td>
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<tr>
<td>Language spoken at home</td>
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<tr>
<td>English</td>
<td>93% (n=8,369)</td>
<td>92% (n=1,560)</td>
<td>95% (n=187)</td>
<td>98% (n=46)</td>
<td>Not asked</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7% (n=609)</td>
<td>9% (n=145)</td>
<td>5% (n=10)</td>
<td>2% (n=1)</td>
<td>-</td>
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<tr>
<td>Type of household</td>
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<tr>
<td>Self and partner/spouse only</td>
<td>34% (n=3,088)</td>
<td>89% (n=1,525)</td>
<td>92% (n=183)</td>
<td>86% (n=43)</td>
<td>100% (N=50)</td>
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<tr>
<td>Other</td>
<td>58% (n=5,276)</td>
<td>11% (n=192)</td>
<td>9% (n=17)</td>
<td>14% (n=7)</td>
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<tr>
<td>Variable</td>
<td>Whole ALSWH 1973-78 cohort (N=9,081)</td>
<td>Not selected</td>
<td>ALSWH 1973-78 cohort: Invited substudy sample (N=200)</td>
<td>Selected/ invited sample Interviewee sample (N=50)</td>
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<td>----------------------------------------------------------</td>
<td>--------------------------------------------------</td>
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<td><strong>Fulfil substudy criteria</strong></td>
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<tr>
<td></td>
<td>Substudy survey (2005)</td>
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<tr>
<td><strong>Work/ student status</strong></td>
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<tr>
<td>Paid work only</td>
<td>57% (n=5,009)</td>
<td>68% (n=1,153)</td>
<td>75% (n=149)</td>
<td>76% (n=38)</td>
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<tr>
<td>Study only</td>
<td>4% (n=396)</td>
<td>2% (n=33)</td>
<td>2% (n=3)</td>
<td>4% (n=2)</td>
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<tr>
<td>Paid work and study</td>
<td>21% (n=1,876)</td>
<td>26% (n=435)</td>
<td>23% (n=46)</td>
<td>18% (n=9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neither</td>
<td>18% (n=1,569)</td>
<td>4% (n=63)</td>
<td>1% (n=1)</td>
<td>2% (n=1)</td>
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<tr>
<td><strong>Main occupation ‘now’</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Manager/ professional</td>
<td>44% (n=3,953)</td>
<td>64% (n=1,085)</td>
<td>59% (n=116)</td>
<td>66% (n=33)</td>
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<tr>
<td>Tradesperson or related worker</td>
<td>3% (n=279)</td>
<td>3% (n=48)</td>
<td>1% (n=2)</td>
<td>-</td>
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<tr>
<td>Advanced/ intermediate clerical or service worker</td>
<td>25% (n=2,269)</td>
<td>25% (n=431)</td>
<td>35% (n=69)</td>
<td>28% (n=14)</td>
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<tr>
<td>Other</td>
<td>8% (n=735)</td>
<td>4% (n=63)</td>
<td>3% (n=5)</td>
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<td></td>
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<tr>
<td>No paid job</td>
<td>19% (n=1,729)</td>
<td>5% (n=81)</td>
<td>3% (n=6)</td>
<td>6% (n=3)</td>
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<tr>
<td><strong>General health</strong></td>
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<tr>
<td>Excellent/ very good</td>
<td>55% (n=5018)</td>
<td>63% (n=1,078)</td>
<td>60% (n=119)</td>
<td>54% (n=27)</td>
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<tr>
<td>Good</td>
<td>35% (n=3,178)</td>
<td>30% (n=518)</td>
<td>35% (n=69)</td>
<td>38% (n=19)</td>
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<tr>
<td>Fair</td>
<td>8% (n=751)</td>
<td>6% (n=98)</td>
<td>6% (n=11)</td>
<td>8% (n=4)</td>
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<tr>
<td>Poor</td>
<td>1% (n=123)</td>
<td>1% (n=23)</td>
<td>1% (n=1)</td>
<td>-</td>
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<tr>
<td><strong>Health Care Card</strong></td>
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<tr>
<td>Yes</td>
<td>18% (n=1,601)</td>
<td>7% (n=112)</td>
<td>7% (n=14)</td>
<td>6% (n=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>82% (n=7,453)</td>
<td>93% (n=1,605)</td>
<td>93% (n=186)</td>
<td>94% (n=47)</td>
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</tbody>
</table>

**Note:** Numbers in parentheses indicate sample sizes.
<table>
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<tr>
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<tbody>
<tr>
<td></td>
<td>Not selected</td>
<td>Selected/invited sample</td>
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<td></td>
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<tr>
<td></td>
<td>ALSWH 1973-78 cohort: (N=1,720)</td>
<td>Invited substudy sample</td>
<td>(N=200)</td>
<td>Interviewee sample</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Contraceptive use</td>
<td></td>
<td></td>
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<tr>
<td>Don’t need - pregnant/baby</td>
<td>9% (n=795)</td>
<td>9% (n=146)</td>
<td>11% (n=22)</td>
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<tr>
<td>Don’t need - other</td>
<td>15% (n=1,329)</td>
<td>6% (n=101)</td>
<td>3% (n=6)</td>
<td>8% (n=4)</td>
</tr>
<tr>
<td>Choose not to use</td>
<td>6% (n=537)</td>
<td>10% (n=167)</td>
<td>9% (n=17)</td>
<td>2% (n=1)</td>
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<tr>
<td>Pill only</td>
<td>33% (n=2,979)</td>
<td>46% (n=785)</td>
<td>45% (n=90)</td>
<td>42% (n=21)</td>
</tr>
<tr>
<td>Pill and other</td>
<td>13% (n=1,206)</td>
<td>10% (n=173)</td>
<td>14% (n=27)</td>
<td>22% (n=11)</td>
</tr>
<tr>
<td>Condom and/or other (no pill)</td>
<td>16% (n=1,444)</td>
<td>13% (n=229)</td>
<td>13% (n=26)</td>
<td>12% (n=6)</td>
</tr>
<tr>
<td>Other (no pill/condom)</td>
<td>8% (n=684)</td>
<td>6% (n=105)</td>
<td>6% (n=12)</td>
<td>14% (n=7)</td>
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<tr>
<td>Stillbirth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>99% (n=8,070)</td>
<td>100% (N=1,716)</td>
<td>100% (N=200)</td>
<td>100% (N=50)</td>
</tr>
<tr>
<td>One or more</td>
<td>1% (n=56)</td>
<td>0% (n=3)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Miscarriage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>88% (n=7,358)</td>
<td>95% (n=1,631)</td>
<td>96% (n=192)</td>
<td>98% (n=49)</td>
</tr>
<tr>
<td>One or more</td>
<td>12% (n=998)</td>
<td>5% (n=89)</td>
<td>4% (n=8)</td>
<td>2% (n=1)</td>
</tr>
<tr>
<td>Termination (Abortion)</td>
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<td></td>
</tr>
<tr>
<td>None</td>
<td>85% (n=7,146)</td>
<td>89% (n=1,536)</td>
<td>86% (n=170)</td>
<td>82% (n=41)</td>
</tr>
<tr>
<td>One or more</td>
<td>15% (n=1,274)</td>
<td>11% (n=182)</td>
<td>14% (n=28)</td>
<td>18% (n=9)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Fertility problems</td>
<td></td>
<td>Not selected</td>
<td>Selected/ invited sample</td>
<td></td>
</tr>
<tr>
<td>No, never tried to get pregnant</td>
<td>61% (n=5,523)</td>
<td>82% (n=1,404)</td>
<td>82% (n=163)</td>
<td>94% (n=46)</td>
</tr>
<tr>
<td>No, had no problem with fertility</td>
<td>32% (n=2,879)</td>
<td>12% (n=209)</td>
<td>14% (n=28)</td>
<td>6% (n=3)</td>
</tr>
<tr>
<td>Yes, but have not sought help/treatment</td>
<td>2% (n=206)</td>
<td>2% (n=31)</td>
<td>2% (n=3)</td>
<td>-</td>
</tr>
<tr>
<td>Yes, and have sought help/treatment</td>
<td>4% (n=400)</td>
<td>4% (n=68)</td>
<td>3% (n=5)</td>
<td>-</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Exclusively heterosexual</td>
<td>90% (n=8,083)</td>
<td>92% (n=1,577)</td>
<td>95% (n=188)</td>
<td>90% (n=45)</td>
</tr>
<tr>
<td>Other</td>
<td>10% (n=935)</td>
<td>8% (n=139)</td>
<td>5% (n=10)</td>
<td>10% (n=5)</td>
</tr>
<tr>
<td>Aspired marital status at age 35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>86% (n=7,677)</td>
<td>92% (n=1,562)</td>
<td>91% (n=182)</td>
<td>84% (n=42)</td>
</tr>
<tr>
<td>In a stable relationship but not married</td>
<td>13% (n=1,172)</td>
<td>8% (n=139)</td>
<td>9% (n=17)</td>
<td>16% (n=8)</td>
</tr>
<tr>
<td>Single (not in a stable relationship)</td>
<td>1% (n=87)</td>
<td>0% (n=2)</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Aspired number of children at age 35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No children</td>
<td>8% (n=722)</td>
<td>7% (n=122)</td>
<td>4% (n=7)</td>
<td>6% (n=3)</td>
</tr>
<tr>
<td>1 child</td>
<td>15% (n=1,337)</td>
<td>14% (n=243)</td>
<td>14% (n=28)</td>
<td>26% (n=13)</td>
</tr>
<tr>
<td>2 children</td>
<td>54% (n=4,871)</td>
<td>63% (n=1,076)</td>
<td>64% (n=126)</td>
<td>60% (n=30)</td>
</tr>
<tr>
<td>3 or more children</td>
<td>23% (n=2,021)</td>
<td>16% (n=265)</td>
<td>18% (n=36)</td>
<td>8% (n=4)</td>
</tr>
</tbody>
</table>

329
<table>
<thead>
<tr>
<th>Variable</th>
<th>Whole ALSWH 1973-78 cohort (N=9,081)</th>
<th>Fulfil substudy criteria</th>
<th>Substudy survey (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALSWH 1973-78 cohort: Invited substudy sample (N=200)</td>
<td>Interviewee sample (N=50)</td>
<td></td>
</tr>
<tr>
<td>Aspire more educational qualifications at age 35</td>
<td>Yes</td>
<td>51% (n=4,620)</td>
<td>47% (n=809)</td>
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<td></td>
<td>No</td>
<td>19% (n=1,762)</td>
<td>23% (n=401)</td>
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<tr>
<td></td>
<td>Not sure</td>
<td>30% (n=2,670)</td>
<td>30% (n=509)</td>
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<tr>
<td>Aspired type of employment at age 35</td>
<td>Full-time paid employment</td>
<td>41% (n=3,647)</td>
<td>35% (n=593)</td>
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<tr>
<td></td>
<td>Part-time paid employment</td>
<td>36% (n=3,260)</td>
<td>42% (n=718)</td>
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<tr>
<td></td>
<td>Full-time unpaid work in the home</td>
<td>5% (n=446)</td>
<td>6% (n=101)</td>
</tr>
<tr>
<td></td>
<td>Self-employed/ own business</td>
<td>18% (n=1,633)</td>
<td>17% (n=296)</td>
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</tbody>
</table>

*“n” = the number of interview participants and indicates the finding is based on written survey data, as opposed to the interview narratives
## Appendix 4.3.7 Component three: coding structure from analysis of the telephone interview narratives

<table>
<thead>
<tr>
<th>Top level node*</th>
<th>Secondary level node*</th>
<th>Third level nodes*</th>
<th>Lower level nodes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey data</td>
<td>demographic data</td>
<td>age; marital status; highest qualification; manage on income</td>
<td>numerous (see appendix 4.3.2 for a copy of survey)</td>
</tr>
<tr>
<td></td>
<td>‘reproductive’ data</td>
<td>aspirations for children</td>
<td>by age 35; ever contraceptive use current; ever experience of reproductive events abortion; miscarriage; stillbirth potential use of ART</td>
</tr>
<tr>
<td></td>
<td>other data</td>
<td>inc; aspirations for paid work</td>
<td>by age 35</td>
</tr>
<tr>
<td>Interview</td>
<td></td>
<td>numerous as relevant [see appendix 4.3.4 for a copy of the schedule]</td>
<td></td>
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<tr>
<td>question</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kids?</td>
<td>perceived experience</td>
<td>positive; negative; responsibility; restriction; expense</td>
<td>past/current contact with children</td>
</tr>
<tr>
<td></td>
<td>why?</td>
<td>Biological connection; “family”; provide grandkids</td>
<td></td>
</tr>
<tr>
<td></td>
<td>how many?</td>
<td>numerous: 0-3+</td>
<td>number re. finances; age</td>
</tr>
<tr>
<td></td>
<td>certainty</td>
<td>unsure; definite; ambivalent</td>
<td>fear of regret; should have priority numerous: low-very high categories uncertain: indecisive; lack desire certain: definite; likely adoption yes; no; maybe if infertile; regardless childlessness</td>
</tr>
<tr>
<td>Timing of kids</td>
<td>expected/ planned</td>
<td>why now?; why not now?; 3yr plan; accident/ plan; “right time”</td>
<td>trying to conceive soon (&lt;2 yrs) soonish (2-5yrs) future (5+yrs) no kids</td>
</tr>
<tr>
<td></td>
<td>age</td>
<td>importance of yes; no</td>
<td>when; age 30 oldest; youngest older mother positive; negative; define younger mother positive; negative; define fertility + age women; men</td>
</tr>
<tr>
<td>Top level node*</td>
<td>Secondary level node*</td>
<td>Third level nodes*</td>
<td>Lower level nodes*</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Security &amp; stability</td>
<td>precursors</td>
<td>numerous inc: career; own home; finances; self/ready; partner/marriage; travel; education; “life”</td>
<td></td>
</tr>
<tr>
<td>Impact timing</td>
<td>numerous inc: time; career; finances; contact with children; upbringing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitions in plan</td>
<td>fixed; changeable; brought forward; delayed</td>
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<tr>
<td>Motherhood</td>
<td>perceived experience</td>
<td>positive; negative; unknown; ability to cope; “just a mum”; “family”; “maternal”</td>
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</tr>
<tr>
<td>Role of; The “good” mother</td>
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<tr>
<td>Mother’s today</td>
<td>delayed; single mother</td>
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<tr>
<td>Own mother</td>
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<tr>
<td>Work</td>
<td>current; future plans</td>
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<tr>
<td>Work + kids?</td>
<td>maternity leave; childcare</td>
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<td></td>
</tr>
<tr>
<td>Career attachment</td>
<td>as identity; financial</td>
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<tr>
<td>“Stay-at-home” mother</td>
<td>expectation; desire; oppose</td>
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<tr>
<td>Contraception</td>
<td>positive; negative; use of; by method; as a given; “safety” of; as a choice</td>
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<tr>
<td>Fertility</td>
<td>as a given; not given</td>
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<tr>
<td>Fertility + age</td>
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<tr>
<td>Problems conceiving</td>
<td>considered before?; fate; how long try before seeking help?</td>
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<td></td>
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<tr>
<td>Assisted reproductive technology (ART)</td>
<td>potential use; current use; knowledge of; methods; as safety net; genetics</td>
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<tr>
<td>Reproductive events</td>
<td>pregnancy (“risk”); abortion; miscarriage; childbirth; health</td>
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</tr>
<tr>
<td>Marriage</td>
<td>importance of re. kids; value; social expectation?</td>
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</tr>
<tr>
<td>Partner</td>
<td>positive/ negative re. kids</td>
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<td>Joint decision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same/ different views re. kids/ timing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society</td>
<td>expectations; fertility rate; government policy; media</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key concepts</td>
<td>choice</td>
<td>yes; no; too much; generational differences; associated with</td>
<td></td>
</tr>
<tr>
<td>Key phrases</td>
<td>numerous inc: “value”; “risk”; “responsible”; “selfish”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Nodes both deductive & inductive
## Appendix 8.1: Contraceptive use: a comparison between the interviewees & the ALSWH 1973-78 urban cohort

<table>
<thead>
<tr>
<th>Contraceptive device</th>
<th>Heard of</th>
<th>Ever used</th>
<th>Use now</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interviewees</strong></td>
<td>(N*=50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>'The pill'</td>
<td>100%</td>
<td>98%</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>(N=50)</td>
<td>(n=49)</td>
<td>(n=18)</td>
</tr>
<tr>
<td>Condoms</td>
<td>100%</td>
<td>94%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>(N=50)</td>
<td>(n=46)</td>
<td>(n=15)</td>
</tr>
<tr>
<td>Withdrawal method</td>
<td>100%</td>
<td>44%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>(N=50)</td>
<td>(n=22)</td>
<td>(n=8)</td>
</tr>
<tr>
<td>Emergency contraception (e.g. morning after pill)</td>
<td>100%</td>
<td>36%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>(N=50)</td>
<td>(n=18)</td>
<td></td>
</tr>
<tr>
<td>Contraceptive implant</td>
<td>88%</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>(n=44)</td>
<td>(n=8)</td>
<td>(n=4)</td>
</tr>
<tr>
<td>Natural family planning (e.g. Rhythm or Billings method)</td>
<td>98%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>(n=49)</td>
<td>(n=2)</td>
<td>(n=2)</td>
</tr>
<tr>
<td>Contraceptive injection</td>
<td>82%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>(n=41)</td>
<td>(n=2)</td>
<td>(n=1)</td>
</tr>
<tr>
<td>IUD (Intrauterine Device)</td>
<td>96%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>(n=48)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>100%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>(N=50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have never used any form of contraception</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I am not currently using any form of contraception</td>
<td>-</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>(n=13)</td>
<td>(n=13)</td>
<td>(n=13)</td>
</tr>
</tbody>
</table>

*"n" = the number of participants and indicates the finding is based on written survey data, as opposed to the interview narratives

**‘Amended’ survey data indicates that the interviewees quantitative (written survey) and qualitative (interview narrative) responses to their contraceptive use have been compared and combined. In the three instances where anomalies occurred the qualitative finding was given precedence and the survey data ‘amended’ to reflect this. See Appendix 8.2 for more detail.
Appendix 8.2: The interviewees’ detailed contraceptive usage: comparing and combining qualitative and quantitative responses

<table>
<thead>
<tr>
<th>Detailed contraceptive use</th>
<th>A</th>
<th>B</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Written survey</td>
<td>‘Amended’ survey &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(quantitative data</td>
<td>narrative &amp; data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>only)</td>
<td>(combined qualitative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&amp; qualitative data)</td>
<td></td>
</tr>
<tr>
<td>The pill alone</td>
<td>22% (n=11)</td>
<td>24% (n=12)</td>
<td>Natasha explained she was in the process of changing from the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>contraceptive implant to the pill when she completed the written</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>survey hence ticking both. She now only uses the pill.</td>
</tr>
<tr>
<td>‘The pill’ + Implant</td>
<td>2% (n=1)</td>
<td>- (n=0)</td>
<td>Despite ticking both “the pill” and “condoms in her written survey,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cherie stated clearly in her interview narrative that she is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>on the pill and does not like taking it.</td>
</tr>
<tr>
<td>‘The pill’ + condoms</td>
<td>10% (n=5)</td>
<td>8% (n=4)</td>
<td></td>
</tr>
<tr>
<td>Condom alone</td>
<td>16% (n=8)</td>
<td>18% (n=9)</td>
<td></td>
</tr>
<tr>
<td>The pill + withdrawal</td>
<td>2% (n=1)</td>
<td>2% (n=1)</td>
<td></td>
</tr>
<tr>
<td>Condom + withdrawal</td>
<td>4% (n=2)</td>
<td>6% (n=3)</td>
<td>Despite only ticking withdrawal method in her written survey,</td>
</tr>
<tr>
<td>Withdrawal alone</td>
<td>6% (n=3)</td>
<td>4% (n=2)</td>
<td>Bronwyn clearly stated in her interview narrative that she also uses</td>
</tr>
<tr>
<td>Withdrawal with natural</td>
<td>4% (n=2)</td>
<td>4% (n=2)</td>
<td>condoms.</td>
</tr>
<tr>
<td>Natural alone</td>
<td>- (n=0)</td>
<td>- (n=0)</td>
<td></td>
</tr>
<tr>
<td>Implant alone</td>
<td>6% (n=3)</td>
<td>6% (n=3)</td>
<td></td>
</tr>
<tr>
<td>Injection alone</td>
<td>2% (n=1)</td>
<td>2% (n=1)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>26% (n=13)</td>
<td>26% (n=13)</td>
<td></td>
</tr>
</tbody>
</table>

*n* = the number of interview participants: *n’s in column A are based on written survey data only; ‘n’s in column B are based on both written survey data and the interview narratives.