

Sexually Transmitted Infections, Sex and the Irish.

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Abstract.

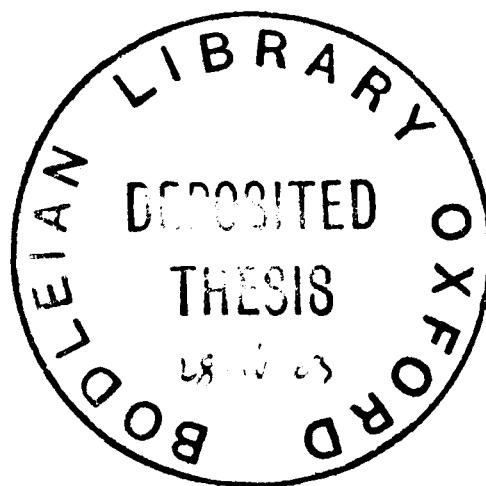
The national reported rates of sexually transmitted infections (other than HIV/AIDS) in Ireland have been increasing over the last decade of the 20th century. Medical professionals and epidemiologists consider the rates of STIs as indicators of the proportion of the population engaging in 'high risk' behaviour. According to this hypothesis, an increase in reported rates reflects an increase in 'high risk' behaviours. This thesis will examine this relationship and determine the reasons for the increased reported rates in Ireland. This will involve an investigation into Irish sexual behaviours and attitudes, thus giving an insight into Irish sexuality, which has previously attracted little sociological interest.

Evidence in regard to Irish sexuality and sexually transmitted infections is limited. In the absence of longitudinal data on sexual behaviours and a national survey on STIs and risk-taking sexual behaviours, the question of the rising rates has to be addressed by collating available data from different sources. This involves: (1) the use of epidemiological and GUM clinics' information, (2) a socio-historical account of Irish sexuality and sexually transmitted infections and (3) a comparative analysis of Irish sexual behaviours and attitudes with four other countries utilising the International Social Survey Programme's 1994 dataset, Family and Changing Gender Roles II. It is concluded that the increasing reporting rates of STIs are not being directly caused by accompanying increases of 'high risk' sexual behaviours in the general population but are produced by a number of factors including a growing public openness about sexuality and sexual health awareness.

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Contents.

Chapter 1	Introduction - Towards a Sociology of Sexually Transmitted Infections.	Page 1
Chapter 2	The Epidemiology of STIs in Ireland.	Page 17
Chapter 3	Is the Irish GUM Clinic System responsible for the changes in national reported rates?	Page 36
Chapter 4	Lessons From the Past: How Sexual Morality Impedes Preventative Strategies for Sexually Transmitted Infections.	Page 55
Chapter 5	Who's at Risk? The Irish and Their Sexual Partners.	Page 77
Chapter 6	What Sexually Transmitted Infections Reveal about Irish Sexuality.	Page 105
Chapter 7	Irish Sexual Attitudes - A Norm of Western Societies in the Late 20 th Century?	Page 125
Chapter 8	Irish Sexual Behaviours – A Comparative Perspective.	Page 160
Chapter 9	Conclusion - Explanations for the Spread of Sexually Transmitted Infections.	Page 183
Appendix I	Definitions of Sexually Transmitted Infections.	
Appendix II	Appendix to Chapter 7.	
Appendix III	Survey Questions	
	Bibliography	

Chapter 1: Towards a Sociology of Sexually Transmitted Infections.

The reported increase in the incidences of sexually transmitted diseases in Ireland is a worrying sign of the changing face of our society.
(Opinion, Irish Examiner, 28th November 2000).

Introduction:

In the last decade of the 20th century, the volume of scholarly works on human sexuality increased enormously. Encompassing assertions of sexual identities and rights, sexual politics and contraceptive cultures, sexual practices and lifestyles, sexual behaviours were investigated in a large number of fields ranging from social history to anthropology and biology to law. If collected into a cohesive group of sexual research, the writings display enormous variations from biological urges to cultural meanings and often with contradictory views and findings. One common link between all the disciplines engaged in studying sexual behaviours is the human immunodeficiency virus (HIV), the agent responsible for the current global pandemic of acquired immune deficiency syndrome (AIDS). Since its appearance in the early 1980s, HIV/AIDS has reinforced the integral part sexual behaviours play in the public health of a society or nation.

In AIDS related social and behavioural research, a collective body of sociological works, entitled the 'Sociology of AIDS', has been forged. Much of the sociological focus has been on formulating preventative strategies (Moatti et al, 2000) and supporting medical interventions through the promotion of early diagnosis and treatment (Institute of Medicine, 1986). Another branch of the 'Sociology of AIDS' has concentrated on risk management and on sexual risk taking. This research has helped to identify the social groups at risk of AIDS, mark the behaviours or social conditions that increase risk of the disease and find ways to encourage individual and collective changes (Moatti et al, 2000; Lemalle et al, 2000). Recently, 'Sociology of AIDS' has included studies on the personal experiences of people living with HIV, the impact of therapeutic advances in HIV care and the implementation of social network analysis in building mathematical models of HIV transmission (Moatti et al, 2000).

Another aspect to AIDS related social and behavioural research is the growth of the sex survey, such as Hubert et al, (1998), Michael et al (1994) & Wellings et al (1994). These studies have provided essential information on the variety of sexual behaviours and practices in western societies. However, Di Mauro (2000) has pointed out that there is too much emphasis on identifying 'high risk' sexual behaviours¹. As a result, knowledge about personal meanings and sexual norms is overlooked. This is the problem with

¹ This refers to unsafe sex, which can be defined as sexual intercourse (anal, vaginal or oral) without the use of a condom and where one or both persons have more than one current or recent sexual partner or one partner is known to have an STI (Overseas Development Administration, 1996).

‘Sociology of AIDS’. In the absence of existing data on sexual behaviours, it has had to quickly provide empirical information and consequently, the understanding of HIV/AIDS in sexual and personal relationships is under-theorised (Erickson & Steffen, 1996; Scott & Freeman, 1995). Sociology has been co-opted into supporting medicine and public policy in defining sexuality and aspects of sexual behaviours as social problems or risks (Di Mauro, 2000). Language used by governments and medical professionals is one of dangerous sex, dangerous people and protection of the population from unsafe sex (Turner, 1995). In short, society is constructed as a risk society and sociological studies attempt to estimate the risk of AIDS.

Against this sociological background of HIV/AIDS, this study aims to direct attention to the other sexually transmitted infections (STIs). The rates of incidences² and prevalence³ have been increasing throughout the world, especially since the emergence of HIV (Eng & Butler, 1997; United Nations, 1994). Despite the number of social and cultural factors that facilitate sexually transmitted infections, the ‘treatable’ STIs tend to be reserved for epidemiological research. Epidemiology does have much to offer in terms of the general distribution of the infections and determining cause and prevention through the comparison of population groups in relation to their risk of exposure to disease (Bowling, 1997). However, epidemiology does not reveal the social and cultural factors that contribute to why certain individuals and groups are more likely to be infected. Effective STI prevention can be hampered by a wide range of social factors including the socio-cultural taboos relating to sexuality lack of access to services, poor funding, inadequate training of health care professionals and lack of awareness about the infections (Eng & Butler, 1997). Furthermore, epidemiology does not study the effects of sexual culture nor does it analyse the sexual behaviours that aid the transmission of STIs. Such understanding requires a sociological point of view. Sexual behaviours depend on social interactions and are influenced by society and the surrounding culture. The use of sociology can provide invaluable insight into these factors of sexuality.

National reported rates of STIs in Ireland are reported to be increasing since the late 1980s. In the 1990s, the rising rates attracted much media, medical and public attention with the rising rates being viewed as consequences of changing sexual practices in Ireland (Murray, 2002). Indeed, STIs were considered to be indicators of the proportion of ‘high risk’ sexual behaviours in the Irish population and the growth in STIs raised Irish medical professionals’ concerns about the “complacency regarding safer sexual practices” (Horgan, 2000:3). This is an interesting premise. Has there been a sudden increase in ‘deviant’ sexual behaviours in its population? Are STIs really increasing? What are the social and behavioural explanations for this increase? And have the proportion of Irish people engaging in risk-taking sexual behaviours changed?

Unfortunately, there is a lack of suitable data on STIs and sexual risk taking in Ireland and as a result, we cannot provide a definitive answer on whether the prevalence and

² In the context of STIs, incidences refer to new infections in a population.

³ Prevalence is a measure of the frequency of a condition in a population.

incidences of STIs have changed in Ireland⁴. Instead, we can use the rising reported rates as a starting point for the exploration of Irish sexual culture in the 1990s. Reported rates of STIs are being used as proxy measures of 'high risk' sexual behaviours. However, if we wish to make conclusions about sexual behaviours we should directly study the sexual behaviours and their sexual context. There has been much mythology about the Irish sexual culture in relation to its conservatism and sexual morality. In addition, its demographic patterns have been viewed by demographers as being an anomaly amongst late 20th century western societies (White, 1999). Yet, Irish sexuality⁵ and sexual behaviours have received little sociological investigation (Inglis, 1998b; Inglis, 1997). This thesis will attempt to address this gap in sociological knowledge by attempting to depict Irish sexual culture in the 1990s through the utilisation of existing available data. Such an activity will involve using epidemiological, demographic and historical data as well as a comparative analysis of Irish sexual attitudes and behaviours with those of other western countries. Through the combination of data, we can answer three main research questions in relation to STIs and sexual behaviours:

1. Are the national reported rates of STIs in Ireland adequate measures of the levels of 'high risk' behaviours in the Irish population?
2. The majority of STI rates are reported by those between the ages of 20 and 30 years. Does this age group have markedly different sexual behaviours than previous cohorts?
3. Can Irish sexual attitudes and behaviours be viewed as being typical of western societies?

In this introductory chapter, we will concentrate on STIs, offering definitions, specifying some of the reasons why STIs warrant sociological attention and discussing the problematic use of STIs as indicators of sexual risk taking in a population by medical professionals. The chapter will end with an outline of the thesis, demonstrating how the above three research questions will be tackled in the ensuing chapters.

What are Sexually Transmitted Infections?

Sexually transmitted infections can be classified as behavioural diseases in the official international disease classification system (Paalman, 1993). This means that they are contracted through certain sexual behaviours and can be prevented by changes to these risk behaviours. Sexually transmitted infections can be spread through heterosexual sex, sex between men, orogenital sex and manual ('dry') sex. These intimate behaviours are moulded by societal factors and move through groups that share risky behaviours. Twenty-five infectious organisms are transmitted through sexual activity and can cause a

⁴ It should be noted that attempts were made to conduct a sex survey and to study the characteristics of the patient population at GUM clinics. However, accessibility to samples was impossible and the costs and time constraints of the D.Phil. thesis also made it difficult to undertake either of these studies. As a result, it was decided to compile existing data and create a starting point on the topic, with the aim of doing further investigations in the future.

⁵ The term 'sexuality' has two meanings. It can be defined as a sexual identity (e.g. homosexuality) or it constitutes what is publicly considered to be appropriate and inappropriate sexual behaviours (i.e. public sexual attitudes to sexual behaviours). In this thesis, the latter meaning is taken, unless stated.

large number of health consequences (Eng & Butler, 1997). These micro-organisms range from viruses to bacteria, single-celled protozoa to insects (Barlow, 1979).

Until the beginning of the 1970s, sexually transmitted infections were termed venereal diseases and mainly consisted of three sexually transmitted infections, syphilis, gonorrhoea and chancroid. The word 'venereal' was coined from Venus, the goddess of love (Chevallier, 1993). During the 1960s, more sexually transmitted infections emerged, in particular *chlamydia trachomatis*, herpes simplex type II and 'pelvic inflammatory disease', and the venereal diseases were renamed sexually transmitted diseases (STDs). As Barlow (1979) pointed out, the change in name was one of labelling rather than incidence and reflected a number of modifications, which were occurring in sexual health at that time. The previous name of 'venereal diseases' had been charged with moral judgement due to their association with prostitution and sexual deviance. Since the new diseases were now occurring among non-promiscuous couples, it was widely felt that the term should be changed. Furthermore, with the development of new health approaches, there was a new generation of health professionals, who wanted to expand their work and area of influence, including those of the venereology sector (WHO, 2000a). Despite the provision of the invaluable treatment of syphilis and contribution to prevention of the spread of gonorrhoea, venereology was held in low esteem by the medical profession (McKeown, 1979). In Britain, doctors in the VD clinics were renamed as specialists in genitourinary medicine and the clinics themselves were renamed GUM clinics. This was an attempt to improve the image of the service and reduce the stigma for the user (Leeson & Gray, 1978). In Ireland, the clinics were renamed STD clinics (the name changed again to GUM clinics in the late 1990s). Both STD and GUM clinics now covered a wider range of sexually acquired problems being presented, for example, Hepatitis B (Thin, 1982). Such sexual health transformations were not done in isolation from the changes in sex mores, which were ensuing in western societies at that time. Premarital sex and several changes in partners in early maturity became socially acceptable and the introduction of the oral contraceptive pill liberated many women from the concerns of pregnancy (Learmouth, 1988).

In the 1990s, sexually transmitted diseases became sexually transmitted infections because the term 'diseases' was considered inappropriate for asymptomatic infections, like trichomoniasis in men. Diseases were viewed as being caused by the infections and that if the individual remained asymptomatic, the infection remained undetected (Laumann et al, 1994). Additionally, health professionals attached to new reproductive health concepts wanted to see sexually transmitted diseases in the context of 'reproductive tract infections', which include both sexual and non-sexual transmitted micro-organisms (WHO, 2000a). During the 1990s, STIs were being incorporated with other reproductive health issues, such as family planning, under the wider term of 'sexual health'. Genitourinary specialists also recommended the provision of GUM clinic services as being more beneficial on a 'one stop shop' basis (Thin, 2000). The aim was to provide a range of services for various aspects of sexual health within the same premises. By the turn of the 21st century, the GUM clinic system in Britain had started to implement the 'one stop shop' service.

Sexually transmitted infections can be divided into two separate groups, with the first one consisting of HIV/AIDS and Hepatitis strains A and B, which are often but not always spread sexually. In Ireland, as in most western societies, Hepatitis, HIV and AIDS rates are reported separately to the other sexually transmitted infections. These remaining sexually transmitted infections form a second group, sometimes referred to as the 'treatable' STIs, and can be categorised into bacterial infections, viral infections, parasitic infections and non-specific genital infection (Please see Appendix 1 for definitions).

Why Sexually Transmitted Infections Warrant Sociological Investigation:

The spread of sexually transmitted infections is fundamentally social. STIs are spread through particular types of risk behaviours so we need to understand the forces that shape these behaviours. While sex can be deemed a private matter, it does involve social interaction. Through networks of relationships between individuals, it affects groups, families, communities and ultimately, the wider population. Sexual behaviours and lifestyles can be influenced by the norms, beliefs and mores governing the sexual culture⁶. These in turn can affect the development of legislation and deploying of sexual politics at the macro level. Assertion of sexual identities, categorisation of sexualities and the deriving of legislation are socially and culturally informed and also require the analysis of the social scientist. It is worth noting that changes at the cultural or societal levels, such as liberalisation of sexual attitudes and secularisation, may not necessarily bring about subsequent changes in behaviours. Furthermore, common practices of certain behaviours may not result in their normalisation. Because sexual behaviour is generally considered an individual's choice and since the interaction is usually performed in a private realm, sexual behaviours exist to some extent outside the opinions expressed by the public domain. Despite histories of public perceptions of the norms of sexual behaviour in societies, measures of the extent and variety of sexual behaviours are more difficult to ascertain. Sociological investigations can help reveal the discrepancies.

In addition, sexually transmitted infections are of interest to the sociological study of sexual health because they cause morbidity, are costly to treat, are disproportionately higher in women than men, facilitate the spread of HIV and share the same risk behaviours as HIV/AIDS. While not all of these issues are directly addressed in this thesis, they are included here to highlight some of the potential fields of study that STIs can provide for the sociological researcher.

(1) The Biological Consequences of Sexually Transmitted Infections.

Sexually transmitted infections are important contributors to morbidity. While the mortality rates and the cardiovascular and neurological complications of syphilis and gonorrhoea tremendously declined in western societies in the late 20th century, there has been no reduction in the problems posed by sexually transmitted infections (Barlow, 1979). They still cause acute discomfort, pain, infertility, ectopic pregnancies, puerperal sepsis (severe maternal infection after birth) and genital cancers (Davidson & Blakey,

⁶ Sexual culture consists of "the systems of meaning, knowledge, beliefs and practices that structure sexuality in different social contexts and is constructed interactively and collectively" (Lear, 1997, pg 2).

1995; WHO, 2000a). Frequently, they go undetected and untreated before they result in serious reproductive morbidity (Panchaud et al, 2000). After maternal morbidity, STIs are the highest cause of morbidity internationally in women aged between 15 and 45 years (Schofield et al, 2000). Although, McKeown (1979) noted that the “diseases that shorten our lives are not usually the ones that diminish their quality from day to day” (McKeown, 1979:112), nevertheless, the effects STIs, in particular, gonorrhoea, have on morbidity should not be undervalued. Although medicine and science have developed the necessary ‘technical tools’ - that is treatments - societies still lack the corresponding ‘social’ tools needed to aid the eradication of gonorrhoea (Day et al, 1998). In keeping with the overall limited number of estimates of morbidity (Ham, 1992), there are very few epidemiological data on the complications of STIs. Data on salpingitis, ectopic pregnancy, infertility are available but most of the time hidden somewhere in a mass of other health indicators and data (Piot, 1992).

(2) Financial Implications of Sexually Transmitted Infections.

Sexually transmitted infections have an economical impact on a society. Similar to HIV/AIDS, the majority of cases are in those under the age of 30 years. This means that the most economically productive age group is affected (Thin, 2000). Unlike AIDS, which has depleted workforces and wealth producers – particularly in Sub-Saharan Africa (Gilies et al, 2000) – STIs may not kill off the workforce but they can still have an impact. Employees often have to take days off due to the severe symptoms of the infections. This loss of labour by employees can have financial and productivity effects on businesses.

In terms of health economics, the provision of genitourinary services for sexually transmitted infections is expensive. The US economy alone spends approximately 8.4 billion dollars (5.25 billion pounds) each year for medical treatment of STIs (Center for Disease Control and Prevention, 2000a). These direct costs include expenditures for medical and non-medical services and materials, physician services, laboratory services, hospitalisation, medical supplies etc. If the indirect costs are added (that is wages lost due to illness or premature death etc), the Institute of Medicine estimates that the annual costs of selected treatable STIs and sexually transmitted HIV infections are 17 billion dollars (Center for Disease Control and Prevention, 2000a). Along with the human suffering associated with STIs, this cost is shared by all Americans through higher health care costs and taxes (Eng & Butler, 1997). It is cheaper for a state to prevent STIs rather than cure them (Center for Disease Control and Protection, 2000a).

There have been attempts in the USA and in Europe to reduce the cost of sexually transmitted infections through improving their preventive measures. One proposal involves the implementation of cost-effective chlamydia screening programmes. While it is important to combat the spread of chlamydia through better detection, it is beneficial to do so at the cheapest cost possible. Studies done in Denmark and Britain have shown that urine samples of men and women obtained at their homes and sent to a laboratory can be efficiently tested using polymerase chain reaction assay or ligase chain reaction assay. These home samples are as effective in detecting chlamydia as those obtained by doctors

and are much cheaper to operate (Ostergaard et al, 1996; Anderson et al, 1998; Grun et al, 1997). Research such as this example still cost time and money and when the current outcome of sexual health services is the rising or stabilised rates of sexually transmitted infections, it is apparent that more resources will be used in order to measure the discrepancy between inputs and outputs in the provision of services. However, Ham (1992) points out that there is no clear or simple correlation between inputs into health care and outcomes. A greater investment in health services will not necessarily lead to better health. Since sexually transmitted infections depend on the sexual interactions of individuals, then perhaps resources should be placed instead in health promotion campaigns geared towards encouraging behavioural change.

(3) Gender Differences in Morbidity of STIs.

In most countries, STIs are the second highest cause of morbidity in women aged between 15 and 45 years after maternal morbidity (Schofield et al, 2000). Women are more vulnerable than men in obtaining a sexually transmitted infection for biological, cultural and social reasons. Biologically, heterosexual transmission of HIV infection is more efficient from men to women than from women to men (Tortu et al, 2000). The use of oral contraceptives, age and pregnancy can contribute to cervical abnormalities, which increases risk of HIV infection. Women are also more susceptible to certain sexually transmitted infections than men and suffer the burden of STI-associated complications. A variety of women's health problems, such as infertility, ectopic pregnancy and chronic pelvic pain can result from unrecognised or untreated STIs. About 10% to 20% of women with gonorrhoea and chlamydia will develop pelvic inflammatory disease (Center for Disease Control and Prevention, 2000a). If a pregnant woman is infected with an STI, this may result in the baby suffering a range of serious health problems including severe central nervous system damage and death. From 1973 through 1992, more than 150,000 women in the USA died of causes associated with STIs (including HIV infection) and their complications (Eng & Butler, 1997).

It has been argued that the primary reason for the attempts to control STIs is the complications that women suffer (Piot, 1993). However, in the epidemiological and medical literature on the sexual transmission of HIV/AIDS, women are often construed as a 'high risk' group like homosexuals (Waldby, 1996). This insinuates that the 'general population' is one of heterosexual men, with women often being presented as indices of infection in the population rather than being significant within themselves (Waldby, 1996). Women are viewed as being the transmission point between high and low risk males and between high-risk male and foetus (Waldby, 1996). Typically this includes prostitutes, women who injected drugs, black African women and those labelled 'promiscuous' (Richardson, 2000). Any woman is susceptible to being considered as 'high risk'. In Britain in 1918, it was a criminal offence for any infected woman to have intercourse with a member of the armed forces, even if that man was her husband and he had infected her in the first place (Weeks, 1989). This law appeared at the time that Sir Ernley Blackwell estimated that up to 75% of the venereal diseases amongst the British troops in World War I were spread not by prostitutes but by 'amateurs', i.e. casual sex (Weeks, 1989). The blame of spreading STIs did and continues to fall on the woman.

Within the groups of women who have been targeted as being 'high risk', there is a remarkable lack of understanding of women's exposure to sexually transmitted infections. Prostitutes ('commercial sex workers') have been studied extensively as a source of HIV and STIs (Lim et al, 1995). They are considered to be at risk because they have sex with multiple partners and they may engage in sex without protection. Yet the most likely sources of infection for prostitutes are their non-paying partners and not their clients. This is because they are less likely to use condoms with their non-paying partners, who often have a history of injecting drug use. Roddy et al (1998) in their research on the effect of nonoxynol-9 in condom lubrication on the risk of acquiring STIs, found that most of their subjects, that is, Dominican female sex workers, had 99% of their vaginal sex with clients protected with condoms but only 43% of vaginal sex was protected with their non-clients. In 1991, the Eastern Health Board in Ireland initiated a Women's Health Project to care for the estimated 600 prostitutes working in Dublin city (McDonnell et al, 1998). This project is a member of EUROPAP, a European network for HIV and STI prevention among prostitutes (McDonnell et al, 1998). The purpose of the project is to provide health-care services for prostitutes through a weekly drop-in clinic during the late evening. A quarter of the women who attended the project between 1991 and 1997 had a STI, despite routine STI screening not being part of the service. The acquisition of a sexually transmitted infection was associated with the prostitutes' non-commercial sexual relationships (McDonnell et al, 1998).

Drug use, in particular the injection of 'crack', can result in the involvement in 'high risk' behaviour. The injection of crack is most prevalent amongst women in low socio-economic urban areas (Mahowald, 1993). Crack use is more accessible to potential users and more addictive than other illegal drugs. Female crack users are also more likely to prostitute themselves in order to satisfy their habit and are unlikely to use protection (Drusin, 1996). Unlike homosexual men, where the risk is as great amongst the affluent, the risk of AIDS is greater for women who are poor. AIDS is now the leading cause of death among women aged 25-44 in cities such as New York and Miami, where drug use is rampant and there are high levels of poverty. However, the understanding of women and AIDS is incomplete (Tortu et al, 2000). Current models of infection are derived from studies of gay men and men who inject drugs. These cannot be generalised to women, as models of infection may be different for men and women, given the importance of HIV heterosexual transmission to the infection of women. In relation to lesbian sex, it is widely maintained that it is an insufficient route for sexually transmitted infections (Wilton, 2000). However, Richardson (2000) has argued that lesbians and bisexual women do engage in a wide variety of sexual practices with other women, some of which may carry a risk of HIV exposure and STIs such as herpes and chlamydia. Examples include unprotected oral sex during menstruation, sharing sex toys and sex involving bleeding. This results in a lack of HIV and STI prevention strategies targeted at lesbians (Richardson, 2000).

Women's social and economic positions influence their health behaviour and put them at risk of being infected by HIV or by other sexually transmitted infections. In western societies, men have a stronger position in society and the behaviour of heterosexual men places women at risk of infection (Campbell, 1999). Research in Wales during the 1990s

showed that heterosexual men were the least informed about HIV and the least likely to see this as a health issue about which they personally need to be concerned (Davidson & Blakey, 1995). This not only results in a longer time interval for women, during which the infection is more likely to be passed onto others, but women's dependency on their partners' diagnosis may mean they suffer unduly due their partners' lack of interest in seeking treatment. In the developing world and in many cultural groups in the developed world, women's low socio-economic status and lack of power relative to men, makes it difficult for them to take preventative measures. Power relations within sexual relationships are important and can influence women's risk behaviour. They may rely on financial help from their sexual partners (Day & Ward, 1997). Women can also be emotionally dependent on their partners and risk losing him or verbal or physical violence if she insists on the use of condoms (Campbell, 1999). The social consequences of infection can be devastating for women. In many cultures, women known to have an STI, or who are unable to conceive, risk rejection by their male partner, possible social exclusion and loss of income (Van Wondenbergh, 1998). Additionally, women experience greater demands in coping with the sexually transmitted infections and HIV. Women are usually the main caregivers so while women are responsible for the care of family members with HIV, there may be no one to nurse them when they are ill (Van Wondenbergh, 1998).

Given the association of STIs and HIV/AIDS with the prostitute, intravenous drug user or the homosexual, women may not recognise themselves as potential patients. They may be too embarrassed to come forward for treatment. Since STIs can be asymptomatic in women, many women may have to rely on their sexual partners being diagnosed before they are alerted to seeking medical attention. This is further complicated by cases of casual sexual encounters where it may be difficult to trace the women through contact tracing. Health seeking behaviours may be changing with Ireland and other western countries and STIs may be losing some of their stigma, but negative images about women and STIs persist and can make it difficult for women to seek help. Furthermore, gendered power relationships can prevent many women from receiving treatment. These undoubtedly help to increase the incidences and prevalence of STIs in a population and need to be addressed in health promotion campaigns.

(4) Sexually Transmitted Infections as Facilitators for the Spread of HIV.

Sexually transmitted infections can be considered the most important co-factor in the transmission of HIV viruses, as the presence of sexually transmitted infections in individuals facilitates the sexual transmission (Tortu et al, 2000; Nicoll & Gill, 1999; Overseas Development Administration, 1996). This is quite important as AIDS is one of the top ten causes of death world-wide. Since the start of the pandemic in the early 1980s, over 47 millions people are estimated to have been infected with the virus (Nicoll & Gill, 1999). Fourteen million of these have died. Although the rates of HIV have stabilised in many European countries (Infuso, 2000), the countries with the initial high incidences, that is Spain, France, Italy & Switzerland, continued to show rapid increases in AIDS incidence (Smallman-Raynor et al, 1992). In 1990, Switzerland had the highest rate of 20.5 per 100,000 as opposed to the Western European average of 10.3 per 100,000

(Smallman-Raynor et al, 1992). Since the start of the 1990s, there has been a major decline in AIDS incidence due mainly to treatments especially Highly Active Antiretroviral Therapy (HAART) (Thin, 2000). It should be pointed out that while the mortality rate of AIDS decreased dramatically, the existence of adequate treatments have been associated with an increase in its prevalence. Improvements in treatments have delayed the process from being HIV infected to having 'full blown' AIDS. With people living longer on the treatments, there are now larger numbers of infected people around who can pass the HIV virus to others

Under the 'epidemiologic synergy' theory, co-infection with HIV and another STI mutually reinforces each other in terms of transmission (Haverkos & Quinn, 1995). Studies from Central Africa have consistently found a positive correlation between the occurrence of genital ulcerative diseases (GUDs) - STIs which cause ulcers, especially chancroid - and infection with HIV (Smallman-Raynor et al, 1992; Green, 1999). There are three possible explanations for this connection. Firstly, GUDs can cause lesions and breaks in the skin or open portals for virus entry during sexual intercourse with an infected person (Cox, 1999). This helps the transmission of HIV infected lymphocytes. Secondly, HIV-infected individuals are also more likely to have HIV in their genital secretions if also infected with another STI. Center for Disease Control and Prevention (1998a) report that men infected with both gonorrhoea and HIV are twice as likely to shed HIV in their genital secretions than those who are only infected with HIV. The median concentration of HIV in the semen of men affected with both HIV and an STI can also be up to 10 times higher. Thirdly, GUDs may invoke an immune response, which brings lymphocytes to the surface, thereby exposing HIV target cells during intercourse (Smallman-Raynor et al, 1992).

There is some disagreement on which STIs actually help the spread of HIV. Smallman-Raynor et al (1992) maintain that GUDs have persistently been the only STIs correlated with HIV infection. The Center for Disease Control and Prevention, USA argues that the geographical distribution of heterosexual HIV transmission in the Southern States closely parallels that of syphilis (Center for Disease Control and Prevention, 1998b). The World Health Organisation also associated syphilis with HIV and estimated that by curing or preventing one hundred cases of syphilis among an STI high risk ('core') group, approximately 1,200 HIV infections linked to those one hundred episodes of syphilis could be prevented (WHO, 2000). Since HIV replicates within lymphocytes, any infection that activates a person's immune system not only produces more antibodies to fight the infection but at the same time produces more HIV (Cox, 1999). It is estimated that individuals who are infected with any sexually transmitted infection are at least two to five times more likely than uninfected individuals to acquire HIV, if exposed to the virus through sexual contact (Wasserheit, 1992). In relation to HIV's role in the spread of STIs, people infected with HIV are more susceptible to contracting other STIs due to a weakened immune system (Fowler, 1997).

(5) Sexually Transmitted Infections, HIV and Their 'Risk' Behaviours.

The behaviours that place adults at risk of acquiring HIV sexually are the same for other sexually transmitted infections. Rates of STIs, such as syphilis, chancroid and chlamydia, do increase within the very same 'high risk' or 'core' groups as those at risk from HIV infection. In the context of STIs, 'core' groups are groups experiencing higher rates of 'high risk' behaviour. These 'core' groups include prostitutes, injecting drug users, homosexual men and anyone who changes sexual partners frequently. In many countries, 'core' groups are considered responsible for amounts of HIV and STI transmission disproportionate to their numbers, especially in the early stages of national epidemics (Day & Ward, 1997; Overseas Development Administration, 1996). For all STIs, a stable, mutually monogamous relationship with an uninfected person eliminates any new risk of sexually transmitted infections. Additionally, all individuals who have sex with an infected person are at risk of acquiring an STI (including HIV), despite the source of that person's infection.

Globally, the predominant mode of transmission of HIV is unprotected heterosexual intercourse. This is also the main route for other sexually transmitted infections. In western countries, the first phase of the HIV/AIDS pandemic in the 1970s and early 1980s was concentrated in the homosexual sub-population before spreading throughout the injecting drug users in the second wave. Currently in Europe, transmission remains most prominently through men having sex with men in the northern countries, while in the southern countries of Spain, Portugal and Italy, most infections have been found amongst drug injecting users (Nicoll & Gill, 1999). In the USA, the epidemic appears to be transferring from homosexual to heterosexual communities (Thin, 2000) and in Europe, heterosexual contact cases are increasing at a rate faster than that of other exposure categories, which has led Haverkos & Quinn (1995) to argue that this is the start of the third wave of HIV infection. HIV can spread heterosexually from bisexual men and from injecting drug users to non-injecting drug users. Some drug users may have become more vigilant in relation to clean needles but may not use protection during sex (Hickey et al, 1994). However, projections done by the European Centre for the Epidemiology and Monitoring of AIDS, Paris, reveal that this wave is difficult to predict as there is a lack of clear understanding of what is happening in the heterosexual population and the IV drug using population (Piot, 1992). It can be asserted though that since HIV and STIs are spread through the same 'high risk' behaviours and can mutually facilitate each other, then efforts to reduce incidences of STIs are vital, if a potential third wave is to be prevented.

Measures used to avert the sexual transmission of STIs are the same for the sexual transmission of HIV. These involve abstinence from sexual activity, the reduction in the number of sexual partners and the consistent use of condoms reduces exposure to infected semen and vaginal secretions (Haverkos & Quinn, 1995). It is probable that epidemics of heterosexually transmitted HIV infection in industrialised countries have been limited in size by the relative success of efforts to control STIs (Renton et al, 1998). There have been problems pertaining to the combination of prevention programmes for HIV/AIDS and STIs. Some people argue that STI programmes are not always the main player in the

curtailment of STIs and that HIV is, in many ways different to treatable STIs. Others believe that the old STI programmes were successful and should be utilised in relation to HIV/AIDS (Ekeid, 1992). HIV and STIs do have similar measures of prevention and target audiences so the best way to combat HIV on a policy level is to integrate HIV/AIDS prevention with STI control. There should also be an aim to make healthy choices in sexual lives easy choices (Ekeid, 1992). Relatively high rates of HIV transmission through heterosexual intercourse in Africa is related to the lack of adequate health care for the STIs, which are widespread (Turshen, 1989). It is thus important to combine the preventive measures and to ensure that there is a reduction in 'high risk' behaviour and subsequent incidences of sexually transmitted infections.

Further sociological investigation into sexually transmitted infections can be recommended. The biological and financial consequences of STIs and the 'high risk' behaviours they share with the spread of HIV provide ample scope for the examination of preventative strategies in western societies. While 'high risk' behaviours do contribute to the incidences and prevalence of STIs, the increases in rates cannot be solely viewed as a consequence of changes in individuals' choices of sexual behaviours.

Sexually Transmitted Infections as Indicators of 'High Risk' Behaviour:

Incidences of gonorrhoea and other STIs are used as proxy markers of changes in sexual behaviour, not only by the media but also by epidemiologists, geographers and medical professionals. Sexually transmitted infections are commonly used as biological markers of the patterns of risk-taking sexual behaviours in a population (Hankins, 1998; Connor et al, 1997; Aral & Peterman, 1996). If there is a change in risk behaviours then the reported incidences of all STIs will similarly be affected (Mason et al, 2001). Gonorrhoea is the most commonly used biomedical marker as it is almost exclusively transmitted via sexual intercourse and hence is considered a reliable marker of sexual behaviour (Wardropper et al, 1995; Carne et al, 1987). It is also used as a proxy measure for trends in condom usage and as a biomedical marker for new cases of HIV infection because these rates can be difficult to assess directly (Low et al, 1997; Aral & Peterman, 1996). However, gonorrhoea can find other routes for transmission. Piot (1992) found that throughout Europe, there were homosexual men who had presented themselves at clinics with rectal gonorrhoea but claimed to have used a condom during anal intercourse or had no receptive anal intercourse at all. Throughout medical writings, such as the *International Journal of STDs and AIDS*, it is argued that the prevalence of certain STIs in a population are useful as indicators of the levels of 'high risk' behaviour in a population. There is some debate about which STIs are better markers than others. Some commentators view gonorrhoea as a good measure of risk behaviour, as most men develop symptoms after a short incubation period, seek treatment and give details of contact (Corson, 1993). Others like Adler (1997) believe that gonorrhoea is not the best proxy outcome measure for monitoring rates of 'risk' behaviour because it is susceptible to vigorous case detection and contact tracing. He maintains that other routine markers associated with sexual lifestyle, such as the antibody to herpes simplex virus type 2, could be a more suitable objective marker of patterns of 'risk' behaviour in populations (Adler, 1997).

Discussing which STIs are better markers overlooks the crux of the matter. Sexually transmitted infections are not optimal in looking at trends of sexual behaviours in a population. Their predictive value is limited by a number of factors. Firstly, the sensitivity of laboratory tests has an effect on the incidences (Aral & Peterman, 1996). The results of these tests vary not only with population prevalence, pathogen but according to diagnostic test quality and laboratory conditions (Aral & Peterman, 1996). Routine national data is also subject to treatment bias and ascertainment (Adler, 1997). Problems of interpretation can even occur in countries such as the United Kingdom, whose surveillance system is considered accurate enough to show the true trends in disease prevalence and the changes in geographical patterns of infection. These spatially referenced public health data are affected by differing analyses because researchers within and across different disciplines often adopt techniques with which they are already familiar but which may not be the most appropriate to the needs of the study (Dunn et al, 2000). Researchers such as geographers, epidemiologists and statisticians are using the same types of data but different approaches and little is known about whether they obtain similar results (Dunn et al, 2000).

Secondly, the spread of STIs depends on the properties of the transmitted pathogens, the duration of infection period in the infected persons, the probability of transmission and the frequency of exposure of susceptible individuals to infectious individuals (Aral & Peterman, 1996). Some people are also more likely to transmit or receive an infection than others and certain STIs, such as genital warts and parasitic STIs, can spread despite condom usage and through close proximity without sexual intercourse. Bodsworth et al (1993) reported STIs diagnosed in virgins attending a STD clinic in Sydney, Australia. The biological characteristics of the causative agents of STIs do play an important role in the transmission of their infections and it is difficult to conclude that changes in reported incidences are due to changes in 'unsafe' sexual behaviours in a population when the various STIs spread through a range of routes.

Thirdly, while changes in STI rates among a group of individuals may provide evidence for the effectiveness of an intervention in the group, they do not directly reflect the overall outcome of the disease rates in a population (Aral & Peterman, 1996). Spread of the infections depends on where the particular group is placed in the overall network of sexual relationships. Some people may restrict themselves to people of their own 'core' group or to others of similar 'high risk' behavioural or may move between the 'core' group and the wider population. This will vary from individual to individual. Using STIs as biomedical markers of the spread of infections is also problematic given that accessibility to health services fluctuates between sub-populations and areas of residence. For example, national rates of infection for the whole adult population mask known variations in the incidence of gonorrhoea by geography, age and sex. (Low et al, 1997). A large proportion of both homosexual and heterosexual populations are what are termed 'repeaters'. These 'repeaters' represent a limited group of highly sexually active individuals who have a prior history of STIs and who continue to put themselves at risk (Piot, 1992). Not distinguishing between this group and the new cases in national rates results in an over-estimation of the prevalence of the infections in a country. Furthermore, it distorts the depiction of STIs as markers of 'high risk' behaviour.

Finally, using STIs as proxy measures of 'risk' behaviours overlooks the influence of other cultural and societal factors. Changes in community composition – such as increase in 'crack' use, decreased employment opportunities, accessibility to health services – have an important affect on the levels of STIs (Aral & Peterman, 1996). Individuals themselves are constantly changing throughout their lives. As they age, they enter and leave relationships, change the duration and nature of each partnership and adapt different sexual attitudes and lifestyles. Reported rates of STIs are similar to STI prevalence surveys. They only represent those who presented themselves to GUM clinics and this results in non-randomised samples, which are not representative of the population (Renton et al, 1997). They also overlook any specific characteristics of those who use the clinics, which differentiates them from the wider population. They can suggest associations, for example the link between young age and an increased risk of infection but ultimately, they cannot and should not be used as representative of the proportion of high risk behaviour in a population. They need to be used in conjunction with sexual behaviour and attitude surveys and sexuality studies. The epidemiology of STIs may offer some insight into the incidences and prevalence amongst certain sectors of a population and by location but ultimately it lacks the detailed and more representative information about 'sexual interaction' that comes from social scientific research. The level of 'high risk' behaviour and the general changes in sexual mores and lifestyles can only be fully asserted through the examination of sexual behaviour of the wider population.

Outline of Thesis:

At first glance, the thesis appears to form a disparate collection of chapters, incorporating epidemiology, a review of GUM clinics, social-constructionism, secondary data analysis and historiography. However, due to the absence of longitudinal data and a national sex survey – particularly one including questions on sexual risk-taking and STIs – and the constraints of time and funding in personally gathering this evidence, I have had to address the issue of STIs and Irish sexual culture by pooling existing sources of data. The end result is a collection of theories and methodologies but each one adds an explanatory piece to the sociological interpretation of the rising reported rates of STIs and Irish sexual culture.

The first research question of whether the national reported rates of STIs in Ireland are adequate measures of the levels of 'high risk' sexual behaviours in the Irish population is addressed in Chapters 2, 3 and 4. Chapter 2 provides an epidemiological account of sexually transmitted infections in Ireland from the 1940s to the 21st century and discusses the general trends of STIs in western societies, stressing the similarities Ireland shares with its western counterparts. Building on the observations highlighted in Chapter 2 in relation to the Irish surveillance system, Chapter 3 elaborates on the determining role of the GUM services in the increasing reported national rates. Within the same period that the reported rates have increased, the Irish GUM services have undergone improvements due to the HIV/AIDS pandemic. Furthermore, these changes have been accompanied by a more favourable climate towards sexual health seeking behaviours. The end result has been more attendances at GUM clinics, resulting in higher rates of reporting.

Furthermore, the rates are also affected by the inherent problems in the Irish surveillance system.

Chapter 4 provides a socio-constructionist approach to sexuality and STIs. This chapter not only describes the socio-historical entanglement of STIs and sexuality in western societies but it also points out that reported rates of STIs have more to do with public sexuality (i.e. public attitudes about sexual behaviours) than actual sexual behaviours. To prevent STIs, the adoption of 'safe sex' behaviours needs to be enforced in a population. However, raising public concern is problematic because the public perception of STIs is closely linked to public anxieties about certain aspects of sexuality. When looking at STIs in a society, we have to be aware of the social meanings people attach to STIs and that medical responses to STIs are often shaped by moral assumptions about the sexual behaviours of those who are infected. This has implications for the Irish situation, as the reported national rates do not yield much information on the 'high risk' groups yet preventive campaigns are being targeted at groups such as prostitutes and adolescents.

Chapter 5 tackles the issue of sexual risk-taking in the Irish population. Using the International Social Survey Programme⁷ dataset on Family and Changing Gender Roles II – referred to in the thesis as ISSP (1994) - the Irish component on sexual behaviours is analysed for evidence of 'high risk' sexual behaviours. In the absence of contraceptive usage, this comprises of an assessment of multiple partnerships individuals have within specific units of time. This can help to determine the proportion and characteristics of the Irish population engaging in 'high risk' behaviours and the likelihood of exposure to potential risks of STIs. The focus in this chapter is on the determination of whether or not those aged between 18 and 30 have different sexual behaviours than older generations. Furthermore, using the measure of multiple partnerships, we can assess if the likelihood of the younger age group exposing themselves to the potential risk of STIs is greater than for the older age groups.

In Chapter 6, the social history of Irish sexual culture and the construction of Irish sexual morality are described. This sets the scene for the comparative analysis of Irish sexuality in the 1990s in Chapter 7. Furthermore, the chapter attempts to shed light on the existence of the variety of Irish sexual behaviours and STIs in the past. Despite the existence of Irish sexual morality, STIs and other so-called 'deviant' sexual behaviours (such as prostitution and illegitimate births) were prevalent yet hidden. By revealing the disjuncture between behaviours and public perceptions of sexuality, Chapter 6 builds on Chapter 4's argument that changes in reporting of STIs are more likely to be influenced

⁷ The International Social Survey Programme is a voluntary grouping of study teams in 26 countries, each of which undertakes to run a short annual self-completion survey in a probability-based sample of adults over the age of 18 years. Each national survey contains an agreed set of questions, so comparisons can be made between countries and the topics vary from year to year with a view to replicate the cross-national survey every four or five years (Davis & Jowell, 1989). The topic of family was examined in 1988 and again in 1994, this time with an appendix on sexual behaviours in some of the participating countries. Unlike some other cross-national research, the ISSP survey has been relatively free from problems in the practicalities and methodologies (Davis & Jowell, 1989).

by changes in public attitudes than by changes in sexual behaviours. The more favourable the attitudes to sexuality, the lesser the stigma of STIs and the greater the likelihood that people will seek medical help.

The third research question of Irish sexual attitudes and behaviours being typical of western societies can be assessed using the ISSP (1994) dataset. Australia, USA, Poland and Spain were deemed as suitable comparable nations for the examination of the effects of Irish sexual morality and the trend of sexual permissiveness in western nations. Overall, Irish sexual permissiveness was more conservative than the other countries in the mid 1990s, although, Irish respondents did have many sexual attitudes in common with some of the other countries. Age was seen to have a determining role in predicting sexual behaviours, with those under the age of 40 in Ireland displaying higher levels of sexual tolerance than the older generations. Chapter 8 continues the comparative analysis, although the emphasis is on sexual behaviours rather than attitudes. The chapter looks at whether the pattern of Irish sexual behaviours is different from those of other nations and accounts for the variations within countries.

The assessment of 'high risk' behaviours requires the examination of sexual behaviours rather than inferring from the rates of STIs and Chapters 5 and 8 offer a depiction of some aspects of sexual behaviours in Irish society during the mid 1990s. It should be pointed out that the information yielded is limited by the structure of the ISSP (1994) survey and that many relevant questions pertaining to sexual practices, sexual partners, contraceptive practices and STIs are absent. Additionally, sex surveys are affected by social desirability bias. Individuals may over-report socially approved behaviour and underreport socially disapproved behaviours. Furthermore, people can exaggerate the extent of their sexual performance, in particular male respondents (Erickson & Steffen, 1996). It should be noted that the problem of honest responses occurs in other types of surveys and is not an exclusive feature of sex surveys (Wellings et al, 1994). Indeed, we should not be preoccupied with the likeliness of biased responses, we should just be aware of the possibility. The survey is a valuable research tool and its merits certainly overcome its shortcomings. In summary, the ISSP (1994) dataset can adequately provide us with valid and reliable information on the general sexual behaviours and attitudes in Ireland within the mid 1990s.

Chapter 9 concludes the thesis with a summary of the findings and places these findings in a proposed general model for the production of reported rates in Ireland. It can be surmised that contrary to the usage of reported rates reflecting 'high risk' behaviours in a population, the linkage between reported rates and 'high risk' behaviours is not a simple causal relationship. Instead, the reported national rates are affected by a combination of mechanisms, some of which are implicated in the sexual risk taking of individuals while others influence the process of rates' production.

Chapter 2: The Epidemiology of Sexually Transmitted Infections.

There has definitely been a marked increase in the numbers of young people presenting with STDs throughout the country and the figures now confirm this.
(Dr. Derek Freedman, as cited in *Irish Examiner*, 8th August 1999:5).

Introduction:

Throughout the 1990s, national rates of sexually transmitted infections (other than HIV/AIDS) increased enormously in the Republic of Ireland. The prevalence and incidences of sexually transmitted infections, in particular gonorrhoea, are used as indicators of the proportion of 'high risk' behaviour in a population (Aral & Peterman, 1996). A subsequent increase in reported infections is then taken to represent more people engaging in unsafe sex. Given the huge changes that have occurred in Irish sexual politics at the start of the 1990s and the continual secularisation of the society, the augmenting rates of STIs have recently become a prolific item on the pages of the Irish media. Incorporating voices of concern amongst medical professionals working in genitourinary medicine, articles on STIs focus on the lapsed sexual morals of the Irish people, especially young adults. While liberalisation of sexual attitudes may influence behaviours, drawing a causal link between rising number of 'high risk' behaviours and rates of sexually transmitted infections is too simplistic. Like other contagious diseases and infections, the spread of STIs depends upon a number of factors, some of which involve improvements made to the provision of Irish genitourinary services and the Irish surveillance system.

This chapter will discuss the epidemiology of sexually transmitted infections internationally, before focusing on the Irish national rates. Similar trends can be viewed in other western countries and it is important to note that the examination of the factors responsible for changes in Irish STIs cannot be done in isolation from the wider epidemiological context. Other matters to consider in relation to STI surveillance in Ireland are the pattern of STIs in Ireland since the establishment of Irish health authorities in the 1940s, the reported HIV episodes and the identification of the most prevalent STIs during the 1990s.

The Epidemiology of Sexually Transmitted Infections in Western Countries:

Due to the variety in methods of data collection of sexually transmitted infections across the nations of the world, it can be difficult to standardise results for comparison purposes. Nevertheless, the World Health Organisation (WHO) has managed to develop a system for calculating the annual prevalence and incidence of 'treatable' STIs by region¹. These

¹ This system is known as the Delphi technique and estimates are used because of the lack of information on STIs in many WHO regions. The estimates are calculated by dividing the estimated adult prevalence

estimates take into account the variances in accessibility and quality of STI facilities between countries and are adjusted accordingly. This process then enables comparisons to be made between the different WHO regions. The most recent predictions available on the WHO web-site are for the year 1995. Having reviewed the results of the proceeding years, it is probable that the rates have remained relatively stable. In general, the highest rate of prevalence amongst the 15 to 49 year old age group occurred in Sub-Saharan Africa. The region was estimated to have a prevalence rate of 208 per 1000. This is not surprising as this region is the most badly affected area for HIV (Nicoll & Gill, 1999). The region of South and South East Asia was also estimated to have a high prevalence rate of 128 per 1000 (WHO, 2000). Again these predictions are not entirely unanticipated. Countries in South and South East Asia do have high levels of poverty and prostitution, a booming sex industry, recent devastations of war and economic crises. Furthermore, they have the rampant existence of antibiotic resistant strains of gonorrhoea. This feature can be linked to the practice of using prophylactic treatment by the Americans in South East Asia. During the Vietnam War, American soldiers had been encouraged to use antibiotics before and after intercourse, thus allowing the gonococcus the opportunity to adapt to the antibiotics in the blood stream and become resilient (Barlow, 1979). As a result, gonorrhoea has become increasingly difficult to treat within these countries. Eastern Europe and Central Asia, Western Europe and North America were predicted to have had prevalence rates of 75, 45 and 52 per 1000 respectively (WHO, 2000). Australasia also had a rate of 52 per 1000.

The WHO estimates are useful in establishing the overall trends worldwide. However, a closer inspection on sexually transmitted infections in western countries is of greater interest. This helps to place the Irish rates in context of what is happening epidemiologically across the western world. Such an examination of the rates for Europe, USA and Australasia is not without its problems. It is difficult to ascertain the precise nature of prevalence and incidences of STIs when each country differs in sexual cultures, diagnostic facilities, funding, sexual health programmes and surveillance systems. Geographical location also has implications for the control of STIs because information on one location cannot be generalised to another (Day et al, 1998). Moreover, it is hard to compare statistical data from different countries, when there is a variation in the criteria used for diagnosis and notification (Barlow, 1979). Despite these hindrances, common trends can still be identified within Western and Eastern Europe, USA and Australasia.

Western Europe.

Reported incidences and prevalence of STIs have changed in Europe over the last twenty years of the twentieth century. Since the late 1970s, there has been a decline in the number of reported bacterial STIs but subsequently, there has been an increase in patient visits for viral STIs, particularly genital warts, throughout Europe (Thin, 1982; Piot, 1992). Traditionally, reported STI rates in Southern Europe have been lower than in Western and Northern Europe. This has been attributed to a higher degree of under-

(using midyear population estimates of adults 15 to 49 years of age) by estimated duration of each disease (based on the probability of a symptomatic or an asymptomatic person getting treatment for his or her STI).

reporting in the past (Piot, 1992). With the advent of HIV/AIDS and the subsequent amendments made to surveillance systems, this situation has improved.

Bacterial infections throughout the continent have been steadily declining since the 1970s (Renton et al, 1997; Corson, 1993). Syphilis had actually decreased in severity and prevalence before this period, when effective treatment was just becoming widespread (Leeson & Gray, 1978). Although, it was associated with only a small proportion of the reduction in mortality (0.03% in the United Kingdom), it remained an important cause of death and sickness until the availability of salvarsan to medical practitioners in 1916 (McKeown, 1979). The death rate from syphilis further declined for example, from 18 per 100,000 in 1920 to 8 per 100,000 in 1948 in the USA (Rosen, 1993). By the late 1970s, syphilis was relatively rare and in Britain, the small number of cases was restricted to homosexual men (Leeson & Gray, 1978). There was some increase in the early 1990s in incidences of bacterial infections amongst certain sub-populations in major cities – for example, rectal gonorrhoea in homosexual men and syphilis in heterosexuals (Piot, 1992). Despite localised increases in sub-populations, national rates in Europe did overall show a decline in prevalence. In Britain, the government's target reduction of 20% in the national rate of gonorrhoea from the 1990 level was achieved by 1992 (Low et al, 1997). Spain, which has one of the highest incidences and prevalence of HIV in Europe, decreased its gonorrhoea level in two years from 16 to 10 per 100,000 in 1996. Its syphilis rate remained constant at 3 per 100,000 (WHO, 2000b). In 1996, the majority of countries had gonorrhoea rates of less than 10 per 100,000, the lowest of which occurred in Belgium with 1 per 100,000 (Panchard et al, 2000). Ireland was near the lower end of the spectrum in 1996, with a gonorrhoea rate of 2.29 per 100,000 and a syphilis rate of 0.47 per 100,000. By contrast, England and Wales did have a high rate of 22.4 gonorrhoea cases per 100,000 (The United Kingdom is often divided into Scotland, Northern Ireland, England and Wales for disease reports). However, this could be attributed to the UK surveillance system, which is regarded as being the most accurate in Europe.² It could thus be argued that the rate of bacterial infections is still largely under-reported in the rest of Europe. While this may be true, the reported rates are lower than their previous figures despite the improvements in monitoring and in the face of increasing rates of viral infections.

It is important to realise that the overall decrease in bacterial infections occurred when attendance for treatment was growing - although, some countries, such as Scotland, did experience a stabilisation of rates (ISD, 1989). In England and Wales, the number of consultations in genitourinary (GUM) clinics doubled between 1980 and 1995, resulting in 740,000 new attendances a year (Adler, 1995), i.e. a rate of 1,254 per 100,000. England maintained the highest rate out of all the British Isles – for example, 1889 per 100,000 in 1990 as opposed to 896 for Wales (Corson, 1993). In terms of diagnosis made, 450,000 STI cases were confirmed in 1996 (Madden, 1999), 424,300 of which were for England (Health and Personal Social Services, 1998). This gives it a rate of 762 per 100,000. The same year, Ireland had a diagnosis rate of only 156.1 per 100,000. By

² Britain operates a national network of free open access GUM clinics, which are responsible for STI reporting. The majority of STI cases are seen in these clinics (Laumann & Wellings, 2001). Thus, most cases will be detected and recorded, giving a good indication of prevalence and incidences.

1997, an increase of 9% had been experienced (Hughes et al, 1998) and in 1998, this attendance exceeded one million diagnosed cases (Public Health Laboratory Service, 2000). Yet throughout this period, bacterial STIs were declining. The year 1998 saw a drop of 14% in syphilis and 1% in gonorrhoea (Public Health Laboratory Service, 2000). Thin (2000) asserts that bacterial resistant strains remain at a low level. This is in spite of reports of increases in some social groups due to international travel, emergence of antibiotic resistant strains and population mixing (Young, 1999). The improved diagnosis and treatment of bacterial STIs, most certainly have contributed to the decline (Renton et al, 1997). However, it is believed that laboratory advances may not be able to control viral STIs to the same extent (Thin, 1990).

The trend of viral infections is increasing throughout Europe and this is also reflected in the European incidences of cervical cancer (Piot, 1992). Cervical cancer has been associated with the human papilloma virus, although the causal nature of the relationship is still being disputed. The rise in incidences could be partially attributed to better and earlier recognition of human papilloma virus and cervical cancer but it is probably the result of further spread of the virus in the population (Piot, 1992). This is very possible given that these infections are mostly incurable and once infected, people carry them for life. They can pass the infection onto their partners or can have recurrent attacks, thus augmenting the statistics. As pointed out in Chapter 1, viral infections can be spread outside sexual intercourse and as a result affect a larger proportion of the population than the STIs that are restricted to transmission via copulation (e.g.: gonorrhoea). This draws into question the rise in STIs being facilitated by increased numbers engaging in unsafe sex, especially since 'markers' such as gonorrhoea are declining. Genital warts are the most commonly cited viral sexually transmitted infection in most Western European countries, including Ireland and the United Kingdom (Adler, 1995). By the end of the 1980s, other viral infections including the incidence of *molluscum contagiosum* had also increased. (Thin, 1990). Arguably, viral STIs are relatively new and are still at their most contagious stages. We can thus expect epidemic levels for some time in the near future.

Despite the rise in incidences of viral STIs, medical professionals have focused their concerns on chlamydia. Infection by *chlamydia trachomatis* has become the most rapidly spreading sexually transmitted infection in Europe. This does not necessarily mean that the infection is being facilitated by growing proportions of 'high risk' behaviour in a population. Its increase – or stabilisation in some countries - can mainly be attributed to improved diagnosis (Piot, 1992). It was in the past heavily under-estimated due to the absence of adequate diagnostic facilities for chlamydial infection. Chlamydia's prevalence and incidences do vary considerably between countries. In 1996, its lowest rate was 7.8 per 100,000 in Belgium, whilst the highest was 255 per 100,000 in Denmark (Panchaud et al, 2000). The Irish rate was 10 per 100,000 for the same year, again near the low end of the rates. In Britain, the most commonly diagnosed conditions made in the GUM clinics are the non-specific genital infections, especially non-gonococcal urethritis (Thin, 1990). Interestingly, much of this condition remains unclear and there is a lack of evaluative information on it as a disease entity or syndrome. Further investigation is also needed in relation to its aetiological factors, sexual transmission and therapy. (Thin, 1990).

Eastern Europe.

With the exception of Poland, bacterial STIs have been escalating in Eastern Europe, throughout the 1990s (Ratcliffe et al, 1998; WHO, 1995). In Russia, syphilis increased from 5.4 cases per 100,000 in 1990 to 227 cases per 100,000 in 1997 (Renton et al, 1999). Gonorrhoea is estimated to be as high as 600 per 100,000 (Panchaud et al, 2000). For the 1970s - and subsequently, much of the 1980s – European epidemiologists had little information on STI control measures (Barlow, 1979). It was believed then that the countries of the former Soviet Union viewed accurate figures as a bad reflection on their political systems (Barlow, 1979). In Russia, the official sanctioned view was that STIs (especially, syphilis and gonorrhoea) were a feature of a morally corrupt capitalist society and that their prevalence and incidences in the population represented capitalist behavioural forms and ideology (Renton et al, 1999). A Committee for the Control of Venereal Diseases was created with the revolution in 1917 and a network of specialist clinics, known as dermatovenereological dispensaries (DD), was formed in 1921. This network was later termed the National Dermatovenereology Service (DVS) (Renton et al, 1999). There was a strong view that people with STIs had to be controlled. It was a crime punishable by law to refuse treatment when found to be infected and to have sex after being diagnosed. Failure to identify sex contacts was liable to a fine after 1971 (Renton et al, 1999). Patients and their contacts were monitored for up to 5 years and could be prevented from accessing a variety of municipal facilities and from undertaking work and travelling outside Russia. These laws were enforced and more than 100 prosecutions per year took place in Russia during the 1960s (Renton et al, 1999). The recent political and economic upheavals have changed views in regard to STIs and the escalating trends of the 1990s can be attributable in part to a new openness about seeking treatment.

Similar to the rest of Eastern Europe, a dermatovenereology service was developed in Poland but its exception in the trends of STIs has been attributed to the country being more westernised than many of the other old Eastern bloc countries (Bingham & Waugh, 1999). In other words, Poland maintained a liberal attitude in relation to STIs, thus overruling the taboo of sexuality and resulting in the encouragement of treatment and prevention of sexually transmitted infections. Chlamydia is the most commonly reported sexually transmitted infection and in 1996 the rates for males were almost three times that of females – 1952 compared to 602 (WHO, 1998). This was similar to the other reported rates of gonorrhoea, where males were 4 times that of females – 1050 cases as opposed to 225 (WHO, 1998). It is possible that the difference is simply due to the infections being more prevalent in men who are engaging in either homosexual or heterosexual behaviours or both. However, homosexual men may be targeted more than other groups by health prevention strategies, thus augmenting the rates for men or perhaps, women do not feel encouraged to come forward for treatment. The asymptomatic nature of STIs in women could also be playing a role, as could the use of home remedies, which women may be more likely to try before seeking treatment from their doctor. Diagnosis by a general practitioner may also not be recorded in the national rates and Polish women may prefer to use this method. This reckoning is speculative and more information about the Polish provision of facilities for STIs is needed to explain the discrepancies in rates.

USA.

In the 1970s, the USA had one of the highest rates of STIs and had the biggest budget for research and education into these infections (Barlow, 1979). Despite great research, especially from The Center for Disease Control and Prevention in Atlanta, Georgia, none of the concentrated effort had any effect on the levels of gonorrhoea or syphilis in the USA in the 1970s (Barlow, 1979). The number of infections was in reality not greatly different to that of the pre-antibiotic era (Barlow, 1979). In the 1990s, the rates were even higher with an estimate of 15.3 million new cases of STIs in 1996 (rate of 5,371 per 100,000), a jump of 3.3 million from the 1986 estimate (Center for Disease Control and Prevention, 2000a). However, like Europe, the rates now mostly consist of increasing numbers of viral infections and declining rates of bacterial sexually transmitted infections.

Throughout the 1990s, the most commonly reported STI was genital warts (roughly 5.5 million cases per year). Chlamydia had the third highest rates with an average of 3 million new cases a year (Center for Disease Control and Prevention, 2000a). Unlike Europe, trichomoniasis was very prevalent, taking second place in the rates with approximately 5 million new incidences a year (Center for Disease Control and Prevention, 2000a). Herpes and bacterial vaginosis are also extremely widespread (Center for Disease Control and Prevention, 2000a). Syphilis, gonorrhoea and chlamydia are decreasing due to the implementation of screening and treatment programmes. These programmes were originally instated during World War II and continued over the following decade with mass screening surveys, health education campaigns and blood tests for pregnant women and couples about to be married (Rosen, 1993). Between 1990 and 1995, syphilis steadily lowered in rate, resulting in 1995 being the lowest on record for a decade (Leonard & Ross, 1997). However, the disease rates were highly skewed by geographical region. Only 588 of the 3116 counties account for 89% of all cases of syphilis. These counties were mainly Southern and all registered rates exceeded the US government's objective of 4 cases per 100,000 (Leonard & Ross, 1997). For example, Houston, Texas had a rate of 29.9 per 100,000 in 1995, nearly 5 times the national rate (Leonard & Ross, 1997).

It is estimated that more than 68 million (23.8%) Americans now have a treatable but an incurable sexually transmitted disease such as herpes, human papilloma virus infection, hepatitis B or HIV infection (Hopkins Tanne, 1998) and approximately two-thirds of these are younger than 25 (Haverkos & Quinn, 1995). Most estimates are based on either studies of at-risk populations, such as people visiting public clinics or official government counts of reported new cases of infection. However, Laumann et al (1994) conducted a survey of the sexual behaviours of the US population and from their sample of 3,432 respondents, found that the combined reported lifetime number of cases for any STI was 169 per 1000. These figures are alarming and are not helped by Hopkins Tanne (1998) claiming that by the age of 24, one in three sexually active people in the USA have had a sexually transmitted infection. An explanation for these publicised particulars could be that monitoring STIs in the USA has improved enormously in the last decade. Screening and more sensitive detection tests for asymptomatic infections are now more widely

available (Hopkins Tanne, 1998). This would mean that a larger proportion of the population are being reached. Nevertheless, in the absence of cures, viral infections continue to defy current control measures, mainly due to the major problems that persist in the US surveillance system. People are only diagnosed when they seek treatment for symptoms or are offered screening by a health care provider. Since most STIs do not cause symptoms and there is not widespread screening for all STIs, many people do not know they are infected (Center for Disease Control and Prevention, 2000a). The operation of a health insurance system does mean that many infected individuals on lower incomes do not seek medical help, perhaps resorting to home remedies, which help to keep the infections in the community. Additionally not all diseases are reportable in each state (Center for Disease Control and Prevention, 2000a). This is worrying, especially given that the estimated rates are already high and the USA has the second largest number of HIV/AIDS cases in the world.

Australasia.

Australasia has significantly lower rates than Europe and the USA. In Australia, it has been argued that this could be a consequence of a data system that is limited by different notification and screening procedures used in each state (Schofield et al, 2000). Despite the inaccuracies and inconsistencies, overall, trends are similar to Europe. Like Europe, Australia has also experienced a decline in bacterial infections over the past 20 years. This persistently continued in the 1990s, when gonorrhoea fell from a rate of 20 cases per 100,000 in 1996 to 17 in 1999 in Southern Australia (www.stdservices.on.net, 2001). Syphilis dropped from 3 per 100,000 to 1 per 100,000 in the same years (www.stdservices.on.net, 2001). Chlamydia has increased significantly throughout socio-economic groups and geographical areas (Schofield et al, 2000). This has been attributed to the introduction in 1996 of DNA amplification technologies such as polymerase and ligase chain reactions as since then, the rates have stabilised (www.stdservices.on.net, 2001). For South Australia, the rate for 1996 was 72 per 100,000 and 73 per 100,000 in 1999 (www.stdservices.on.net, 2001). Genital warts has also been increasing especially within the urban areas of Sydney and Adelaide (Schofield et al, 2000). Like Europe, attendance increased throughout the 1980s and 1990s and majority of cases were amongst those under 29 years. New Zealand is similar to Britain and Australia with its free confidential sexual health services (Turley et al, 2000). While the surveillance system does comprise largely of returns from the sexual health clinics, they do reflect the trends seen in Europe, USA and Australia. In 1999, 7400 STIs were diagnosed (rate of 195 per 100,000) in 6988 attendees at the sexual health clinics (Turley et al, 2000). This indicates that a proportion of the rates were repeat episodes. Indeed, the majority of cases were genital warts, which do have repeat occurrences throughout an individual's lifetime. Chlamydia and non-specific urethritis were also common. Most of the infections were diagnosed in those under the age of 25, reflecting trends in Europe, USA and Australia.

Age and Sexually Transmitted Infections:

Sexually transmitted infections can affect people of any age (WHO, 1975), yet despite this, age is inversely related to the prevalence of STIs in a population (Coetzee & Mathews, 1998).

In Europe, the overall rates of STIs, including the declining bacterial infections, are highest amongst those who are under the age of 29. The bulk of STI cases in Britain occur amongst the 16 to 24 age group in women and the 20 to 29 age group in men. (Renton et al, 1997). Rates are highest in the 20 to 24 age group for both sexes (Corson, 1993). This is not surprising, as they are the group most likely to be exposed to STIs, due to their willingness to experiment sexually with multiple sexual partners than older age groups (who are largely married or monogamous). College students and adolescents are particularly more likely to experiment with partners with anti-precautionary attitudes (Lear, 1997). In keeping with the rest of Europe, the majority of cases seen at the Irish GUM clinics are amongst the age group 20 to 30 years³. This accounts for about 60% of all the reported cases. While the number of attendees is considerably less for those under 20, the addition of both rates accounts for most of the overall reported STI rates. In the Irish county of Waterford, about 75% of all patients seen in the clinic for the last five years of the 20th century were aged 30 years and younger. Even in the 1980s, Mohammed & McQuoid (1984) found that the chlamydia was more common in Dublin women under the age of 25 years than older. It could be argued that younger people are more likely to access the clinics as they have fewer preoccupations with the old image of the VD clinics. Another influential factor is that urban areas attract young single people for employment or as third level students and thus, those under the age of 30 make up a large proportion of the potential clientele that surround the clinics.

In relation to teenagers, the World Health Organisation has argued that “while incidence data are not available on a global level, there are indicators that age-specific rates of sexually transmitted diseases are highest among 15 to 19 year olds, with concomitant increases at least in the industrialized countries in age-specific hospitalisation rates for pelvic inflammatory disease and cervical cancer” (WHO, 1989:11). They also pointed out that this age group often lack easy access to STD services (WHO, 2000a). This not only includes physical access but teenagers may feel too embarrassed to approach clinics for help. They may feel guilty or may fear reactions from parents and health workers. Adolescents are usually the group that delays seeking treatment (WHO, 1993). They are more inclined to try self-medication such as disinfectants or painkillers or borrowing medication from friends (WHO, 1993). Unfortunately, these mask rather than cure the infections so the sufferers could unwittingly spread the infection. Rates for adolescents do vary between countries. Although in western nations, the highest rates tend to fall in the older age group of 20 to 30 years olds, the rates for teenagers do appear to be increasing, including Ireland (O’Doherty, 1998). In Britain, diagnosis of genital chlamydial infection, genital warts and even gonorrhoea have been increasing throughout

³ Material on numbers of new cases and demographic characteristics of the patients visiting the GUM clinics in Ireland was obtained personally from the individual GUM clinics or through written requests for the information.

the 1990s in the 16 to 19 year olds (Public Health Laboratory Service, 2000). Incidences of pelvic inflammatory disease amongst the under 18s have also risen in the 1990s (Fitzpatrick et al, 1992). In contrast, recent research in the USA - like the replicating conduction of the *Risk Behavior Survey* carried out by the Center of Disease Control in the 1990s - have found that number of teenagers engaging in sexually activity under the age of 18 is decreasing (Riseman & Schwartz, 2002; Nicoll & Gill, 1999). Trends of STIs and teenage pregnancies were demonstrated to be declining and the changes were credited to improved sex education programmes, cultural backlash against the sexual revolution and fear of disease.

The issue of STIs and teenagers has perpetuated moral outcry on teenage sexuality, particularly in the British media. Unfortunately, this results in the STIs being lost amidst the wider concern of teenagers being more sexually active than previous generations. This generalisation has implications for education and preventative measures. Sexual cultures vary geographically and socially and the sub-cultures of adolescent sexualities are no different. Teenagers' sexual interactions, norms and values fluctuate according to a number of factors, such as neighbourhood, type of schooling and areas for socialisation. Even familial influences play a role, for example, whether the teenager is first born or has older siblings. Those in the latter group may be more likely to engage in relationships at an earlier age, due to the exposure to and likelihood of imitation of the behaviours of their elder brothers and sisters. While there has been plenty of qualitative research done on adolescents' sexual behaviour and attitudes, it is important to place these within their relevant contexts and not generalise the results across an entire population. Sex education programmes should be tailored to suit the needs of the different audiences otherwise they run the risk of teenagers not heeding the message because they view the material as being irrelevant to their lifestyles.

The Irish media has been imitating the moral outcry of the British media, yet it is difficult to understand why people are arguing about changing sexual practices amongst the young, when there is no longitudinal information on their sexual attitudes and lifestyles in Ireland. Certainly, concern about teenage sexual behaviours is valid but the argument here is that there are many assumptions about sexual behaviours with little empirical support. This risks the failure of prevention campaigns, as the programmes are not based on actual behaviours. In Ireland, there are no large scale studies to account for geographical differences, social class distinctions nor are there past studies on sex, which could be used as a comparison. A number of short papers have been done on small selected groups of school children and university students (Condon et al, 1993; MacHale & Newell, 1997; The Alliance, 1998, Inglis, 1998). These studies are methodologically flawed in both conceptualisation and operationalisation. They should have been treated as small qualitative studies but their results from the non-random selection of teenagers were used as representative of the population. While all the surveys were trying to depict teenagers that were sexually active, two projects carried out in two schools in the cities of Cork and Galway did note that less than 20% of their respondents had their first intercourse below the age of 16 (The Alliance, 1998; MacHale & Newell, 1997). This indicates that at least two teenage sub-cultures are different from public perception of

most teenagers being sexually active and larger scale projects or indeed a compilation of small-scale qualitative research is warranted to help provide a more accurate picture.

The Rates of Sexually Transmitted Infections in Ireland:

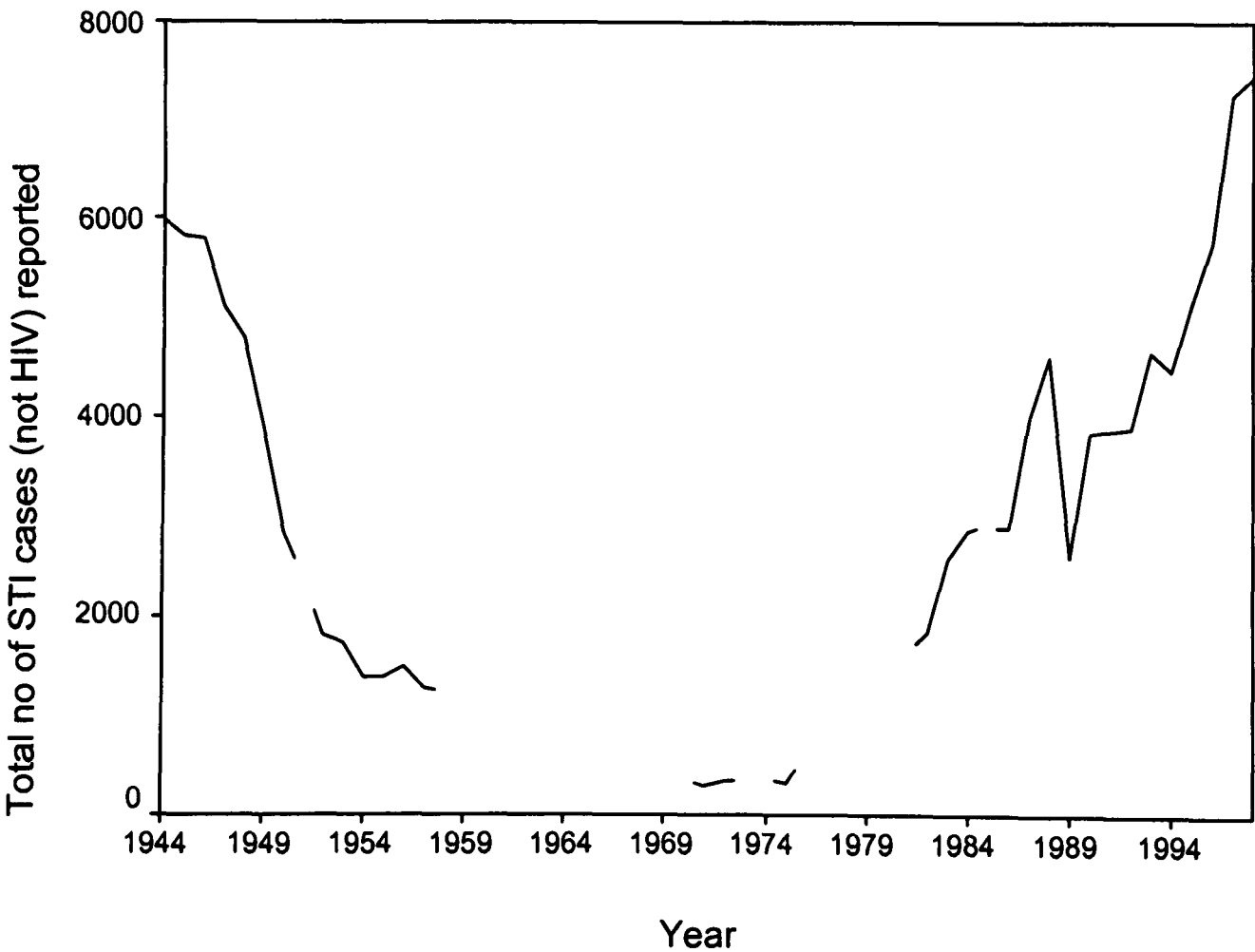
When juxtaposed with other European countries earlier in this chapter, the Irish rates were low in comparison. Such an observation could lead to the conclusion that the rising rates in Ireland are not a source of concern. On the contrary, the pattern of sexually transmitted infections over the 1990s, reveal that the rates have escalated quite rapidly in a short time. This increase justifies investigation.

Like other Western European countries, Ireland annually records its diagnosed STIs as part of its overall disease surveillance system. Such monitoring is essential for the provision of treatment and the prevention of sexually transmitted infections (De Cock & Low, 1997). Sexually transmitted infections' surveillance data should describe the occurrence of diseases according to time, place, age, sex and relevant personal characteristics (ODA, 1996). In Ireland, the rates published by the Department of Health and Children only include the total number of cases diagnosed for each classified sexually transmitted infection. No information is given on the epidemiology of STIs, even new and recurring cases are not distinguished. This is problematic as their combination is misleading. One person may have more than one disease in one period of time or may be reinfected at intervals throughout the time frame. Counts of cases do mask a number of issues. Changes in the recorded cases can be just as affected by changes in health services as by changes in 'high risk' behaviour. Improvement in treatments and diagnosis or reduction in service activity can augment and decrease reports. Moreover, the provision of more than one clinic in an urban area for the same population can result in duplication of cases (Johnson, 1998). National STI rates really should show STI type by age, sex and district. Effective and efficient control of STIs relies on the epidemiological data available and the incomplete nature of the Irish rates almost certainly hinders this process.

In its favour, the Department of Health and Children do include laboratory data, which contains information on those treated by general practitioners. The rates also report diagnosis rather than observed syndromes (for example, genital ulcers, urethral discharge). This practice improves the reliability of the collection of the reported rates. Furthermore, the individual clinics are most acutely aware of the type of patient who frequents the clinic. Because the responsibility of health services' provision is divided amongst the health boards, such localised information can be fed into the regional policies. This certainly happens with surveillance data, incorporating the demographics of age, sex and in some cases, occupational group, being included in the annual report of each health board. How this information is processed in relation to preventative strategies is unknown. Sexually transmitted infections, with the exception of HIV/AIDS, have not been on the public health agenda of health boards, although there has been some discussion in 2001 for developing an initiative (Murphy, 2001).

Figure 1 displays the reported rates of STIs in Ireland from the early 1940s until 1998. This graph was devised after I collated the annual reported statistics for the years 1945 to 1999 from the Irish Department of Health and Children. My method of collection involved searching through the official yearly reports from the department, which has been renamed and reformed through out the period - *Report from the Department of Health* (1949 – 1969), *Statistical Information Relevant to the Health Services* 1982. *Prepared by the Planning Unit, Department of Health* (1970 – 1985) and *Health Statistics* (1986 to 1999). The first report appeared in 1944 and the purpose of using data from 1945 to 1999 is to observe trends over a larger period of time than simply the last decade. Unfortunately, information is missing for the decades of the 1960s and 1970s. This was due to the absence of statistics on venereal diseases (as they were called previous to 1986) in the reports for this period. It is unlikely that the clinics stopped collating their statistics and so it is probable that it was an editorial decision not to include the rates in the annual reports. Perhaps it was felt that VD had been successfully controlled and their space in the printed reports was given to other more topical diseases. The rates of STIs are reported to the Department of Health by the Irish genitourinary (GUM) clinics and by the hospital medical laboratories. General practitioners are not obliged to report cases of STIs, although most general practitioners would either refer patients to the STD clinics or use the laboratories to test for presence of sexually transmitted infections. The STI rates do not include HIV nor do they include Hepatitis B.

Figure 1
Total number of cases of sexually transmitted infections reported to the
Department of Health and Children.



According to the graph, the trend of STIs in Ireland started at epidemic proportions after World War II, then declined in accordance to trends in western countries in the 1950s. With the emergence of AIDS, in the mid 1980s, the rates increase, dipping briefly before escalating throughout the 1990s. While information is missing for the 1960s and 1970s (although, statistics are collected for the years 1971, 1972 and 1975), evidence from a survey of general practitioners during the 1970s suggest that Ireland did have relatively low incidences of sexually transmitted infections (Freedman et al, 1981). The national frequency for 1978 was estimated to be 7.7 per 100,000 for syphilis, 97 per 100,000 for gonorrhoea (Freedman et al, 1981). Interestingly, these rates are actually higher than those seen in the 1990s, yet were not viewed then as sources of concern. This indicates that STIs are not just 'social' diseases because of the social behaviours involved, but due to their social production. They are deemed important health risks when it suits the public agenda. It is no coincidence that STIs were prominent in the Irish media after the sexual political upheavals of the 1990s. Sexually transmitted infections do appear as focal points of concern when issues of sexuality and sexual morality are brought into question. This will be further discussed in Chapter 4. Absence of rates does affect the accuracy of the reports and the sporadic reports of the 1970s can mean a minimising of the problem. Catterall (1983) argued that during the 1970s, Ireland had incidences of STIs comparable to other countries of similar size and these incidences would continue to increase with the development of air-travel and tourism.

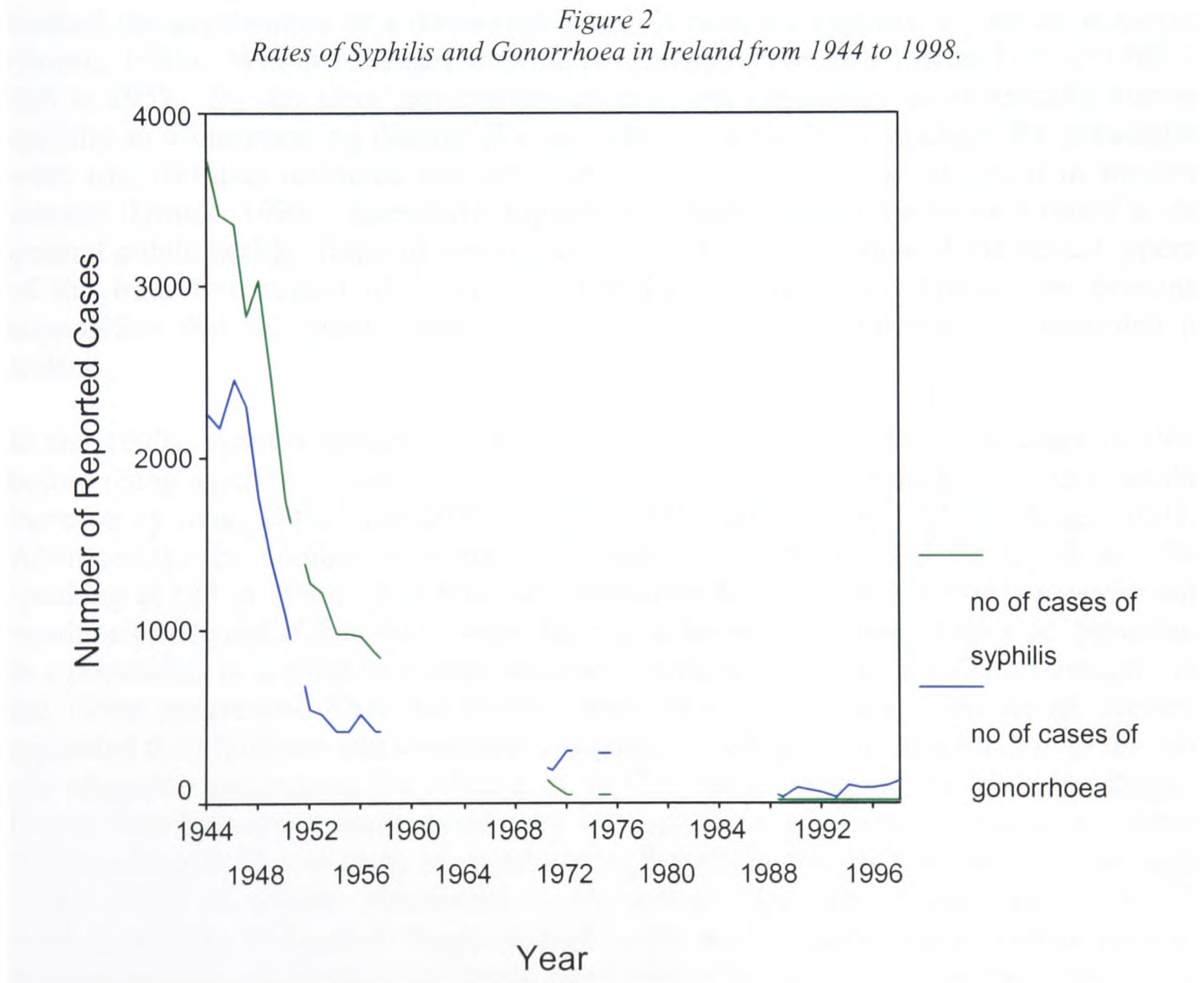
It can be argued that the trend of STIs observed over the period of time has more to do with changes in the surveillance system than in the actual prevalence and incidences. Indeed, the declining and inclining slopes of the line correspond to two significant periods in the history of sexually transmitted infections. After World War II, there was huge public concern in the western societies about the rates of venereal diseases amongst the returning soldiers and the wider populations of European countries. This concern prompted an effort by states to control and prevent the diseases. While Ireland was neutral in World War II, Ireland would have followed the actions of its neighbours and would have pursued the control and regulation of the diseases. Venereal diseases were targeted and efforts made in improving their detection and diagnoses. This is reflected in the rates as the highest numbers are recorded in the years closest to the end of the world war. In relation to the increasing slope on the other side of the line, this rise occurs after the HIV/AIDS panic of the mid-1980s. This event did prompt an improvement in the provision of services for STIs and HIV throughout Britain and Ireland, including a greater vigilance in the reporting of cases. For example, in 2001, a targeted screening programme for syphilis was introduced resulting in a leap from 35 recorded cases in 2000 to 189 cases in 2001 (McCarthaigh, 2002). Therefore, it can be argued that the increasing rates can be partly attributed to greater accuracy in reporting techniques of both these periods.

Syphilis and Gonorrhoea in Ireland.

When isolating the two bacterial infections from the rest of the STIs (as illustrated in Figure 2), it is evident that the same declining trend for bacterial infections occurs in Ireland as for the other western countries. Previous to 1945, VD was nationally reported

in terms of mortality rates in the Register General’s annual reports. Deaths solely attributable to syphilis averaged 23 a year between 1923 and 1940, with a further average of 28 deaths from conditions or complications arising from syphilis⁴. Fluctuating from year to year, the rates of syphilis peaked with 33 deaths in 1931 and dipped briefly to 13 deaths in 1934. A large proportion of the deaths were infants under the age of one year (resulting from the acquisition of the infection in the womb) and some years these deaths surpassed the usual largest proportion of deaths, that of male adults. Gonorrhoea claimed 3 deaths on average annually. The reported deaths disappeared from the pages of the Register General’s annual report in 1941, when their place was taken by deaths from TB and cancer. When comparing these mortality (both adult and infant) rates to other communicable diseases in the same period - such as influenza, which claimed 2,534 lives as opposed to syphilis’s 384 deaths - syphilis appears not to be a major contributor to mortality. These rates do occur after the introduction of the VD clinic system and the widespread availability of treatment. Since the output of health services can be measured in terms of mortality rates, the fall in deaths to zero from VD in Ireland can be viewed as a success of VD clinics and campaigns in controlling the infections.

Figure 2
Rates of Syphilis and Gonorrhoea in Ireland from 1944 to 1998.



⁴ Taken from the Register General’s Annual Reports, 1922 to 1945.

It is interesting to note that at a time of fewer clinics and facilities, the total number of syphilis and gonorrhoea cases in the late 1940s are as high as the combined rates of STIs in the middle of the 1990s. Illegitimacy rates in that period also soared. Since gonorrhoea is considered an 'unambiguous' STI, it is used as a marker of 'high risk' sexual activity in a population (Day et al, 1998). Does this mean that the war generation were engaging in more 'high risk' behaviour than the sexually active adults of the more liberal 1990s generation or even those involved in the 'sexual revolution' of the 1960s? War times are well documented to heighten the sexual exploits of the people. General heightening of nervous tensions tends to increase sexual activity (Hyam, 1990). However, Berridge (1999), points out that it is injudicious to speculate that sexual mores had loosened during war-time. The increase during World War II, he argues, was due to fewer women marrying upon realising that they were pregnant, shortages of contraceptives and increased mobility of the population. Ireland may not have been in the war, but it would certainly have been affected by the war in its neighbouring countries and this would contribute to a similar pattern of social behaviour. As previously stated, Ireland like other countries, instituted control measures after World War II. The introduction of penicillin for the treatment of syphilis by John F. Mahoney in 1946 marked the acceleration of a downward spiral of rates for syphilis in western countries (Rosen, 1993). Within a decade, Irish cases of syphilis had fallen from 3359 in 1946 to 860 in 1957. By this time, government officials and physicians internationally viewed syphilis as a disappearing disease (Drusin, 1996). In the USA, budgets for prevention were cut, facilities restricted and teaching about STIs kept to a minimum in medical schools (Drusin, 1996). Elsewhere, syphilis was deemed to no longer be a threat to the general public health. Rates of syphilis disappeared from the pages of the annual reports of the Irish Department of Health and Children at this time. Hence, the previous supposition that the disease was considered to have been successfully controlled in Ireland.

In the 1990s, syphilis remained low, falling from 20 cases in 1991 to 8 cases in 1993 before rising again to 15 cases in 1998. At the turn of the 21st century, syphilis cases did increase by over 500% from 2000 figures to 189 cases in 2001 (McCarthaigh, 2001). Additionally, the number of gonorrhoea cases rose from 24 in 1993 to 98 in 1994 (peaking at 125 in 1998). It is however, premature to speculate whether these rates will continue to rise and if they do, whether the rise is the result of more 'high risk' behaviour in a population or are due to implementation of a more vigorous surveillance system. As the 1990s progressed, STIs did become more of a health issue. The health services expanded their facilities and awareness campaigns (backed by the introduction of the new sex education programme for schools in 1997). As an example, in 2001, the Eastern Health Board screened homosexual men for syphilis in gay bars and saunas in Dublin city, resulting in 30 new cases of syphilis being detected amongst 500 men (McCarthaigh, 2001). This of course, contributed to the overall high rate of that year. The STI campaigns of the 1990s were largely fuelled by the fear of AIDS. These resulted not only in more vigilant surveillance but forced more people to present themselves at clinics. As previously noted, STIs facilitate the transmission of HIV and share the same risk behaviours and their increased rates could be significant for the present and future rates of HIV in Ireland.

HIV/AIDS in Ireland.

AIDS first came to the attention of the Irish medical community in 1982 when two homosexuals were diagnosed with Kaposi’s sarcoma (Freedman, 1987). Following the protocols undertaken internationally, the Irish health services hastily developed their HIV/AIDS policy and HIV antibody tests, carried out by the Virus Reference Laboratory were made available through GUM clinics, hospitals and general practitioners. Similar to other western countries, the first wave of infection was amongst the homosexual community. The main risk group (intravenous drug users) emerged in 1986 (Des Jarlous & Friedman, 1987). While initially the spread of HIV was contracted through the sharing of needles, efforts to curtail HIV infection through the provision of clean needles were compromised by the group’s involvement in the sexual transmission. Intravenous drug users are more likely to take precautions when drug taking than during sexual intercourse (Hickey et al, 1994). This has implications for the wider community in three main ways. Firstly, prostitution is often used by drug users to make money quickly in order to feed their habit (Freedman, 1987). They are more likely than the professional prostitute to have unprotected sex. To the professional, STIs and HIV are bad for business, whereas the amateur seeking a quick fix may forgo condoms for extra money. Secondly, intravenous drug users may develop stable relationships with non-users either while still being an addict or post-addiction. If the infected is asymptomatic or equates prevention methods with safe drug taking, they place others at risk of infection. Finally HIV positive intravenous drug users not in stable relationships can spread infection and/or other STIs through casual sexual encounters or short-term relationships. As a result, intravenous drug users do pose a threat to the sexual spread of HIV, especially via heterosexual transmission. Hickey at al (1994) reported that drug injectors are responsible for over 87% of heterosexually transmitted cases of HIV in Ireland.

Table 1: Rate of HIV cases per 100,000

	1992	1993	1994	1995	1996	1997	1998	1999
Ireland	20.4	21.1	20.9	14.7	17.0	11.5	11.8	11.0
Spain	127.0	137.4	184.2	176.1	161.4	116.6	86.6	71.1
Poland	0.9	1.8	2.6	3.0	2.8	3.0	3.1	3.1
UK	27.2	30.7	31.6	30.0	23.9	18.1	13.4	11.9

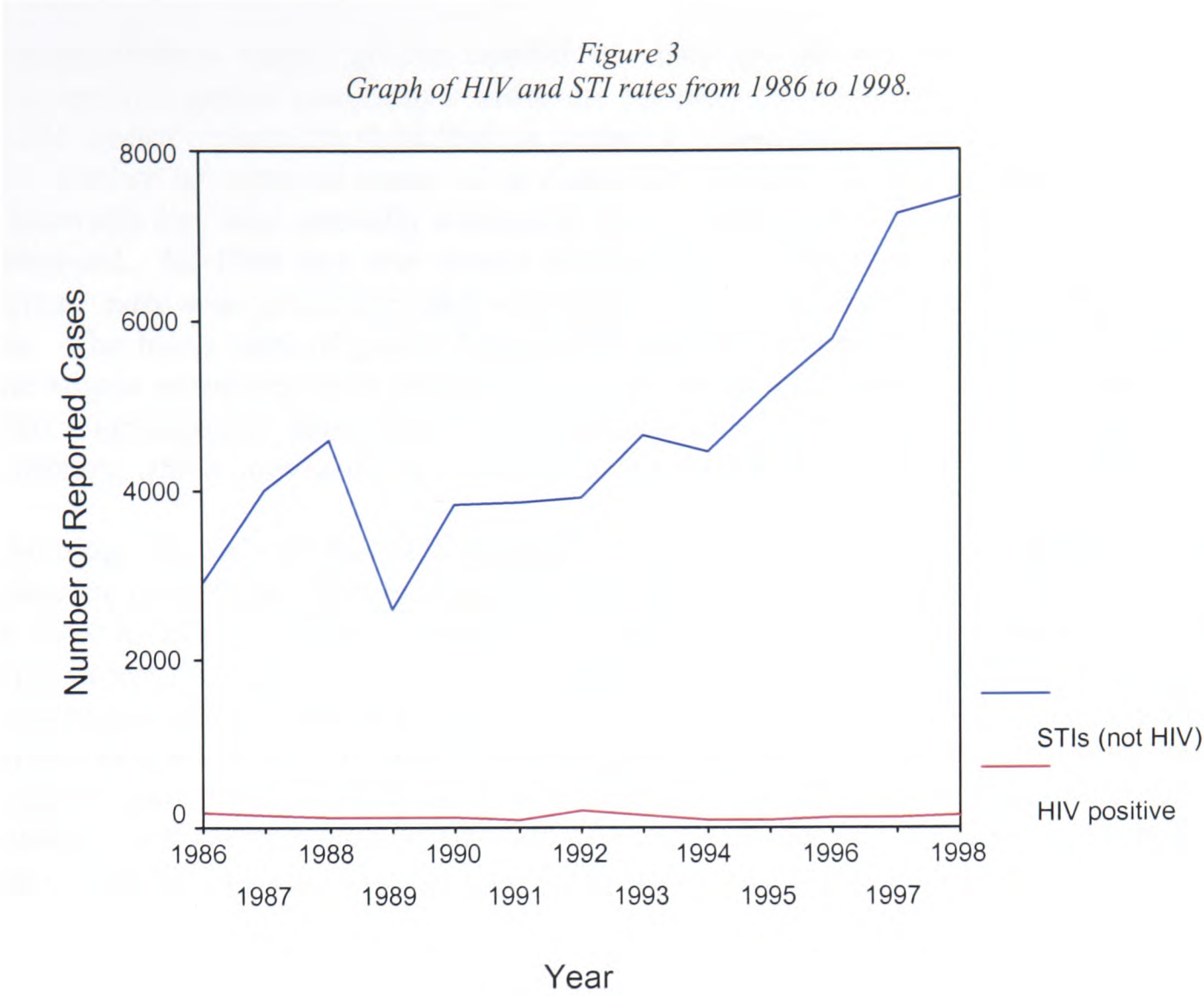
Source: European Centre for the Epidemiological Monitoring of AIDS, 2000.

Heterosexual transmission of HIV has been increasing in Ireland. By 1992, 11.8% of HIV cases were ‘heterosexual’ in origin (Desmond et al, 1993). According to the Virus Reference Laboratory, the number of new heterosexual cases doubled from 25 to 50 cases the following year (Department of Health and Children, 1999). The rest of the 1990s saw the counts of cases jump back down to the early 20s before climbing up to 47 cases in 1998. That same year there was a total number of 2,062 HIV positive people living in Ireland (McSweeney, 1999). Unlike the ‘treatable’ STIs, overall rates of new HIV cases have been decreasing throughout the 1990s. Table 1 shows the rate of HIV per 100,000 for Ireland compared to those of Spain, Poland and United Kingdom. The Irish rate is very similar to that of the UK, which is not surprising as both countries operate similar

GUM services, HIV testing and surveillance systems. Spain has one of the highest rates of HIV cases in Europe, although like UK and Ireland, these rates have been dropping, perhaps indicating that HIV has been contained. Poland, on the other hand, has increasing rates of diagnosed cases. This may be due to improvements to the health services post-communism. Desmond et al (1993) argue that the official rates underestimate the prevalence of HIV in the Irish population. Using mathematical modelling, they predict that five times as many people may be infected with HIV than are reported. This is quite possible as within the same period, other STIs have been increasing. Since these STIs share the same 'high risk' behaviours as HIV, those who have considered themselves at risk from a sexually transmitted infection could also have been exposed to HIV. Using this assumption, one would expect the patterns of HIV and STIs to be similar.

The rates of HIV and other STIs in Ireland from 1986 to 1998 are illustrated in Figure 3. HIV rates were first published in 1985 but these rates (363 cases) were the cumulative figures for the early 1980s and so have been dropped from the graph. The trends do not appear to be related. It is evident that while cases of other STIs quite dramatically increase over the period, the reports of new cases of HIV remain stabilised, apart from a peak in 1992. This is interesting as one would anticipate that an increase in the former would lead to a rise in the latter. Although, HIV cases do increase slightly towards the end of the 1990s.⁵ In December 2001, one of the Irish health boards, The Southern Health Board, issued its sexual health strategy for the 21st century and reported that heterosexual transmission of HIV had jumped from just over 60 cases in 1999 to over 125 cases in 2000. This means that currently the most common mode of transmission of HIV is sexual in origin. The leap in cases could be due to a time lapse between the manifestation of HIV and previous diagnoses of the STIs that facilitate HIV (e.g.: syphilis and viral infections). However, this assumption is reliant on the diagnosed not modifying their sexual behaviours and that the STIs are being transmitted via the same sexual routes as HIV. Furthermore, it is too premature to establish whether the rise will continue or whether it is the result of a targeted campaign, like what happened in relation to the syphilis screening in Dublin in the same year. It does however lead to the question of which STIs account for most of the augmentation of rates in the 1990s.

⁵ It should be pointed out that this is at odds with the trend in Table 1, where the rates of reported HIV cases per 100,000 were seen to be decreasing in the last decade of the 20th century. Such discrepancies in published data do make it difficult to compare the trends and raises a query about the accuracy of the STI rates. Within health statistics, it is quite common that rates are modified in later years when information becomes available after the publication of the first calculation. Furthermore, various compilers can round the figures off to different numbers and this action does account for some of the differences found between publications of *Health Statistics*. However, it is difficult to explain the differences between Table 1 and the graph, especially since the data from Table 1 for Ireland was sourced by the European Centre from the Department of Health and Children. There would be a difference between cases diagnosed in laboratories and those reported to clinics but that would mean that the former would result in higher rates for Table 1 not lower. It is possible that the explanation for the difference lies in the haphazard compilation of statistics on HIV and STIs in Ireland. A more systematic approach to recording the infections is needed.



The Most Commonly Reported Sexually Transmitted Infections.

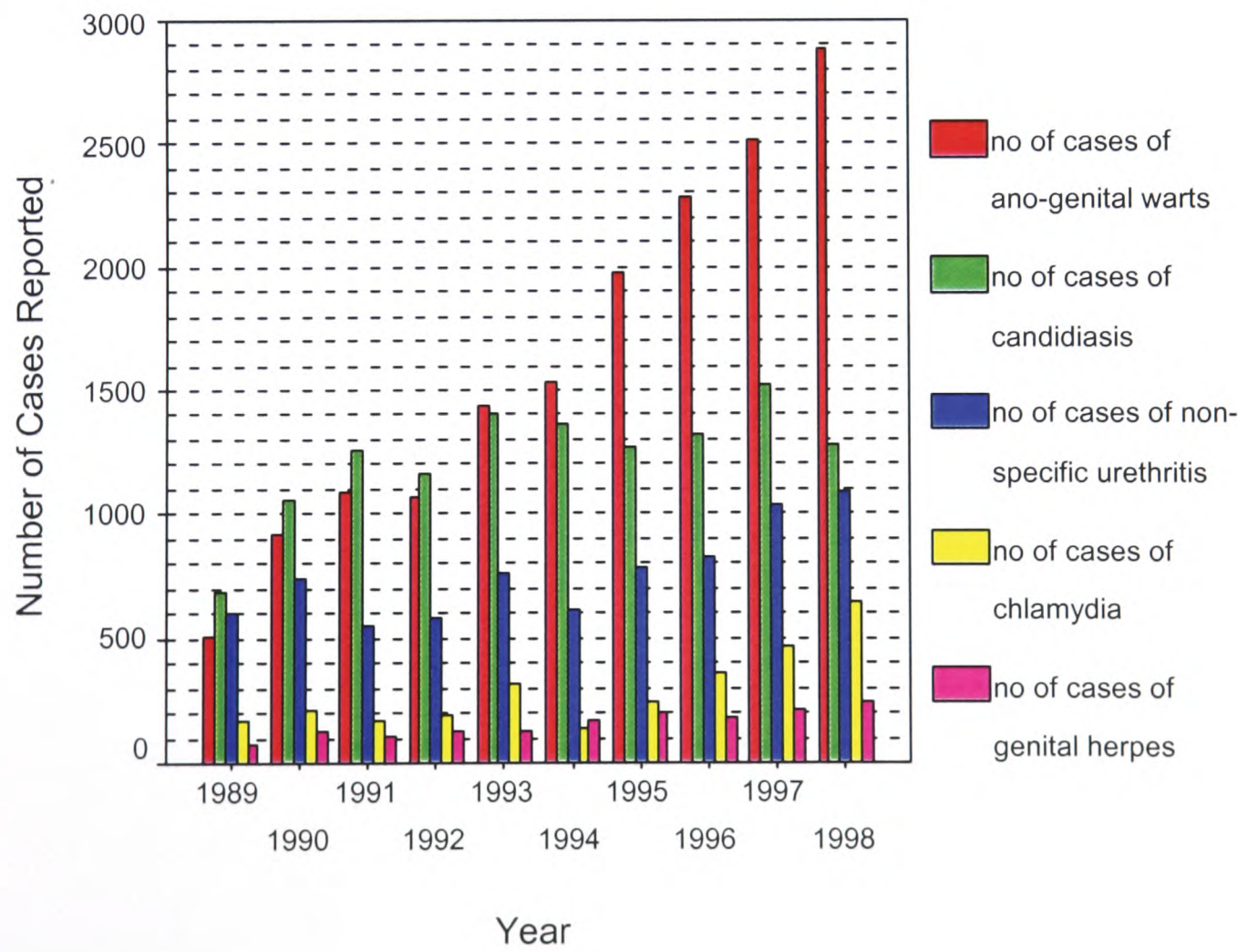
The five most frequently cited sexually transmitted infections in Ireland from 1989 to 1998 are illustrated in Figure 4. Similar to the trend of viral infections in Europe, ano-genital warts occupy the largest proportion of the cumulative rates. Cases of this infection have risen from 505 in 1989 to 2886 in 1998 (13.9 per 100,000 to 79.7 per 100,000). While ano-genital warts are associated with the facilitation of HIV, it is worth reminding oneself that the rates do not distinguish between the new and recurring cases. The huge jump in rates over the nine years includes repeat episodes between years and within years. Without information on the number of new diagnoses each year, it is hard to surmise the prevalence of ano-genital warts in the population. Furthermore, the viral infection can be spread through activities other than sexual intercourse, which may not necessarily provide the means for the spread of HIV.

The second most reported STI is candidiasis or ‘thrush’. Although it can be sexually transmitted, it is remarkable that ‘thrush’ is included in the statistics. Candidiasis largely occurs in women and without sexual transmission (See Appendix). It is a sizeable proportion of the overall rates and its inclusion skews Ireland’s rates for national comparison purposes. It does however suggest popular usage of the GUM clinics for sexual health purposes. In other words, women, who traditionally would have visited the GP for this private issue, are now coming to GUM clinics instead for treatment then GUM Clinics are being viewed more and more as a norm for sexual health. With this

destigmatisation comes greater number of visits and greater likelihood of diagnoses. Non-specific genital infections – which are the most common diagnoses made in the UK GUM clinics – form the third highest category. Like ano-genital warts and chlamydia, the number of reported cases of non-specific urethritis is rising from year to year. Chlamydia has been annually increasing since 1996, previously to which it was largely stabilised. Its 1998 rate was almost double that of 1996 (646 to 364 cases). Genital herpes' rates were generally stable until 1996, since when they have been on the increase too. The lower rates of genital herpes than genital warts may be partially explained by the stigma associated with herpes that is not found with genital warts (Posner, 1998). This stigmatisation does lead to a modification of behaviours amongst genital herpes sufferers, which does lead to a limitation in the spread of the virus (Posner, 1998).

Omitting 'thrush', all the STIs depicted in Figure 4 have been consistently increasing since the mid 1990s. This is also reflected in the other STIs, such as pubic lice (70 cases in 1990 to 105 in 1998) and *molluscum contagiosum* (39 in 1990 to 84 cases in 1998). The exceptions are the very rare conditions of chancroid, *granuloma inguinale* and *lymphogranuloma venereum*, which had no reported cases for most of the decade and trichomoniasis, which fluctuates with each passing year. Such a uniform overall increase suggests that the rise might be accounted for by the growing number of attendees at clinics due to the ensuing liberalisation of sexual attitudes and the improvements done to the GUM clinic system after the HIV/AIDS pandemic.

Figure 4
The Five Most Frequently Reported STIs in Ireland from 1989 to 1998.



Conclusion:

In this chapter, we have looked at the epidemiology of STIs in Ireland and the general trends for western societies. As elsewhere in Europe, USA and Australasia, Ireland has experienced increasing rates of viral infections and chlamydia with declining trends of bacterial sexually transmitted infections. The majority of Irish cases occur within the age group of 20 to 30, a trend that is typical of other western countries. Ireland has distinctively low rates in comparison to other European countries and the USA, yet when examined in isolation the rates reveal a dramatic increase with 1999 rates being almost three times than those of 1989. The largest proportion of rates consists of ano-genital warts and candidiasis. These infections distort the rates – the former does not have any distinctions between new and recurring cases and so the combination would inevitably result in increases over time, while ‘thrush’ is most commonly transmitted by non-sexual means.

The Irish surveillance system is marred by its lack of detail, in particular geographical particulars and demographics. Until these problems are addressed, it is difficult to have confidence in the presence of any real changes or in the identification of ‘high risk’ groups or areas. What is evident is that the GUM clinic system appears to be utilised by growing numbers of individuals, facilitated by the improvements in accessibility and availability after the HIV/AIDS pandemic. Given the problems with the surveillance of STIs, could this improvement in services be the main factor behind the rises in rates? Certainly the diseases themselves are aided by behaviours, lifestyles and contraceptive practices but mindful that it is the increase in reported rates that is under investigation here, service provision and methods of reporting will have key roles to play.

Chapter 3:

Is the Irish GUM Clinic System Responsible For the Changes in National Reported Rates?

Sexual health is the Cinderella service of the NHS, seldom thought of, seldom discussed, seldom prioritised. It makes me angry that a service which is fundamental to the lives of the majority of people in Britain is neglected and disregarded.

(Anne Weyman, Chief Executive of the Family Planning Association,
Family Planning Association. 1998. *Sexual Health Agenda*:1:2:1).

Introduction:

The prevention, alleviation and control of sexually transmitted infections in a population have traditionally and continuously been the domain of a system of genitourinary medical (GUM) clinics in Ireland. These clinics have their historical roots in British venereology. Since the advent of HIV/AIDS in the mid 1980s and the subsequent changes in health services to deal with the epidemic, the improvements in Irish health services may actually be a contributing factor to the increases in the reported national rates of STIs. In Scandinavia, higher reported rates of STIs were linked to well-developed screening programmes (Sandfort et al, 1998). The high reported rates of STIs in the United Kingdom could arguably be connected to their monitoring of the infections being more accurate and more thorough than most other countries. The reported rates can then be viewed as a success of the health services in detecting the levels of sexually transmitted infections in their national population. While their system has its problems, it is nevertheless being continuously improved and this can be reflected in their better surveillance. In Ireland, the collection of data and the fact that there are only eleven GUM clinics (two clinics deal with a population of 500,000 people in the counties of Cork and Kerry) makes it hard to confidently argue that the true rates of STIs are increasing. As seen in Chapter 2, the reported rates since 1988 have tripled but how much of this actually portrays the incidences and prevalence in the population is unknown. Faults with the Irish surveillance system have had as much influence on the overall reported rates as the services' improvements since the impact of the HIV/AIDS epidemic. There is always the possibility that the reported rates may be an under-representation of the true prevalence of STIs in the Irish population. Again, it is difficult to provide evidence of this in relation to Ireland when only gross rates are reported and there is little information on the characteristics of those who are being diagnosed or presenting themselves to the clinics.

In this chapter, it is argued that the reported rates of STIs may be fabricated (or underrated) by the processing of STIs diagnosis and notifications in Ireland. STIs exist in Irish society. The prevalence and incidences of STIs are perpetuated through sexual encounters, but their increased reported rates may have more to do with the Irish surveillance system than their actual levels in society. We will examine the changes that

the GUM system underwent in the 1990s as a result of the HIV/AIDS pandemic and the emerging emphasis on sexual health. This section will be supplemented with figures obtained in person from individual GUM clinics in 1999. While growth in the accessibility and acceptability of services results in large number of attendees, inherent problems with the Irish surveillance system do comprise the reported rates' reflections of the levels of STIs in the population. Following on from this discussion, we will look at the difficulties facing the current primary preventative strategies for STIs and how they will fail to halt the increasing trends.

The Irish GUM Clinic System:

In 1916, the British Royal Commission on Venereal Diseases recommended that county and borough councils provide free and confidential treatments for patients with venereal diseases (Renton et al, 1999). This was an attempt to combat the epidemics of syphilis and gonorrhoea at the time of World War I (Johnson, 1998). In 1917, the Venereal Diseases Act was passed and 117 clinics were set up throughout the country. At the time, Ireland was subject to British rule and, adhering to the new law, the first VD clinic opened in Dublin in 1919. All clinics offered open access, free confidential services and treatment for sexually transmitted infections. Services were voluntary and self-referred. They operated – and continue to operate – as a national network, which is important for STI control. This involves local clinics co-operating, sharing information (particularly contact tracing), using common protocols and information systems (Johnson, 1998). In 1948, the Irish government introduced the Infectious Disease Regulations (reformed in 1981), under which all health authorities¹ had to provide free and confidential services for the treatment and diagnosis of sexually transmitted infections. Additionally, such services are obliged to report any cases of STIs to the chief medical officer of the district (*Infectious Disease Regulations*, 1948). This is similar to the United Kingdom, where STIs are not compulsorily notifiable under law on either an anonymous or named basis. However, GUM clinics are obliged to annually report aggregate numbers of cases seen (Renton et al, 1997).

By the turn of the 21st century, there were eleven hospital based STD clinics, two of which were in Dublin City with the remainder in major urban centres spread out along the eastern and southern coasts (i.e. in the cities of Waterford, Cork and Limerick and the town of Tralee in Co. Kerry) or in major inland towns in the south west and west of Ireland (Ennis in Co. Clare, Neenagh in Co. Galway; Castlebar in Co. Mayo and Sligo city). There are no clinics for the Midlands. None of the clinics are open full time from Monday to Friday. Clinic hours vary for each clinic from two hours a week to 13 hours. There are additional health project groups such as The Alliance in Cork city and the Gay Men's Health Project in Dublin but these deal primarily with HIV and AIDS.

¹ The Irish health services consists of eight health authorities, which were set up under the *Health Act* of 1970 and cover eight specific regions of the Republic of Ireland and a population of three million and seven hundred thousand (Cronos Database, EU, 1998). Each health authority governs the health services provided in their respective districts and all are financed by the Department of Health and Children. Previous to 1970, local authorities such as County Councils were responsible for the provision of health care.

Unlike Ireland and the United Kingdom, the rest of western Europe deals with STIs through the specialism of dermatovenereology, with only 10% of cases seen being STI related (Barlow, 1979, Goldsmith, 1992). This system results in a higher likelihood of under reporting. The USA also does not have a clinic based specialist service. Its Institute of Medicine does not recommend this particular system, although they do state that clinics dealing with sexually transmitted infections should be free and have open access (Eng & Butler, 1997). Other GUM clinic systems that are similar to the UK and Irish systems can be found in South Africa, Australia and New Zealand. The two latter countries had their systems set up after 1916 and were based on the British version. Clinics were centred mostly in main cities and national STI reported rates were collected from that period to this day. The early treatment in Australia, was inadequate. Patients averaged 10-20 visits per illness (Hart, 1999). They also had huge attendances in squalid conditions in after-normal hours, peaking at 200 on one evening in 1920 (Hart, 1999). These problems have since been rectified and while studies point out further necessary improvements, the low national reported rates and STI prevention efforts are commendable. For example, in 1995, the STD Control Branch set up an internet site to answer any questions an individual may have in relation to the spread of sexually transmitted infections. This now has over 200,000 visitors annually (Hart, 1999). New Zealand (which has a similar population to Ireland) currently has 31 sexual health or STI clinics in direct contrast with the Irish 11 clinics. However, the larger land mass of New Zealand with a more dispersed population may necessitate more clinics and, without information on where the clinics are and on the size of the populations that the clinics cater for in each region, it's difficult to ascertain whether accessibility to New Zealand STI services is better. Like Ireland, their clinics are located mainly in urban centres and most are linked to public hospitals. Other rural areas have limited or no access to sexual health clinics and again, similar to Ireland there is a large variation in opening hours of the clinics, with clinics in the larger urban centres operating for more extensive periods, including evening sessions, whereas the smaller clinics may be open only a few hours a week (Turley et al, 2000).

The Irish GUM clinic system functions in the same way as its current British counterpart. Clinics operate either a 'walk in' protocol or an appointment system. Some clinics offer both on different days - for example, the clinic in the Victoria Hospital, Cork, which also runs phone help-lines. A registration number is given to the patient upon his/her attendance at the clinic to preserve anonymity. A set of records is then drawn up for each patient on registration and to maintain their confidentiality, they are not held with general hospital records. Four stages can be identified in the majority of visits. Firstly, a sexual history would be taken (this can help the diagnosis). Secondly, the patient undergoes a physical examination of the genitals. Then cultures are taken and forwarded to the nearest laboratory. The results can return within 24 hours or 48 hours and then the treatment can be prescribed if needed. Finally, a patient may be referred to a health advisor for contact tracing or for other information. A follow up appointment may also be made. Like in Britain, the majority of patients are offered routine STI screening (Mansell & Payne, 1996). Many people do attend a general practitioner first and it is an encouraged practice that general practitioners refer their patients to the GUM clinic. This

is important not only for the recording of reported rates but general practitioners may have a low level of awareness of the asymptomatic nature of many prevalent STIs or may not properly assess a patient's risk of exposure (Wray et al, 1998). Jarvis et al (1998) found that British citizens were likely to use emergency departments for the treatment of STIs, especially during weekends and holidays. The current policy and procedures for dealing with STIs in emergency departments have not been investigated in the UK and there is no information in regard to this practice in Ireland. Jarvis et al (1998) did discover that the majority of emergency departments do refer patients to the GUM clinics. However, it is evident that some acute cases would need prompt attention and it is crucial that information on the Irish emergency departments' arrangements be gathered and distributed.

Why Have the Reported Rates in Ireland Increased in the 1990s?

The reported rates of STIs in Ireland are unduly affected by the Irish health services. Certainly 'high-risk' behaviours are involved in the production of STIs and an increase in the numbers of people indulging in the associated risk behaviours would increase spread of infection in a population. However, these changes are only partly reflected in annual reported rates. Figure 1 surmises how the reported rates of STIs are produced in Ireland. It is argued that in Ireland, a combination of the HIV/AIDS pandemic and changes in sexual morality have led to improved services, screening and prevention and in an increase in visible sexual health seeking behaviours.

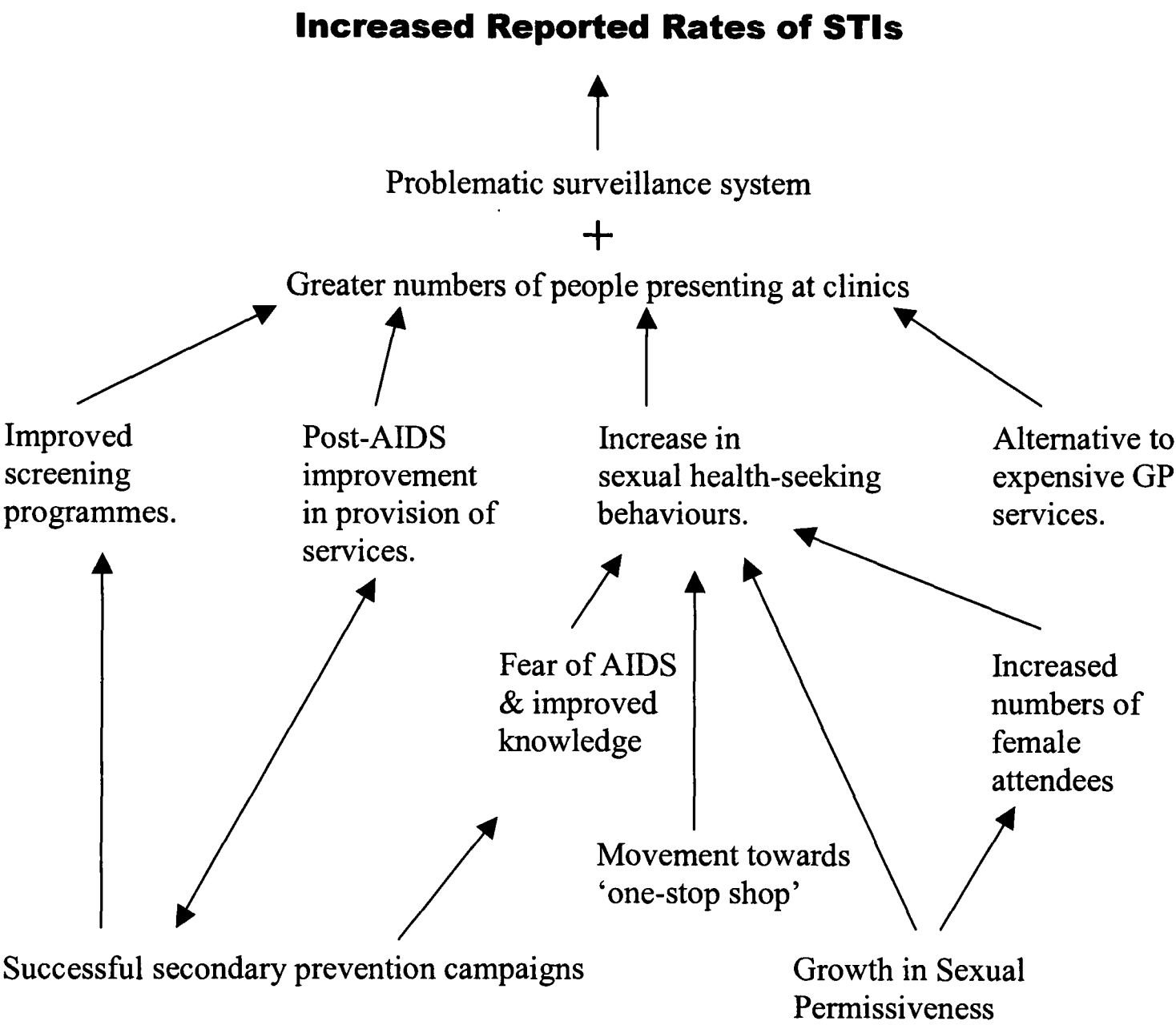
The Irish Surveillance System.

In Ireland the official reported rates are reported to the Department of Health and Children annually and consist of the returns from the GUM clinics. These rates are then published in the Department of Health and Children's publication *Health Statistics* and comprise solely of the total number of cases of STIs and the total number in each category of classified sexually transmitted infection. Additional information on risk groups pertaining to HIV/AIDS is published separately with the reported rates of HIV infection and deaths from AIDS. The GUM clinics themselves do record patients by age group and sex and some record socio-economic group and this information has been sporadically published in Health Boards' annual reports over the past decade, such as the Southern Health Board². By reporting the total number of cases, the surveillance system overlooks those patients who may either have had several episodes of at one time corresponding to separate STIs or may have had re-infections of the same STI recorded throughout the year. It is unclear just how big a proportion of the reported rates these groups of people hold. Furthermore, changes in the number of infections diagnosed in GUM clinics may be reflecting changes in the number and type of patients presenting themselves to a clinic rather than true disease prevalence (Ross & Champion, 1998). People may also attend multiple clinics within a given area, for example, Dublin. On each occasion they would be processed with a registration number and recorded in the statistics. One other problem is that duplicate reporting is also likely to occur if patients

² The Southern Health Board is responsible for the provision of health services to the counties of Cork and Kerry.

are tested in a general practice surgery and again in a GUM clinic (Hughes & Catchpole, 1998).

Figure 1
Display of how increases in the Irish reported rates of STIs are Produced.



Irish GUM clinics record consultations but with no further demographic and behavioural information, it is difficult to argue that the true rates of STIs are increasing in a population when the records are insufficiently detailed. It is possible that the rates may be endemic within certain groups without necessarily spreading throughout the population. The Irish surveillance system also makes the reported rates difficult to interpret locally which would aid preventative strategies. It ignores the complicated interaction between local behaviour patterns, local services and the quality of local surveillance systems (Johnson, 1998). This is problematic as it is difficult to assess the spread of STIs in a population, when the clinics that do the reporting are situated in urban areas. By recording just the number of episodes, clinics protect patient confidentiality but this results in insufficient epidemiological information to target disease prevention. Effective primary prevention requires an understanding of the behavioural and

demographic risk factors for the acquisition of STIs to which surveillance has the potential to make a significant contribution (Catchpole et al, 1999). The Irish surveillance system needs to be revised. If STIs are to be effectively and efficiently controlled, they require a suitable system for the recording of their epidemiology.

The United Kingdom is considered to have the most reliable and comprehensive surveillance system for recording sexually transmitted infections (Smallman-Raynor et al, 1992). This system largely consists of returns from the national network of GUM clinics (now known as KC60) to the Department of Health, which are collected in a consistent and standardised way in order to ensure quality and accuracy. In existence since 1931 and revised three times since 1970 – most recently in 1995 – the KC60 forms were introduced in 1988 to replace the previous VD(R) and SBH60 returns as the primary data set for surveillance of sexually transmitted infections. In 1999, the KC60 was reviewed again with the aim of improving its productivity and quality (Catchpole et al, 1999). Under the responsibility of the PHLS Communicable Disease Surveillance Centre (CDSC) since 1996, the compilation of data records all STIs diagnosed for many decades. Every clinic is required to report numbers of initial patients by diagnostic group on a quarterly basis and these figures are used to estimate the number of incident cases in the population (Renton et al, 1997). The data is then broken down into region of clinic attendance and sex. With the shift from disease control to sexual health by GUM services, the UK surveillance system now draws on a number of sources (Renton et al, 1997). These include KHO9 returns from GUM clinics, special prevalence surveys, laboratory reports of STIs sent to the PHLS Communicable Disease Surveillance Centre, surveillance of anti-biotic resistance of gonococcal strains by the PHLS Genitourinary Infection Reference Laboratory (GUIRL), infectious and congenital syphilis infections in blood donations by the National Blood Authority and PHLS Communicable Disease Surveillance Centre (Hughes & Catchpole, 1998).

While the KC60 returns also do not provide any information on copulation rates, they do provide some data on whether certain STIs were acquired homosexually – although, this information has been found to be highly variable and not all clinics will submit the required data (Renton et al, 1997). None of the returns from the Irish GUM clinics contain information on sexual behaviours except in relation to HIV diagnoses. Both Ireland and Britain also lack national screening policies for genital *chlamydia trachomatis* infection, unlike the USA. This needs to be reviewed and in 2001, the Southern Health Board proposed a sexual health initiative, which would include chlamydia screening (Murphy, 2001).

The Irish surveillance system does not gather enough information to map the epidemiology of STIs in Ireland. This is of concern as there is a dependency on surveillance systems for information regarding sexually transmitted infections. Statistics from GUM clinics are used to provide the main source of data on the epidemiology of STIs (Hughes et al, 1998). This is problematic as the statistics are primarily a measure of the workload within GUM clinics. Much of the geographical variations are lost in the clinic-based analysis. Many cities result in disproportionate high reported rates, when their clinics could be visited by people from a number of areas or when people visit a

number of clinics within one area. However, in the Trent and Thames regions of England and in Scotland a collection of non-aggregate anonymised person-based data has been piloted (Hughes & Catchpole, 1998; Catchpole et al, 1999). This is a form of disaggregating information containing demographic and behavioural characteristics into anonymised case reports in electronic format. Its advantages include accounting for multiple infections diagnosed at the same clinic episode and new or recurrent infections diagnosed at different times within the same clinic. Core or 'high risk' groups could be more clearly identified and the inclusion of area of residence would allow for the estimation of incidence rates at sub-regional levels (Catchpole et al, 1999).

There is a growing concern about health inequalities in sexual health between different population groups. In order to analyse these inequalities, a surveillance system that can identify ethnic and socio-economic variations is preferred (Catchpole et al, 1999). In Ireland, especially in Dublin, there has been an increase in ethnic minorities with the arrival of asylum seekers and refugees from the wars in former Yugoslavia. Although still small in population numbers, the possibility that they are seeking medical treatments in GUM clinics should not be overlooked, especially since their contribution to an increase in the overall population in specific urban areas would mean more people for the health authorities to cover. Clinical services need to be accessible, approachable and 'consumer friendly' especially for marginalized groups, for example the travelling community. Having more accurate records could help policy makers target or research why some groups may be using the services more or less than others. Some anxiety has been raised over the maintenance of patient confidentiality and the financial and logistical implications of establishing this electronic reporting system (Catchpole et al, 1999). However, it is hoped that this can provide a basis for more appropriate targeting of STI programmes (Johnson, 1998). This is something worth considering in relation to Ireland where the epidemiology of sexually transmitted infections is basically non-existent.

Britain and Ireland have some of the lowest reported rates of AIDS in Western Europe. If this is viewed as an outcome of GUM services, then STI control is being successful. National trends in STI diagnosis can also be used to provide a general indicator of the effectiveness of GUM services, although interpretation is more difficult. For example, *chlamydia trachomatis* has remained relatively constant over the past 10 years in the United Kingdom (Johnson, 1998). This could be the result of GUM services not adequately targeting the population or effective and efficient screening could have contained the disease. Changes in the structure of a health service do affect the outcomes or reported rates of sexually transmitted infections. The Overseas Development Administration (1996) has accredited the rise in national reported rates of STIs with the removal of disincentives to self-presentation for care for STIs, initiatives in staff training, improved provision of medication and enhanced reporting. Furthermore, spurious falls in reported rates have been associated with the introduction of user charges, collapse of staff morale and hence STI reporting (Overseas Development Administration, 1996).

Improved Provision of Services.

With the onset of the HIV/AIDS pandemic, interest in genitourinary medicine increased in the 1990s. Internationally, this has involved the emergence of a large number of organisations whose goal is to promote awareness, research and other issues pertaining to genitourinary medicine. In 1992, the Association for Genitourinary Medicine was set up with a nationwide regional representation and committee structure and took over many of the representational and political activities of the speciality, allowing the long established Medical Society for the Study of Venereal Disease (MSSVD) to concentrate on its teaching and training role (Thin, 2000). The International Journal for STDs & AIDS was initiated in 1990. It is now the official journal of the Association for Genitourinary Medicine (AGUM), who met for the first time in November 1993. It is also the official journal for the International Union Against the Venereal Diseases and the Treponematoses (IUVDT). This international organisation, which is also linked with WHO, changed its name to International Union Against Sexually Transmitted Infections in the mid 1990s. In 1998, within the WHO, the old Expert Advisory Panel on Venereal Diseases, Treponematoses and Neisseria Infections changed its name to Expert Advisory Panel on Sexually Transmitted Infection (WHO, 2000). Both changes reflect the attempts to eliminate the old stigma of VD by merging STIs into the holistic favourable image of sexual health. The World Health Organisation has also expanded its role in advising on methods of treatment, prevention and training for staff. In Britain, other associations involved in STD management include Genitourinary Nurses Association (GUNA) and the Society for Health Advisers in Sexually Transmitted Diseases (SHASTD) (Sutton et al, 1999).

Intriguingly, Ireland appears to be absent from these international proceedings. Unlike other EU countries, it is not a member of the International Union Against Sexually Transmitted Infections and in the ten years of the International Journal for STDs & AIDS, articles pertaining to Irish GUM services have only appeared on a few occasions. Even national journals such as the Irish Medical Journal, has relatively few submissions on the topic of sexually transmitted infections (other than HIV/AIDS). Those involved in the GUM services appear to guard their services in the same way they protect their clients' identities. Securing figures for the number of consultations per year and descriptive statistics on those who visited the clinics for this thesis proved to be a very time consuming and difficult task. There was also a reluctance to impart information on the running of the services. It can only be surmised that the directors of GUM clinics would be aware of the global changes in sexual health in the same way that the rest of the health services engage with the latest worldwide happenings in their respective fields.

The second impact of HIV on GUM services was on a national level for each country in the western world. Funding was made available for research and for services concerned with sexual behaviour and its health consequences (Renton et al, 1999). This marked a much needed change in the provision of GUM services in Ireland and Britain. Medical commentators such as Barlow (1979) had previously argued that the United Kingdom and Ireland were the only countries in the world "to have made a separate medical speciality out of the study, diagnosis and treatment of the sexually transmitted diseases and this is

reflected in a lower incidence of infection and a generally higher standard of patient care and clinic facilities than is found elsewhere” (Barlow, 1979:1). Yet, despite claims such as this, British and Irish clinics had suffered many problems.

In the UK, the old image of the ‘VD clinic’ persisted throughout the 1970s and early 1980s – under-regarded and under-funded (Fitzgerald et al, 1994). Many of the clinics were located in decaying premises, hidden in an inaccessible corner or in the basement of a hospital. The clinics were usually referred to as ‘special clinics’, which meant that the clinics were under the guise of various names, such as STD clinic, GUM clinic, even clinics with proper names, for example, Harrison Department, John Hunter Clinic. (Fitzgerald et al, 1994). As a result, the public had no familiar reference term for these services and this helped to retain STIs as a secretive subject. For the patient, this was made even more confusing with inadequate sign-posting within hospitals and no common entries in telephone directories, all of which did nothing to diminish people’s embarrassment in locating a clinic. There was little involvement of other medical specialities in STI management or research and there were few screening or case finding programmes other than among patients presenting themselves at clinics (Renton et al, 1997). Not all clinics had well developed contact tracing techniques and those that did, mostly gathered their information through voluntary referral by index cases using anonymized contact slips (Renton et al, 1999). Little sexual health education or health promotion was being targeted at the general public, although some staff in some clinics did provide lectures to children and teenagers at schools. Berridge (1996) regarded the genitourinary services as not being a “high class speciality of science...it was a ‘Cinderella speciality’ with poor facilities and second rate people working in it” (Berridge, 1996:25).

In Ireland, the Irish VD clinics (as they were then called) were considered ill-prepared and ill-equipped to deal with the HIV/AIDS epidemic. As the Dublin based genitourinary specialist, Dr. Derek Freedman, pointed out:

Our facilities for the control of sexually transmitted diseases were lamentable in the 1970s and early 1980s. They consisted of part-time clinics run by part-time personnel, poorly staffed and equipped, with no contact-tracing facilities, save that done on the patient’s own initiative

(Freedman, 1987:68).

Throughout the 1970s, there had been only one venereologist in Dublin and elsewhere the GUM clinics were staffed by part-time clinicians. There were only five clinics for the whole country during the 1970s and 1980s (Barlow, 1979). Figures of STIs were also unreliable - in 1976 not one case of STI was reported from the county of Tipperary. “It is probable that many patients are treated privately and so these cases are not notified and also that some patients may come to England for diagnosis and treatment” (Barlow, 1979:29). Even if this was the case, what can be concluded is that genitourinary services were neglected in Ireland before the onset of the HIV/AIDS epidemic.

Genitourinary medicine and its services did have its merits in the UK in the early 1980s. Most health authorities had at least one GUM clinic providing diagnostic treatment and contact tracing services (Renton et al, 1997). Moreover, the network of GUM clinics

were progressively being run by physicians with specialist training in genitourinary medicine and by trained nurses and health advisers. Genitourinary medicine's main advantage from the patient's point of view was the open access and non-judgemental services. Above all, GUM clinics stressed confidentiality, a concept which involves the responsibility of the individual for behaviour change and public education as a means of achieving it. Since genitourinary medical approaches had worked to control syphilis and gonorrhoea after World War I, GUM clinics became the primary clinical location for HIV and AIDS (Berridge, 1996).

With the onset of HIV, three national studies were undertaken in the UK to assess the practices of the GUM services. No equivalent report or study took place in Ireland, although it is probable that the Irish GUM clinics would have been influenced by the results. Commissioned by the British government, the Department of Health published *The Report of the Working Group to Examine Workloads in Genitourinary Medicine* in 1988. This became commonly known as the Monks report. The government's strategy for health, *The Health of a Nation*, followed in 1992 and it identified sexual health as a priority. Plans were made to integrate sexual health services, for example GUM clinics, obstetrics, gynaecology and family planning) and to provide sexual health education for the general public (Renton et al, 1997). The following year, genitourinary medicine received a much higher profile as a result (Mansell & Payne, 1996). That year also saw the publication of the second government commissioned study, Allen & Hogg (1993), *Work Roles and Responsibilities in GUM Clinics*. In this study, Allen & Hogg (1993) elicited information on the working conditions and roles of genitourinary medical staff in 1990, the same year when the health services were undergoing changes in organisation and local management structures (as a result of the Monks report). They recommended that research was mandatory on the views and experiences of the users of the services. Data on consumer use of Irish health services is non-existent and it is vital in order to tailor the services to suit the consumer.

The Monks Report concluded that British GUM clinics in the late 1980s were badly staffed, poorly accommodated and in dire need of additional resources. They also reported that the service was ill-equipped to deal with demands on its services. In their recommendations, they isolated three key points. Firstly, the improvement of GUM services should be made a priority. Secondly, the availability of further provisions and funding were necessary to implement the improvements and finally, the new NHS Management Board should take the lead in developing the GUM service (Berridge, 1996). In response to the report, clinics were given a new image and received funding to support the expansion of their services. Berridge (1996) viewed the initiatives as being echoes of the earlier policy schemes surrounding venereal disease services in the post war era. Certainly, this was seen in the previous chapter on Irish reported rates of sexually transmitted infections, where venereal diseases were vigilantly reported in the late 1940s and early 1950s, after the explosion of syphilis and gonorrhoea epidemics after World War II and disappeared from official reports until the late 1980s when the public's health was threatened again by another sexually transmitted infection, namely HIV/AIDS.

Since these three reports and through increased funding from government and other resources, GUM clinics in Britain have obtained better premises or been improved and staff numbers have been increased. Clinic activities were refocused to include the diagnosis, clinical management and prevention strategies for HIV and AIDS (Renton et al, 1999). Some clinics devised special services for 'high risk' groups such as prostitutes and homosexual men. Others expanded their facilities for the chronic viral infections, such as genital warts and the herpes virus, which were increasingly becoming the main component of the clinics' workload. The workforce was extended to a rate of 0.9 per 100,000 doctors (or over 250 consultants) working in the speciality in 234 clinics in England, Wales and Northern Ireland (Renton et al, 1997). The number of health advisors has risen to 300, which means that they can now spread the workload. Rather than being overburdened with counselling patients seeking HIV antibody testing and supporting those who were HIV positive like they were ten years ago, they can now spend more time on contact tracing, which is vital to STI control (Thin, 2000). While there are additional nurses, there still is some confusion over their roles. The Genito-Urinary Nurses Association report that there persists a discrepancy in the roles of nurses in GUM clinics with the specialist skills and knowledge of the qualified nurse not being utilised in many clinics (Sutton et al, 1999). Elsewhere, Johnson (1998) argues that despite the changes, GUM services still account for a small proportion of the total budget for health services and GUM rank low in order of priorities. Nevertheless, the overall impact of the services is better than before the HIV/AIDS epidemic.

Irish GUM services underwent a similar overhaul to its British counterpart. By the late 1990s in Ireland, the one venerologist had been replaced by three genitourinary specialists based in Dublin, two of whom were at same clinic at St. James's Hospital. Elsewhere, clinics were run by specialists in infectious diseases. New nursing and counselling appointments were made. Clinics expanded to eleven and this expansion would affect accessibility to treatment, as a similar growth in the establishment of clinics in the UK in the 1970s was associated with an increase in rates of attendance (Wellings et al, 1994). The clinics were also renamed STD clinics from VD clinics (they were later changed to GUM clinics in the late 1990s) and in some cases, the clinics were geographically relocated in order to dispel some of the stigma that had been attached to the VD clinic. An example of this is the relocation of the clinic from St. Finbarr's Hospital to the Victoria Hospital in Cork city. A number of clinics became involved in health education on infection in schools, namely Mater Misericordiae Hospital, St. James' Hospital (both in Dublin), Victoria Hospital in Cork, the Regional Hospitals in Waterford and Limerick and the clinic in Galway. In 1995, 50 schools in the Cork/Kerry region accommodated a HIVAIDS education programme run by a public health nurse or area medical officer. Third level institutions, prisons, family centres and youth clubs were also targeted with HIV awareness days by the GUM clinics and leaflets were widely promoted in GP practices and other public health centres.

While this section has highlighted the lack the empirical studies on GUM services in Ireland, it is suffice to say that though the services are not perfect, they are better than what they were prior to the HIV/AIDS pandemic. Growth in the number of GUM clinics and consequently of staff does make clinics more accessible. This compounded with the

fear of AIDS and increased sexual health seeking behaviours means larger number of attendees, more diagnoses and ultimately higher rates. Furthermore an interview with a genitourinary medical nurse at the Cork Clinic, December 1999 revealed that patients prefer the services of the GUM Clinic to that of their own GP because the clinics offered anonymity, quick diagnoses and non-judgemental staff. Patients are then more likely to return and would encourage other friends and acquaintances to attend.

Changes in Sexual Health Seeking Behaviour.

Some STIs, such as chlamydia and gonorrhoea, generally present themselves in an asymptomatic form in women. The infections can then remain undetected for a long period of time, thus enabling the infections to further spread through a population. While the prevalence and incidences would subsequently be increased, the reported rates would only reflect this rise if infected individuals presented themselves at clinics. When looking at diseases such as STIs, it is important to recognise the effects that health behaviours and knowledge can have on the surveillance of the diseases in a population. Not only would ignorance of the infections and reluctance to seek treatment affect the accuracy of reported rates and sustain the prevalence of the infections in the population, in addition, increased awareness would augment the numbers of people attending clinics. When reported rates are seen to increase, a proportion of the rates will be due to changes in people's health seeking behaviours.

The total number of patients attending GUM clinics in Ireland has grown throughout the 1990s. While the proportion of new patients varies from clinic to clinic, the absolute number of new consultations is rising. The GUM clinic in Cork, for example, experienced a decrease from 61% of consultations being new in 1990 to 26% in 1997. However, the actual figure of 1997 was 888 people a figure that is almost three times that of the 1990 number, 347 patients. The overall number of people attending clinics has risen tremendously. In 2000, a total of 5,068 people attended the clinic compared to 1990's 909 attendees (Hickey, 2001). Of these cases, 1230 were new patients, while 1990 had 347 (Southern Health Board, 2001). In Dublin, St. James's Hospital, in conjunction with the Gay Men's Health Project, views over 25,000 new patients a year (Hopkins et al, 2001). Similar experiences can be seen in the clinics of Galway and Mayo. While the proportion of new cases is stable at around 35%, the absolute numbers have increased from 402 in 1995 to 572 in 1999. During 1998, the overall total of people seen at the clinic was 1,847 (Donnellan, 1999). While not all of these cases were diagnosed, the statistics reveal that the number of people who consider themselves at risk of possessing a sexually transmitted infection, has risen. This could be a result of a greater number of people indulging in 'high risk' behaviour or it is more likely to be due to more people deciding to attend a GUM clinic.

The late 20th century saw a growth in emphasis on sexual health in the western world. This partly due to the rise in importance of health seeking behaviours (Shilling, 1993) and the medicalisation of previous psycho-sexual problems in the last twenty years of the century (Fee, 1993). With the set up of the national health services in UK and Ireland after World War II, the public health approaches underlining these health services,

viewed illness as being morally accountable (Pill & Stott, 1986). In relation to STIs, these approaches resulted in a repositioning of STIs (VD) from being punishments for deviant behaviours to the individual being morally irresponsible for not seeking medical help when infected or for not using preventive methods. By the mid 1980s, many individuals were resorting to health professionals for help with sexual matters, despite the instruction of sexology being neglected in medical schools throughout Europe (Landsfelt & Porter, 1986). Medical schools and schools of public health had begun conducting a significant proportion of AIDS-related research in sexuality. This denoted the expansion of medical interest in sexuality to new areas beyond the traditional confined specialities of gynaecology, obstetrics and sexually transmitted infections (Aggleton & Parker, 1999). Family planning had also grown into a respectable medical activity (Barrett & Harper, 2000). By the 1990s, individuals were confronted with the need to self-monitor their sexual health as a vital part of their sexual careers. This is compounded by the overall trend in western countries in late 20th century to maintain and improve the body through diet, exercise and the adaptation of 'healthier' lifestyles. It was now the individual's responsibility to take care of his or her sexual health as well as the general health of their bodies. People were encouraged to present themselves at clinics. Sex is a point of connection between individuals and in order for western states to maintain healthy populations individuals need to install sexually healthy lifestyle choices.

The main driving force behind the change in sexual health seeking behaviours in Ireland was the impact of the AIDS epidemic in the mid 1980s. Throughout western societies, the HIV/AIDS pandemic was constructed as a consequence of certain 'lifestyle' choices in public health approaches (Gabe, 1995). This emphasised the individual's responsibility to his or her health (Fife & Wright, 2000). In the late 1980s, extensive media coverage of the HIV/AIDS pandemic prompted a rise in attendance at Irish GUM clinics. These patients, known as the 'worried well', largely tested negative for HIV but many of them were diagnosed with STIs, thus augmenting the reported rates (Freedman 1987). While the initial panic of HIV had subsided by the 1990s, the Irish health services had begun to promote HIV awareness and the Irish media were recruited to help educate the public about HIV and other sexually transmitted infections. Articles in the local press help to publicise the services of GUM clinics and to increase knowledge of STIs among the public (Fitzgerald et al, 1994). This can lead to problems of ascertainment bias in judging the reported rates and incidence of sexually transmitted infections. For example, the increase in chlamydia screening in United Kingdom in the latter years of the 1990s, was attributed to the attention the lay and medical press had given to chlamydial infections (Adler, 1997). Along with the health services' efforts to promote awareness of STIs and to improve the provision of services, the appearance of STIs on the pages of the Irish press brings knowledge about the infections into people's homes. Previous to the HIV/AIDS pandemic, STIs were largely absent from the media. This was probably due to the lingering effects of the prohibition of publishing information about venereal diseases in the 1920s. Increased availability of information combined with the western trend of body maintenance means that Irish individuals are more likely to come forward for diagnosis.

People are more aware of the importance of looking after their sexual health (O'Doherty, 1998). Less stigmatisation of the clinics and greater awareness of body health results in people being more willing to try professional help at the clinics. The combination of STIs with other issues of sexual health in one clinic helps dissolve the embarrassment that some potential patients feel towards having a possible sexually transmitted infection. As Alder (1995) has argued, "the knowledge that many patients seen in clinics do not have a sexually transmitted disease has helped to reduce the stigma attached to clinics" (Alder, 1995:3). Large urban centres also help the feeling of anonymity, psychologically aiding the attendee from 'being seen by the neighbours'. Additionally, general practitioners are practising more referrals of patients to the clinics and improved contact tracing techniques. In the clinics of Galway and Mayo, 30% of attendance were GP referrals, whilst in 1995, the GP referrals accounted for 21.6% of all cases for the Cork clinic. General practitioners are often cited as the most common source of finding out about GUM clinics (McClean & Reid, 1997).

The climate of sexual permissiveness in a country also influences sexual health seeking behaviours. During the 'sexual revolution' of the 1960s and 1970s, sexually transmitted infections in the USA and in the UK were regarded almost as an occupational risk (Paalman, 1993). People frequented clinics to cure their infections quickly, efficiently and without too much interference to their sexual lifestyles. In Britain, hospital admissions generally increased by 43%, during which, the VD reported rates went up 34% on the previous decade. This increased attendance at VD clinics indicated a greater willingness to seek advice from the specialised service (Weeks, 1989). It is very possible that the recent growth in sexual permissiveness in Ireland has aided the readiness of individuals to present themselves at clinics during the 1990s. Evidence of this can be found in the increase in absolute numbers of women attending. At the start of the 1990s, the majority of cases were male but by 1996, both sexes were equally likely to attend. In the Cork clinic, women now account for over 60% of total cases seen, as opposed to just 30% in 1990. Although, women are usually more committed to health maintenance, in relation to STIs, men have traditionally been more likely to seek care from GUM clinics (Schofield et al, 2000; Lewis et al, 1999; Leeson & Gray, 1978). This can be partially explained by the connection of STIs with sexual promiscuity. Women were more likely to view an infection as a negative event and did not wish to be judged (Lewis et al, 1999). Stigmatising an illness does lead to a resistance to seek medical treatment so women used self-medication or visited their general practitioner (Leary & Schreindorfer, 1998).

The increase in female cases has augmented reported rates. Furthermore, it is worth bearing in mind that a large proportion of reported rates consists of 'thrush', which women more commonly suffer from than men. The fact that women are now using the clinics to report this condition is indicative of more Irish people using the GUM clinics as a 'one stop' service for their sexual health. The vast majority of cases are self-referral – 48% in the Cork Clinic for 1995 – so people are voluntarily being treated in a public clinic as opposed to the privacy of the GP. This raises an important point. The Irish health system is a combination of public health services, health insurance and private hospitals and GP practices. Since the GUM clinics are offering free efficient services and

in a country where access to free medical services is limited, this is attractive alternative to the commonly expensive family doctor. The service is also confidential and non-judgemental, which can encourage those who are not comfortable discussing sexual problems within the personal surroundings of their own doctor's surgery.

Throughout Europe in the 1990s, there has been a movement towards making GUM clinics or dermatovenereology departments a 'one stop' service. For fifty years, STI programmes had been carried out on a 'quickly in and quickly out' basis. The approach was simply one of diagnosis and treatment and doctors rarely inquired about a patient's sexual behaviour (Fowler, 1997). Over the last ten years of the 20th century, a new generation of younger, well-educated clients have demanded respect for and an acceptance of their lifestyle (Ekeid, 1992). This has led people to want the convenience of addressing their sexual health under one roof (Goldsmith, 1992). In Australia, STD clinics are increasingly used for matters other than sexually transmitted infections. In 1999, about 43% of males and 45% of females who presented themselves at the Adelaide Hospital had no illness or symptoms of infection (www.stdservices.on.net, 2001). They were in attendance for other reasons. Even self-referred virgins have presented themselves with concerns about the 'normality' of their genitals, while others had non-STI genital symptoms (Bodsworth et al, 1993). British GUM clinics also have a high proportion of people who attend the clinics that do not have an infectious condition (Renton et al, 1997). They may be merely having a check up or may have a psycho-sexual problem. According to Adler (1995), about 18% of consultations in the United Kingdom just want check ups, advice or counselling. Moreover, in a study on first users of GUM services in the UK, most service users although nervous about using them, regarded the clinics not only as centres for treatment of STIs but also for care of other sexual health problems (McClean & Reid, 1997).

The advancement towards the GUM clinic as a sexual health clinic should be viewed as being ultimately beneficial for the reproductive or sexual health of a population. Firstly, fertility and sexually transmitted infections are linked. The use of barrier and spermicidal contraception are effectual against the spread of sexually transmitted infections and against unwanted pregnancies. Secondly, infections do have implications for fertility. People who are risk from sexually transmitted infections are also at risk from pregnancy. By having a 'one stop' shop, it would be easier to monitor and control sexually transmitted infections because a larger proportion of the population would be attracted to the premises in order to attend other sexual health services. Indeed, this is just what the Institute of Medicine (USA) has advocated. They have stated that services for sexually transmitted infections would be more effective if they were integrated into primary care and reproductive health services, similar to the systems being used in developing countries (Eng & Butler, 1997). Furthermore, one of the advantages of a 'one stop' service, is that clients can be provided with co-ordinated sexual health care and this could include counselling in all areas of sexual health (Kane & Wellings, 1999).

Successful Secondary Prevention Campaigns.

Ireland established and successfully implemented a national strategy for the distribution of information regarding HIV/AIDS. In recent years, directors of GUM clinics have contributed to media articles on the rise of cases being seen and diagnosed and health advisors have visited schools, youth clubs, universities and workplaces to increase awareness about sexually transmitted infections. A sexual health campaign targeting gay communities was also devised and implemented in 2001 (Hopkins et al, 2001). Although there is yet to be a national programme for the promotion of sexual health including sexually transmitted infections, Health Boards had begun drafting proposals in 2000 to develop sexual health promotion in their areas and the rising reported rates have placed sexually transmitted infections firmly on the agenda. One of the health authorities, the Southern Health Board issued a ten-year sexual health strategy in 2001 (Southern Health Board, 2001). The reduction of the incidences of STIs is targeted but whether the aims will be implemented remains to be seen, particularly since there is an obvious lack of evidence-based studies on Irish 'high risk' groups and no representative sample of Irish sexual behaviours since the ISSP survey in 1994. One of the reasons behind the proposal was the apparent drop in age at first sexual intercourse (Murphy, 2001). No longitudinal data exists to support this assumption. Furthermore, the strategy was not formulated using a systematic review of evidence in the area. It does not base its arguments on the interventions either successfully or unsuccessfully utilised within sexual health nor does it reflect upon the current operation of sexual health services. While the board should be applauded for attempting to tackle issues of sexual health, future strategies need to review the Irish surveillance system, the provision of genitourinary medicine and they do need to address the usage of primary preventative strategies.

In relation to sexually transmitted infections, there are two forms of prevention – primary and secondary. The former involves health promotion and health education and aims to prevent future cases of sexually transmitted infections. Secondary prevention entails educating the public about what to do when they suspect that they have an STI (Paalman, 1993). This is usually carried out by the GUM clinics where there is an emphasis on teaching people the importance of complying with the treatment, contact tracing and follow up appointments. In Ireland, secondary prevention is the main component of current STIs preventive measures. Its success can be argued to have resulted in higher numbers of attendees through the education of people on where to go for treatment.

Reliance on this form of prevention is risky simply because co-operation is voluntary (Paalman, 1993). As Hopkins et al (1994) have pointed out, contact tracing has been shown to be an ineffective method of control. In their study on patients with syphilis at St. James's Hospital, Dublin, out of 700 sexual partners identified with syphilis, only 103 came forward for treatment. Indeed, throughout the Irish clinics, contact tracing contributed less than 10% of the total number of cases treated. Another drawback with secondary prevention, is that despite investigating the sequelae of STIs, doctors rarely inquire about a patient's sexual behaviour (Fowler, 1997). Since the spread of STIs depends upon the sexual behaviour of individuals, the inspection of the sexual interactions of those diagnosed with an infection or those who believe they have been

exposed to an infection, is essential to the combat of infections in the population. In England, reported rates of acute STIs are increasing in 'high risk' groups, despite the targeting of 'high risk' groups in sexual health education and intervention programmes (Hughes et al, 1998). Although it would increase the workload of the medical professional and is not favourable to the 'diagnosis and cure' basis of westernised medicine, the use of communication about sexual behaviours and the acquisition of STIs on a personal level could be conducive to the prevention of sexually transmitted infections. Targeting those at risk not only requires preventative campaigns at a policy and a general public level, intervention also needs to occur through the 'gate keepers'. Another example of this is the use of on-site screening and serological tests. In Dublin, a programme for on-site testing for syphilis was successfully implemented in June 2001. This has helped to identify more cases (Hopkins et al, 2001). It should be recognised that while the GUM clinic system is largely based on the biomedical model of health, it does have a huge contribution to make to the control of sexually transmitted infections. Effective treatment not only benefits those affected by the disease, but also reduces the number of persons who spread the infection (McKeown, 1979).

Problems with Preventing the Spread of STIs in Ireland:

Primary prevention largely consists of encouraging people to avoid sexual exposure to infections by using latex condoms during sexual intercourse or to change their sexual lifestyles. The use of health promotion in relation to sexually transmitted infections is marred by three main dilemmas. Firstly, while people are at risk from acquiring an STI, the majority of a population will never be exposed to one. It is difficult to influence sexual behaviour when people view STIs as happening to other people rather than themselves (Barlow, 1979). It also means that health promotion campaigns may be viewed as not being cost-effective (Paalman, 1993). Sexually transmitted infections do already cost a state a substantial amount in treatments. However, these costs can be reduced through the preventive strategies, which ultimately are less expensive despite the effort and money needed to implement them in the first place. In terms of disease control, it is necessary to target 'high risk' groups and adolescents should also be reached to prevent infection in a future generation (Paalman, 1993). 'High risk' groups are often ill informed on STIs despite presenting themselves at clinics for treatment (Kellock et al, 1999). Secondly, sexual health promotion and HIV prevention rely on the psychological dimension of behaviour change (Erben, 1992). Because sexual behaviour is viewed as a private matter between individuals, promoting good sexual health is difficult. The freedom to choose one's partner or sexual lifestyle has to be respected. There are also people who are aware of the risk and know how to reduce these risks yet do not take action accordingly. Intervening factors of contraceptive practices and role relations in sexual partnerships also impede behavioural change.

Thirdly, attempts to increase awareness of STIs and to evoke changes in attitudes and behaviours to improve sexual health are affected by the taboo nature of sexuality (Paalman, 1993). Health information and mass media campaigns are at risk from moral debates on sensitive issues such as adolescent sexuality, drug addiction and prostitution and renewed prejudice against historically marginalized groups like ethnic minorities and

homosexuals. Despite the public forums on HIV/AIDS, some sectors of westernised societies are reluctant to openly confront issues regarding sexuality and STDs. This “failure to acknowledge and discuss sexuality impedes STD education programs, open communication between parents and their children and between sex partners, balanced messages from mass media, education and counselling activities of clinicians, community activism for STDs, and behavioral research” (Eng & Butler, 1997). Primary prevention of STIs needs an open discussion of and access to information on sexual behaviours, their health consequences and methods to avoid sexually transmitted infections.

Since the advent of HIV epidemic, primary prevention of STIs has been solely controlled by the GUM clinic system (Johnson, 1998). In Ireland, this has resulted in more emphasis on secondary prevention than on primary. Primary prevention needs co-operation between schools, health services, employers, voluntary organisations, parents and the media (Erben, 1992). In Ireland, attempts have been made to improve sex education in schools. One of the reasons given for the increase in venereal diseases in the 1960s was ignorance of the subject (McGuffin, 1977). By educating school children about sexual health, a generation, who has the potential to change the current lack of sex education, can be produced (Thin, 2000). Peer education is considered to be the most effective, especially under the guidance of medical and educational staff. (Mellanby et al, 1995; Thin, 2000). Here professionals educate opinion farmers among the public who in turn educate their peers. While this system has been piloted in the United Kingdom, the Irish government designed and implemented a programme that involves teachers relating information to children. The Irish Minister for Education launched the new sex and relationship programme for both primary and secondary schools in April 1997. This was immediately implemented, although it is uncertain how many schools are currently executing the programme.

A Roman Catholic version by the Catholic Bishops’ Commission for Catechetics was also developed in response to the state version and Irish schools are free to decide between the two programmes. Both programmes are actually quite similar. Both stress that a school’s role in educating children about sex is secondary to that of parents. This is problematic given that in the past, it has been shown that many parents find it difficult to discuss sexual matters and often were unable to give accurate facts, especially about sexually transmitted infections (McGuffin, 1977). Given that Catholic schools are expected to uphold the Church’s view on sex, marriage and reproduction and that it’s up to the discretion of the school to implement what they want from the Department’s guidelines, it is very likely that children will end up with varying levels of information. This could prove to be a determinant in the promotion of responsible sexual behaviour among the younger generations.

Conclusion:

As Adler (1995) pointed out, the improved services offered by GUM clinics have attracted more people seeking treatment who may not have previously done so. Just how much of the subsequent increase in the number of reported cases reflects a true trend is unknown. What we can determine is that reported national rates of Ireland do largely

owe their rise to the increased numbers of attendees at GUM clinics, a result of improved accessibility and efficiency of services and effective secondary prevention campaigns. Furthermore, the compilation of statistics without demographic or epidemiological detail does distort the overall picture of sexually transmitted infections. The Irish GUM clinic and surveillance systems are embellished with numerous problems that require further investigation and rectification. These problems need to be addressed if more effective and efficient measures of STIs are to be obtained. Nevertheless, it is apparent that the structure and functions of the Irish GUM clinics have a direct impact on the reported rates.

Given that the reported rates are influenced by the Irish health services, it is difficult to argue that the rise in these rates is indicative of an increased proportion of the population engaging in 'high risk' behaviour. Assertions about sexual behaviours can only really be made through surveys on sexual behaviours. Additionally, STIs tell us more about public attitudes to sexuality than actual sexual behaviours. Reported rates of STIs increased within the same period that sexual politics underwent huge changes. Undoubtedly, the changes in public attitudes would have an effect on the reported rates but not in the manner of a liberalisation of attitudes resulting in a laxity of 'moral' sexual behaviours. Changes in the public sphere of sexual morality can lead to public acceptance of certain sexual behaviours, which makes these behaviours more visible. Furthermore, they help to destigmatise GUM clinics and lead to increased numbers of attendees. Reported rates of STIs may be used as evidence of growing sexual deviance in Ireland but these rates are more a reflection of the growth in sexual permissiveness in Ireland during the 1990s. People are more comfortable to come forward for treatment at public clinics than in previous generations. Given this premise, we would expect the numbers at clinics to continue to increase in the near future before eventually stabilising.

Despite not knowing the true levels of STIs in the Irish population, primary preventative measures should still be installed. Preventing STIs requires the adaptation of sexual behaviours but referring to the reported rates of STIs in order to raise public concern and awareness is very problematic. This is because the perception of the rate of infections are closely linked to public panics about sexuality. In order to aid production of effective preventive measures and to retard the increase in reported rates, the entanglement of STIs with sexual morality should be investigated. A socio-historical account of STIs can reveal why primary prevention measures fail to impede the spread of sexually transmitting infections.

Chapter 4: Lessons From the Past: How Sexual Morality Impedes Preventative Strategies for Sexually Transmitted Infections.

Foucault argues that contrary to popular belief, sexuality was not repressed in the Victorian era and gradually reawakened in the twentieth century era of permissiveness because there is no essential human quality or drive to sexuality that can be repressed at one point in history and liberated in another.

(Rossi, 1994:5).

Introduction:

At the turn of the 20th century, social fears about the ‘the great scourge’ (syphilis and gonorrhoea) escalated into a moral panic that syphilis was at the root of all diseases, including hereditary ones that affected lineage. At the forefront were the medical practitioners engaging in public forums and devoting two major international congresses in 1899 and 1902 to venereal diseases. Preserving oneself from VD became the mark of the good citizen who took personal responsibility for his own sexual health and that of the nation. It is a situation that draws parallels with the closure of the 20th century, a time of the HIV/AIDS pandemic, international organisations on STIs and prominent medical voices in the popular media on sexual problems, including teenage pregnancies and impotency. Both syphilis and HIV/AIDS put strain on public tolerance of sexualities throughout western societies. In both situations, science was unable to control the sexually transmitted disease and this just fuelled anxiety about the moral codes of sexual conduct. In Britain, HIV/AIDS was the disease of the marginal, the promiscuous and created a fear that western society had become too permissive (Weeks, 1989). Syphilis was seen as the result of a society that had become too urbanised and secularised, a time of change for female sexuality and rights and the identification of the homosexual. Sexually transmitted infections are and have always been the grounds on which contentions about sexual issues are battled out.

When attempting to explain changes in the incidences and prevalence of sexually transmitted infections in a society, it is essential to take into account their social construction. Arguably, no other group of diseases have been so historically fraught with societal perceptions and social control. Since the syphilis epidemic of the late 15th century, STIs have encompassed social attitudes and values, not just on sexuality but also on race, class, gender and youth. The use of STIs is similar to that of teenage pregnancy, which is also regularly used as a channel for social anxieties about poverty, ethnicity, births outside marriage, religion, gender and parenting. Currently, the blame for the spread of STIs in Ireland falls on the promiscuous single twenty-something, the homosexual, the prostitute and the carefree adolescent. Divisions persist between public health and treatment resulting in limited facilities but prominent medico-moral messages in newspaper articles. This situation is not peculiar to Ireland. Not only is it relevant to other western countries during the same time frame, it is indicative of the continuing social history of sexually transmitted

infections. The presence of STIs can tell us more about sexual attitudes than about actual sexual practices. Since the 19th century, STIs have been used as symbols of a society being corrupted by industrialisation, urbanisation and secularisation. They are signs of a decaying social order and punishment for the sexual irresponsibility. Through their social construction, they express the social fears about sexuality, class, ethnicity and the family. They are moulded into being the evidence of the fears that are superimposed on them.

This chapter focuses on the history of sexually transmitted infections in Europe and the USA as a means to reveal the social influences, which have been exerted on their causes and control. Such a process draws attention to some of the continuities and changes that have affected the depiction of STIs, their carriers and policies. Through a discussion of the historiography of venereal disease and venereology from 18th century to 21st century, interactions between sex, medicine and morality will be exposed. Medical discourse¹ can be viewed as the legitimating of medical power and practice in a society (Turner, 1995). This has implications for the explanations of the presence of STIs in a society. In particular, the infusion of morality with medical discourse provides the background to the current profile of STIs in Irish society. Ireland was part of the British Empire until 1922 and consequently was subjected to the same reforms and control measures as elsewhere in the British Isles. These measures also formed the basis of the current GUM system in Ireland and therefore, current provisions of services and prevention strategies inherit a history of medico-moral efforts. While viral infections and HIV/AIDS are not the same as the syphilis epidemics of the past, they will be moulded by contemporary science, politics and culture (Brandt, 2000). Moreover, the history of STIs can be an essential tool in establishing approaches. For example, the history of VD has shown that health education, compulsory public health measures (e.g.: Contagious Diseases Acts) and the application of cures do not eliminate the diseases (Brandt, 2000). Identification of the history of STIs and the attitudes that shaped them is therefore necessary in order to recognise new and more effective ways of combating the infections.

The Socio-historical Diseases:

Sexually transmitted infections are quintessentially the social historical diseases. They are the diseases with a history and the diseases in history. Originally, they comprised of just syphilis and gonorrhoea with 'soft chancre' added at the end of the 19th century. However, the historical narrative and social construction of syphilis provides the template for the all the sexually transmitted infections. Syphilis provides a link throughout the ages. It has won battles for the Spaniards against the French in Italy, took over from 'The Plague' and leprosy as *the* epidemic, killed kings and maddened philosophers (Taithe, 2001). Irrespective of time or place, STIs have engaged public opinion, medical appraisal and moral judgements. Their story comprises more than just their own history. It is a mapping of social changes and continuities in shaping and articulating perceptions of sexuality. Sexually transmitted infections reflect and reinforce society's beliefs and fears about class, ethnicity and the family (Davidson & Hall, 2001). Sexuality, in turn, can be regarded as a social and historical construct. As Foucault argued, "Sexuality must not be thought of as a

¹ Drawing on Foucault, the term 'discourse' is taken here to mean the organisation of social relationships into conceptual frameworks, which produce the regulations and social norms for a society (Foucault, 1989).

kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover. It is the name that can be given to a historical construct" (Foucault, 1979:105). While the social historian, Jeffrey Weeks (2000; 1989) has reservations about some of Foucault's arguments, he nevertheless agrees that when chronicling sexuality throughout different periods and cultures, sexual theorists must not assume that sexuality is an unchanging biological and psychological given. Instead it needs to be viewed as the product of "diverse social practices that give meaning to human activities, of social definitions and self definitions, of struggles between those who have the power to define, and those who resist" (Weeks, 2000:129). Homosexuality is an example of a social construct. The idea of a homosexual person and an associated homosexual identity has only been in existence for 300 years in western societies (Weeks, 2000).

Medical knowledge does not just arise out of objective and empirical scientific progress, it is socially negotiated (Hyde, 2000). According to the socio-constructionist perspective, the rise of the physician occurred with modern society, which emphasised medical discourse as the language of the powerful (Turner, 1995). Stress was placed on the rational rather than the religious. Medicine did, to a certain extent, replace traditional institutions of law and religion as the main form of population control in western societies (Turner, 1995). Bodies were thus regulated through the medicalisation of sexuality (Aggleton & Parker, 1999). Because of Foucault's work on the history of sexuality in relation to medical institutions, the construct of 'disease' can be viewed as the product of medical discourse, which reflects the dominant mode of thinking (Turner, 1995). Thus, diseases are not regarded as natural events. Instead, their descriptions are used to identify social deviance. The language of the rational and the scientific method enforces social categorising, which had previously been done through religious discourse. For example, racial and female subordinations had to be substantiated and since moral and common beliefs were not enough, scientific rationale was used to 'prove' the governing ethos. As a result, moral tones were incorporated in medical discourse and were rationalised with scientific evidence.

There are a number of flaws in the social-constructionist method, as devised by Foucault, that need to be addressed when looking at the history and construction of VD and sexuality. As Weeks (2000) points out the role of the state as an actor is ignored in Foucault's studies. Combining with either the churches or the medical profession, the state has played a vital role in the construction of attitudes to sexuality through marriage laws, regulation of deviance, judiciary, police and welfare system (Weeks, 2000; Weeks, 1989). Venereal diseases are also the history of governments' responses to perceived threats of inappropriate forms of sexual and gender behaviour to public health (Davidson & Hall, 2001). Secondly, Foucault's approach to sexuality is limited when it comes to analysing the practice of sexuality as a social interactive process. Inglis (1997) argued that sexuality is a social interactive process because actors (individuals) embody, manipulate and change discourses. In other words, sexuality is not merely a constructed means of regulation that is enforced on a population. It is actively maintained and affected by the members of that population. Individuals are continually interacting and engaging with sexuality pertaining to their own sexual interests and its relationship to their other social interests, for example status and respectability. As a result, individuals can change the discourse on sexuality. This is certainly the case with the changes Irish society was undergone in

relation to sexuality in the last decade of the 20th century. Another constraint with the social-constructionist approach is the lack of references to reproductive sex (Rossi, 1994). Sexual behaviours are fuelled by both biological and social factors and so expression of sexuality will include both reproductive and recreational sexual behaviours. Finally, Turner (1995) maintains that Foucault's theory on sexuality and medical discourse fails to account for the unintended consequences of action and that not all aspects of modern medicine were involved in the surveillance of populations. Whilst engaging in a form of social-constructionist perspective on venereal disease, this socio-historical analysis of Irish sexuality and VD will draw on a number of social historians, such as Jeffrey Weeks, rather relying solely on Foucault.

Looking at the historical narratives and processes can reveal much about how beliefs about health, sex and morality are connected. According to Mort (2000), history writing can help to understand the reasons why current dilemmas pertaining to STIs have arisen. The present can be thus seen as historical, a continuation of a process. It is "the product of a particular combination of structural forces" (Mort, 2000:2). The history of STIs – including that of venereology – is intrinsically linked with both medical history and medical discourse. In relation to their place in medical historical writing, diseases in general were established in the 1850s as agents or actors of history by the neo-vitalists (Taithe, 2001). Scientific medicine had been criticised for ignoring the exegesis of medical knowledge in favour of its new methods of organising knowledge (Taithe, 2001). Viewing diseases as agents of history was deemed the only way to counter the rise of scientific medicine. As history became an eminent form of a narrative of modernity in the 19th century, the history of STIs was intertwined and attracted attention as the exemplary historical diseases. They offered historians the opportunity to look at the body and sexual moralities and they gave pathologists evidence of the permanence of their knowledge of syphilis (Taithe, 2001).

Late 19th century saw the physician being elevated to a position of authority. In France, in 1892, physicians got their professional status and ten years later, the Public Health Law acknowledged the importance of their role for society as a whole. Medical professionals had moved in the public eye from being viewed as the figures that brought death to being the experts on all issues pertaining to health and the body (Herzlich & Pierret, 1987). Despite no single agency being responsible for sexuality – family, popular culture, public institutions etc. all exert an influence – discussions on VD in the 19th century, firmly took place within the realm of medicine rather than between professionals and laypeople (Brandt, 1987). Medicine had played a role in the control of infectious diseases, along with rising standards of living, sanitation and natural changes in the host-parasite relationship. However, the same success eluded sexually transmitted infections. From the increasingly perceived inefficacy of medical regulation to the rise of antibiotic-resistance, VD has revealed the limitations of medical power over patterns of sexual behaviour (Davidson & Hall, 2001). Brandt (1987) maintains this is because medical discourse on VD engaged with certain social attitudes and beliefs about its causes and consequences and it affected the responses to the problem.

Syphilis was central in the shift from religious beliefs about illness and sin to scientific explanations that are fraught with moral values. When the notion of illness supplanted sin, it took on some of its moral connotations (Herzlich & Pierret, 1987).

As the 19th century progressed, illness ceased to be viewed as the result of sin but became an organic disorder that was fraught with moral values. Syphilis moved from being a crime against health to a sexual deviance from the social norm (Herzlich & Pierret, 1987). This was because it was closely linked to the modernisation of society, to increased trade and urbanisation and to the decline in rural community values (Engelstein, 1987). Venereal disease was no longer seen as a punishment from God but a punishment from society. The syphilitic was contaminated because he went against the norm. As a result, venereal disease has been associated with corrupt sexualities or a social order being polluted by liberalisation. Notions of dirt prevailed – hence, title of ‘social hygiene’ for the 19th century VD control programme - and even today an association of dirt and disease persists in relation to sexually transmitted infections (Brandt, 1987). This reflects the argument by Canguihem (1978) that the medical categories of the pathological and normal were not objective scientific concepts but were intertwined with political, economic and other social forces. Medical practitioners routinely gathered statistics in order to provide evidence of the ‘great scourge’ that was threatening humans. From these, they could also identify the ‘high risk’ groups. At that point it was the prostitute and the working class woman, but as time progressed the categories grew to include the single sexually active woman, the adolescent, the homosexual and the ‘other’ race. These categories persist today and remain the focus of sexual health campaigns.

The Historiography of Venereal Disease:

Venereal diseases - in particular syphilis in its guise of venereal disease - have produced a considerable historiography for the past 30 years, which has also contributed vastly to the intellectual framework of the history of medicine (Davidson & Hall, 2001; Taithe, 2001). When looking at the history of the diseases, one is reminded that the art of history writing is itself a social process. Firstly, historical knowledge and materials reflect subjective viewpoints as well as historical facts. Henry Mayhew, a prolific writer on syphilis in the 19th century tended to make broad generalisations and often contradicted himself within a few pages (Taithe, 2001). Furthermore only certain historical voices are represented as access to platforms is restricted. Secondly, the compilation and archiving of historical knowledge is also affected by how the historian gathers and collates the information. Personal assessments are made on the quality of historical knowledge, the availability of materials and more importantly, on how the information is to be utilised. Historians do operate within various theoretical frameworks. For example, many social historians use Foucault’s theory on language and discourse as forms of historical knowledge – that is, they look at the linguistic and semiotic meanings and how language of resistance is constructed. Historians may also examine the past with their preoccupations with the present. In other words, they bring to their study an agenda of pre-selected notions. This, of course, has repercussions for the work produced and indeed, the social history of VD is fragmented, clustered around certain topics.

Despite the quantity of work produced, the social history of VD tends to focus on three main periods – the debates surrounding the regulation of prostitution in European societies in the mid to late 19th century; VD controls in the military and civilian population during the First World War; the creation of GUM services in Britain and their development since the onset of the HIV/AIDS pandemic. The last two periods also include discussions on the use of condoms as a means of

documenting the shifting moral and medical assumptions surrounding sexual politics (Davidson & Hall, 2001). Emphasis on these three subject matters have lent themselves to a misconception that after the regulation of 19th century prostitution, First World War and HIV/AIDS were ad hoc crises, between which societies had endured periods of adherence to moral codes of sexual conduct. Furthermore, the World Wars and HIV/AIDS, in the history of medical treatments, are post-salvarsan and post-penicillin, thus giving the impression of VD being medically controlled. It can be safely assumed that these periods endured similar prevalence and incidences of STIs and the apparent silences are just miscast shadows from the larger, more prolific crises. Indeed, Davidson & Hall (2001) have pointed out that the Royal Commission on VD was informed of the pre-existing social anxieties on sex and VD and were not just influenced by the war efforts to combat VD. The 1920s and 1950s were also periods of much discussion on sexual behaviours. It was widely maintained that war had eroded family and community controls and demoralised the nation through the negative impact it had on sexual behaviours (Davidson, 2001). Such rises and silences of sexual anxieties supported by the hailing of medical involvement and discoveries are characteristic of the narrative pattern throughout the history of sexually transmitted infections. Arguably, this helps to fuel the present day's juxtaposition of the liberalisation of attitudes with a mythical past figure of the good moral code-abiding citizen. This imaging is really a continuation of an overall cycle, where aging generations appear to forget the sexual anxieties of their time and blame the invention of premarital sex on the youth.

Medical historians have realised the limitations of the historiography of VD and have begun identifying areas that require further investigation. Two most notable areas of concerns are the lack of diversity in national and cultural responses to VD public debates and the preoccupation of historians with prostitution and morality. Debates on VD have been international as well as localised. Variations, as well as standardisations, existed in VD treatments and in moral responses. Often local knowledge of VD or prostitutes was formulated earlier or for a different purpose (Taithe, 2001). However, comparative studies of the social responses to VD in Europe in different cultural settings remain limited (Davidson & Hall, 2001). In particular, Ireland is absent from these comparisons. Historical monographs on Ireland's VD hospitals are also absent despite the preservation of records such as those of the Westmoreland Lock Hospital (Malcolm & Jones, 1999). In view of the study on the rates of STIs in late 20th century Ireland, it would be beneficial to view Ireland within the wider historical process of the debates on STIs and sexuality. As Weeks (1989) points out various sexual cultures share general sexual forms but the meanings attached to them can be different (Weeks, 1989). Taithe (2001) has argued that there are too many works obsessed with morality and 19th century prostitution. The identification of VD with prostitutes should be treated as a moralistic rhetoric applied to epidemiology. Moreover the history of prostitution could have been written without the need to use VD as the narrative starting point of morality. This is not just reflective of our fear of dealing with diseased sexuality but morality is a means of coping with the randomisation of disease and death. We have difficulties coping with a healthy youth struck down by illness or death, when others live to an old age living on a diet of excess (Taithe, 2001).

To overcome the wielding of STIs and morality, Taithe (2001) suggests a new emphasis on the diseases themselves and on the indiscriminate pattern that

characterises them. Sexually transmitted infections are considered to be random occurrences and Taithe (2001) argues for an understanding of how people rationalise and deal with this randomisation. For example, how did VD sufferers, aware of their illness, maintain and continue sexual relationships and “why would anyone go to see a prostitute if there was not a risk assessment and a (mis)understanding of the probability of accidentally contracting the pox?” (Taithe, 2001:346). Such a premise implies that individuals in current times are capable of making rational choices in relation to sexual behaviours. This overlooks the fact that the discourse surrounding STIs and sexuality continue to be shaped by social forces, such as consumerism.

Morality may be a form of regulation of risk-taking but on an individual level, VD does not rate highly amongst the variety of risks people take on a daily basis. Taking a socio-historical approach to STIs in relation to risk taking is a productive task for the sociologist. Firstly, it confirms a separation between public attitudes and private behaviour – sexual risk-taking has continued right through times of STI epidemics and anxieties on sexuality and silences on sexual politics. Secondly, as Brandt (1987) has pointed out, the medico-moral discourse on STIs has continued to hinder the efforts to control them. Through an analysis of the history of this construction, we can view how present themes of race, gender, stigma, individual suffering and social responsibility arose in medico-moral discourse.

Social History of Sexually Transmitted Infections:

‘The Great Pox’ – 15th to 17th centuries.

The timing of the emergence of syphilis in Europe continues to be unresolved. One school of thought, the ‘Columbian School’, maintain that syphilis was endemic to North America and that the members of Columbus’s first expedition acquired the infection from indigenous Caribbean women, who were themselves immune to it, and brought it back to Barcelona (Learmouth, 1988). Some of the infected Spaniards later joined Charles VIII of France as mercenaries when he laid siege to Naples in 1494. The following year, a plague of syphilis broke out in Naples and spread throughout Europe via France in 1495 to Russia in 1499 (Barlow, 1979). Others, particularly 19th century venereologists, believed that syphilis had already been in existence in Europe. Knott (1904) argued that in medieval times descriptions of lesions on the genital organs were too similar to syphilis to not be related. In 1302, an epidemic of a disease of the genital organs in Venice was considered serious enough to issue a fine for each offence (Knott, 1904). Cooper (1895) maintained that other diseases had been ascribed to manifestations of syphilis and that no other supposition was tenable. Dr. Philippe Ricord, one of the founders of 19th century syphilology, was also convinced that the disease subsisted under different names and in non-venereal forms since ancient times (Engelstein, 1987). Barlow (1979) contends that there are many references in the Old Testament to conditions that may be syphilis - for example, the ‘Botch of Egypt’, which Moses threatened to those who disobeyed the laws. Prehistoric versions of gonorrhoea are also said to have existed amongst the Neanderthal populations, despite the scattered nature of the populations (Tannahill, 1980).

Cockburn (1963) attempts to explain how syphilis manifested into an epidemic. He argues that during the Renaissance, bathing and sleeping were communal and

coincidentally, these arrangements became socially unacceptable with the discovery of the 'New World'. There was also the introduction of frequent washing of undergarments, due to the popularity of cotton clothes. As a result, *treponema*, which had survived as a skin infection, could no longer move freely from person to person and so mutated into a bacterium with a special preference for sexual organs (Learmouth, 1988). This theory accounts for the co-existence of yaws, non-venereal syphilis and venereal syphilis in one country. It is difficult to distinguish the bacterium, *treponema pallidum*, which causes syphilis from that which causes the skin disease yaws, *treponema pertenue*. This suggests that they could have evolved from the same skin organism (Learmouth, 1988). Furthermore, Cockburn's theory ties in with Elias's view on the development of modern sexuality. Elias (1978) maintains that the development of the civilised body did not arise with modern society but developed when the warrior ideal of the Middle Ages transformed into one of court aristocracy. Prior to the mid-sixteenth century, the social mores did not distinguish between the functions of eating, excretion and sexual behaviour. Sexual behaviour was not viewed as being especially intimate nor was it the source of heightened embarrassment and shame. During the 'civilising process', it became an embarrassment to share a bed with strangers, bodily functions became taboo and sexuality was pushed into the back-regions of life (Elias, 1978).

Whatever the origin, the disease did appear in epidemic form at the close of the 15th century and became a major health problem, considered worthy of medical study from the Renaissance onwards. From the onset, the disease was blamed on the foreigner. The French termed it 'the Italian disease', the Italians 'the French and Spanish disease' and the English called it 'the French pox', 'the malady of the French' or 'morbus gallicus' (Barlow, 1979). The English at first termed it the "Spanish Needle" when national relations were bad but by the 18th century, the French were mostly blamed, with the term 'Frenchified' being used to depict being infected. Nations distanced themselves from the epidemic by ascribing its location and origin as elsewhere (Berridge, 1996). Vernacular names also existed, most notably the 'Great Pox' or 'foul disease' in English. The Scots called it 'breck frangagh'. Interestingly, an Irish word for syphilis does not exist. In 1530 Hieronimo Fracastoro published a poem, *Syphilis sive Morbus Gallicus*, about the symptoms, treatment and course of the 'French Pox' as suffered by a mythical young shepherd called Syphilis (Rosen, 1993). The poem was hugely popular and thereafter, the disease was known as syphilis.

During the 16th century, syphilis presented more acute symptoms and was treated like other epidemic diseases. There was a connotation of sickness and pollution affixed to the sufferer. Syphilis, like leprosy, indicated decomposition (Sontag, 1988). When the incidence of leprosy declined in Europe in the 15th century, the cultural perceptions of the disease were interwoven into syphilis (Horton & Aggleton, 1989). At the time, no one connected the epidemic to the conquests of the New World. Instead, people had a wide range of possible explanations from blaming it on the heavy rains in Italy in 1494 to the conjunction of the sun with Mercury, Jupiter and Saturn in 1483 (Knott, 1904).

By 1530, the sexual transmission of the infection was recognised and action was taken to control the sources of infection. The first control measures were directed against the prostitutes, an association which would continue to persist through the history of

sexually transmitted infections. In Italy, where brothels were accepted institutions and prostitution widely practised, women were examined prior to commencing work as a prostitute (Rosen, 1993). Those found with syphilis were not permitted to work. In some Italian cities, foreigners who were ill or suspected of carrying syphilis were denied entry and special hospitals were set up for the treatment of sick citizens, where physicians were required to report cases to the authorities (Rosen, 1993). Such control measures were operated throughout Europe and formed the basis for future control attempts. Condoms first appeared during the 16th century – Fallopus, early authority on syphilis, claims to have invented the sheath in his *De morbo gallico*, published in 1564 (Himes, 1970). Although, forms of contraception had been in existence since at least the ancient Egyptian times, condoms were specifically designed for the prevention of syphilis (Tannahill, 1980; Himes, 1970). It was not until the 18th century that condoms became used for contraception. The term ‘condum’ first appeared in Daniel Turner’s *Syphillis* in 1717 and is reputed to have been named after a doctor in King Charles II’s court, Dr. Condom or Conton, although this is uncertain (Himes, 1970). Because of their usage against VD within non-reproductive sex, condoms became synonymous with promiscuity. They also symbolised a nation’s dissociation from the disease. In Britain, it was known as the ‘French letter’. The French called it ‘la capote anglaise’ (English cape) while the Italians also viewed it as an English invention (Himes, 1970). Such racial imagery of blaming it on another race would remain throughout the discourse surrounding sexually transmitted infections.

‘The Clap’ and ‘The Pox’ – 18th century.

By the 18th century, syphilis had become a chronic disease but it nevertheless remained a major health problem in Europe. Gonorrhoea appeared quite frequently in medical literature. ‘The Clap’ was also the jovial topic of conversation amongst the aristocrats. Gonorrhoea was later misidentified as an earlier stage of syphilis and largely disappeared from public discourse until the late 19th century. Apart from the prescriptions of the fashionable quacks, the main form of treatment in Britain for the disease was urethral lavage (Roy, 1998). Syphilis, meanwhile, was largely treated with mercury. This treatment could be much worse than the disease itself. Physicians used it sparingly, whilst quacks prescribed it liberally, inducing loss of teeth, excessive salivation, abdominal pains and death (Barlow, 1979). Because of this less than ideal form of treatment, the 18th century was awash with various attempts to make mercury treatments easier and to locate other cures. A common lay belief was that intercourse with a virgin child would cure venereal disease (Tannahill, 1980). In Britain, special brothels were set up for this purpose, often employing orphan girls as young as six years old (Weeks, 2000). Mercury treatments were expensive as well as punishing so a huge range of alternative products and devices were available (Taithe, 2001). This market, of course, provided opportunities for the quack as well as those involved in alternative medicines. Quackery and alternative medicines also existed in the 19th century, for example, a watering spa called Lama Lou in France was frequented by those wishing to be treated for a variety of nervous ailments of syphilitic origin (Herzlich & Pierret, 1987). However, such treatments are missing from the historiography of the 19th century.

In relation to 18th century, historians do focus on the discussion of quackery versus professionalism and the venereal perspective is argued to have been structured

through medical discourse on doctors, quacks, wives, children, courtesans and representations of venereal diseases (Merians, 1996). Venereal diseases were placed at the heart of the social problem. Unlike the 19th century, where VD became the route to look at the regulation of prostitution, venereal diseases in the 18th century were just viewed as diseases of the individual body. What was considered to affect society was congenital syphilis. Children's syphilis was prominent in public discussion, mainly because the hereditary nature of syphilis represented fear of racial or population decline (Taithe, 2001). Furthermore, countries at that time actually viewed congenital syphilis as being a demographic and qualitative crisis, unique to their own country (Merians, 1996). Children could also be infected through a number of non-venereal ways – vaccination and wet nursing – prompting much debate on those topics. Whilst syphilis in children remained a health problem in the 19th century, it did not enter the public discourse again until the end of the century, when concerns about the disintegration of the family were reflected in congenital syphilis.

During the 18th century, disease was often romanticised. Tuberculosis was linked to beauty and genius (Herzlich & Pierret, 1987). Syphilis maddened philosophers. This was also the century of the calculated move of the loveless marriage to improve careers, the illicit love affair and increased mobility. New lands were being discovered and improved transport increased trade across the seas. On land, people regularly migrated. The landed classes moved between their country and town houses, the merchants on business and changes in agriculture were creating shifts in the workforces. In France, farm workers would spend a large part of the year away from home looking for work. As a result, their sex lives often consisted of casual sexual encounters (Tannahill, 1980). High percentages of illegitimate births persisted throughout classes across Europe. A large proportion of unmarried mothers were domestic servant girls, living away from home and whose employer was the father. In France, control measures were taken in the form of gentlemen, merchants, lawyers and shopkeepers preferring to maintain a semi-official mistress. This trend of 'kept women' became very popular in Europe from 1750 onwards, though the keeping of a mistress was not as common in Britain and brothels and street walkers remained more prominent. Condoms were used frequently and were easily attainable on the streets and in brothels (Himes, 1970). Poor and rich alike frequented prostitutes (Merians, 1996). Sex was celebrated, was publicly evident and maximising sexual pleasure was encouraged as being good for the health (Hawkes, 1996).

As the 18th century progressed, the middle classes or the bourgeoisie grew in power. The middle classes were eager to differentiate themselves from the upper and lower classes. One route for asserting their identity was to distance themselves from what they viewed as the decadent morals of the aristocracy and the immorality of the lower classes (Foucault, 1979). Sexual behaviours were moralised and focus was on the dangers rather than on the pleasures of sex. Sexuality began to assume major symbolic importance as a target of social intervention and organisation (Weeks, 1989). Gender played an important role in the establishment of the 'new' sexuality. Since Ancient Greece, the female body had been viewed as being an inferior version of the male body but one that could still experience sexual pleasure (Shilling, 1993; Tannahill, 1980). Advances in science in the 18th century asserted that the female body was different from the male body, with a reproductive cycle, but the advances in medical science were fuelled by the growing disconcertion about female liberties, which were seen as threat to society after the French and American revolutions

(Shilling, 1993). As a result, female sexuality was defined as being geared towards reproductive cycle, being a passive recipient in sexual intercourse and women were denied sexual pleasure. This was a critical moment in the reshaping of gender relations and would have repercussions for the legal regulation of prostitution in the 19th century (Weeks, 2000).

Syphilis was seen as God's punishment for indulgence in sinful behaviour, hereby stigmatising the disease. "It was considered the worst form of punishment for the sins of the flesh and the transgressions of Christian morality, deservedly resulted in the sufferers' afflictions. The practice concerning these cases varied and in general, it was considered improper to admit them" (Woodward, 1974:48). This view seriously jeopardised efforts to effectively control the disease (Rosen, 1993). In 1739, the "Inquiry of the Large Hospitals" report found that amongst hospitals in London, venereal patients were not admitted, unless they could provide an extraordinary contribution to the support of the hospitals (Woodward, 1974). Moreover, despite the categorisation of 'innocents' not being part of medical discourse until late 19th century, moralists did sometimes take pity on 'innocent' victims of the disease. In Leeds, in 1775, the trustees of the General Infirmary decided that they would permit married people of 'good character' and children of such patients (Woodward, 1974). From 1746 onwards, the majority of VD cases were sent to the Lock Hospitals. The Lock hospitals were named after the French Logues, meaning 'bandages'. This was because the original Lock hospital in Britain was in Southwark, on the site of an old leprosy house for lepers, who were kept under the restraint of 'bandages' (Walkovitz, 1980). Special wards of general infirmaries, such as those in Leicester, Liverpool and Manchester, were also allocated to venereal disease. These however were not sufficient to cope with the numbers requesting admission. Moreover, others, such as the Middlesex hospital restricted its admission to those who were relatively wealthy (Abel-Smith, 1964). Even with the Lock hospitals, admissions criteria were applied. In the London Lock hospital (founded 1746), it was the policy to never re-admit a patient who had been previously discharged (Abel-Smith, 1964). Others charged a high weekly fee to stay in hospital, thus eliminating access to the lower classes. While this was due to a shortage of patronage and funding, this practice only served to keep the prevalence of syphilis in the population. Many doctors shared the view with hospital trustees that sufferers were not deserving of hospitalisation and treatment, a view that persisted well into the 19th century. Others argued that hospitals were the only places where the treatment of mercury for syphilis could be carried out properly, thus helping to combat the disease. Despite the denial of entry of VD patients to hospitals continuing right up to World War I, venereologists did find their voice in alerting the public to the seriousness of the disease.

'The Bad Disorder' and 'The Other Damage' – 19th century.

Nineteenth century venereology and the public discourses on venereal diseases as the 'social diseases' established the association that endured in late 20th century debates. Venereal disease was socially constructed as an affliction of groups who transgressed a perceived morality (Horton & Aggleton, 1989). From blaming the prostitute to the single sexually active youth, negative connotations between STIs and class, race and gender were also instated at this time. Venereal disease was the social and psychological penalties were 'getting caught' (Patton, 1985). Throughout the regulation campaigns and the 'social hygiene' control attempts, medical practitioners

were central, first helping to rid society of the 'social evil' (prostitution) and later advocating the individual's moral duty to protect the family and the wider society through self-regulation.

The first half of the 19th century was relatively quiet publicly on the connection between VD and sexuality. There was an outburst of public anxiety in the 1840s on prostitution and campaigns for its supervision by police forces (Mort, 2000). The Victorian age in Britain is often regarded as an era of repressive sexual Puritanism, yet an underworld of sexual guilt and perverse eroticism prevailed (Weeks, 1989). Before the debate on sexuality exploded after the instalment of the Contagious Disease Acts in the 1860s, the first 50 years of the century can be viewed as one of medical progress. From roughly the 1820s onwards, syphilology (as it was then known) grew in stature and gained much attention, largely through the efforts of such doctors like Ricord in Paris (Barton, 1868). At the start of the century, venereology was associated with quackery so many doctors shied away from the discipline, despite the financial rewards available (Hall, 2001). Venereology was not taught on the undergraduate syllabus and due to the stigmatised nature of the disease, most patients of VD were not treated within hospitals. By the time of the Contagious Diseases Acts (CDAs), venereology had been elevated, its facilities improved and its expertise respected, a situation that is remarkably similar to what happened in Ireland and Britain during the HIV/AIDS epidemic.

Britain was at the height of its empirical stage and after the poor performance during the Crimean Wars, it was drawn to the attention of the parliament that VD was rife in the British army (Roy, 1998). In 1860, it was estimated to be 369 per 1000 (Hyam, 1990). As VD was an ever-present threat (and no satisfactory cure existed until the 20th century), VD became the manifestation of fears about the imperial decline of Britain (Weeks, 1989). The armies had to be protected and the focus was on the prostitute, neglecting the role men played in the spread of disease. As Herriot (1992) pointed out, many writers at the time argued that prostitution was the cause of VD but no one was ever able to measure the relationship. Instead, the medical community gave the impetus to the movement. They viewed the 'venereal peril' as the most dreadful threat for the future of humanity (Herriot, 1992). From previously refusing to treat VD sufferers, medical practitioners had come to consider VD as a serious physical disorder, not just for the individual, but also for public health. Venereal disease thus came to require both social and individual approaches as an individual's sexual behaviour had implications for the society (Levine, 2001). It should be noted that medical discourse and activities surrounding VD did contain dissenting voices. Many doctors thought that syphilis should be freed of its religious connotations (Herzlich & Pierret, 1987). However, once medical discourse was engaged in the regulation of prostitution, medical practitioners were at the forefront of moral endeavours. The partnership of state and medics was mutually beneficial, venereologists got to use state funds and were endorsed while the state was supported by science and its evidence. This role was opposed by many social critics. Emile Duclaux, a French social critic, viewed the state and its medical advisers as taking on the role of the Church and that they should not be imposing morality on the citizen (Herzlich & Pierret, 1987). There were many doctors who did oppose medical involvement, viewing that a prevention model would have been more appropriate. This opposition has not been fully explored within the social history of venereal disease (Hall, 2001).

In most European countries, public health authorities tried to control VD by monitoring prostitutes. It was believed that the incidence of VD could be reduced if all prostitutes were subjected to regular medical inspection (a movement that was similar in idea to that of the 16th century and screening programmes of 'gay' health spas in Dublin in the 21st century). The regulation movement is considered to have originated in France (Davidson & Hall, 2001). However, the measures Britain undertook and the furore that ensued is of great concern, as Ireland was at that time part of the British Empire. France, meanwhile, did provide licensed medically approved brothels – known as *maisons de tolerance* – throughout the 19th century until 1918. Spain and Italy also maintained the regulation of prostitution as their means to control venereal diseases. Italy, incidentally, had state supervised brothels until 1958. Two years after their closure, rates of syphilis increased (Tannahill, 1980).

The rate of VD in the British army spurred a series of government inquiries in the 1850s and 1860s. The results of which testified to the seriousness of VD and sexual immorality amongst the lower classes (Mort, 2000). The first Contagious Disease Act was passed in 1864 and was applied to a number of naval ports and army garrisons in England and Ireland. The Curragh, Cork and Queenstown – now known as Cobh – were three of the original eleven garrison towns. Under the jurisdiction of the Act, prostitutes or women suspected of prostitution could be retained and subjected to medical examination and treatment if infected. The reinforcement of the Act was carried out by the police force and medical practitioners. Further acts of 1866 and 1869 extended the geographical locations to 18 towns. The measures in these towns were apparently viewed favourably as the state was paying for the control of what was deemed a local nuisance (Hyam, 1990). At that time, Irish prostitutes were considered the worst kind of prostitute – the lowest, bawdiest, foulest-tongued and the dirtiest (Hyam, 1990). This description does contain racial connotations – indeed, the word Irish was used in derogatory terms, including 'Irish toothpick' to mean a small penis and 'Irish fortune' for a vagina - but it also indirectly points to the absence of a history of the Irish prostitute. Like VD and other aspects of sexuality, the Irish prostitute is absent from the historical writings. Despite the fervour on prostitution in Britain and the fact that sexual 'deviances' have always existed in Irish society, issues of sexuality do seem to be marginalized by interest in Ireland's political history and the dominance of the Catholic Church in the Irish state.

Medics were prominent on all the British parliamentary inquiries into the working of the acts between 1867 and 1881 (Mort, 2000). Their expertise was used to back the state action on moral and sexual issues. This boosted the status of medicine and venereologists, such as William Acton, used the connection between VD and prostitution to verify that medics, rather than moralists, had great claim to authority on social and environmental issues (Mort, 2000). The National Council for Combating Venereal Diseases and the National Council of Public Morals were set up, both served by medics. However, in 1869, medical efforts to extend the Contagious Diseases Acts were opposed at the Social Science Congress in Bristol. The same year, the National Anti-Contagious Diseases Acts Association was established, followed by the Ladies' National Association under Josephine Butler.

The main objections to the Acts were that prostitutes and not their clients were inspected, that the examination was basically 'instrumental rape by a steel penis' and

finally, it professionalised prostitutes and assured their necessity to society (Hyam, 1990). Prostitutes were viewed as the agents of venereal contagion, not as victims. Their clients were not subjected to examination, thus showing that the regulation was really a system of controlling women. In Russia, it was argued that the diagnostic tests would not detect infection in men and that clients would be unlikely to submit to such a humiliating procedure and would defect the system by turning to non-brothel prostitutes (Engelstein, 1987). Tannahill (1980) argues that the movement only really wanted prostitution abolished and used feminist arguments to achieve it. Medical inspections were regarded as strengthening the institution rather than containing it. Such an assumption was not entirely wrong. The Contagious Diseases Acts did actually help make prostitution a distinct profession. As women were singled out for specific forms of social control, they worked fulltime for longer periods away from their local communities, saw more clients and became more vulnerable to infection (Day and Ward, 1997). The Anti-Contagious Diseases Acts Campaign became a godly versus medicine debate and the 'purity' movement won. In 1886, the acts were repealed, although they continued for some time in the colonies. In 1885, brothel keeping and procuring (though not prostitution) were criminalized under the Criminal Amendment Act. Venereal diseases continued to be a problem for the armed forces as migration with the Empire, meant separation from family and moral pressures and diagnosis and treatment could be concealed from loved ones (Roy, 1998).

Medics did withdraw from state regulation of prostitution, although not necessarily ungrudgingly. In Britain, some medics lamented the move away from regulating prostitution right up until the First World War. Cooper (1895) icily stated that England had the "credit of preserving syphilis" but attempts to lower the prevalence had been thwarted by "the demands of an ignorant and fanatical section of the populace" (Cooper, 1895:14). De Meric (1901) argued that the root of the problem was undeniably prostitution but that prostitution was a necessary evil. "Sweep prostitution as clean as possible of venereal diseases, and the first step towards their ultimate eradication is gained" (De Meric, 1901:122). He viewed the Anti-Contagious Diseases Acts campaign as a perversion of liberty, branding them as being a small notoriety-seeking minority and blamed them for preventing the only way to combat diseases. In response to those who had argued that the regulation of prostitutes was really a control of women, he reasoned that "persons are taken up for begging, therefore women should be taken up for annoying with sollicitation, which, after all, is but another form of begging" (De Meric, 1901:125). While others gracefully moved on, nonetheless, the widespread belief that science was the key to social improvement remained amongst physicians. "In Europe, questions of public health and public morality were closely intertwined as objects of state policy and of medical expertise. Enemies and partisans of regulated prostitution shared a common concern and lower class sexual comportment and bolstered their devotion to middle-decorum with a medical rationale" (Engelstein, 1987:177).

The last two decades of the 19th century were characterised by one of medical pessimism. Philippe Ricord, the French syphilologist, had earlier in the century proclaimed that syphilis was treatable and controllable. His successor, Alfred Fournier (and holder of the first Chair of Venereal Medicine, the field that he is considered to have founded), viewed the cure of syphilis as being unobtainable. Syphilis had come to be the cultural metaphor for the complex feelings of 'fin de siecle' unease (Davidson & Hall, 2001). The 19th century had seen many successes

against disease but VD continued to evade medical control. In France, the society “was ill with syphilis, in its fantasies as much as in the flesh” (Herzlich & Pierret, 1987:135). Danger of syphilis lurked in every embrace, kiss and sexual encounter. Syphilis was bounded with art and similar to the Romantic writers’ connection between TB and heightened emotional activity, infection with syphilis was viewed as inspiring original intellectual thought (Sontag, 1988). The growth of cities had brought fears of urban masses and a changing nature of familial relationships. Approaches to venereal disease, became concerned with hygiene, contamination and contagion (Brandt, 2000). To further heighten apprehensions, it was joined by gonorrhoea, otherwise known as the ‘other damage’, which had previously been considered benign but had since been proven to cause sterility in women (Herzlich & Pierret, 1987). Together, gonorrhoea and syphilis were the diseases of urbanisation and industrialisation, mostly inflicting adolescences and threatening the fabric of society, the family.

During the Victorian era, the middle class family had become an institution devoted to child rearing and the maintenance of the home (Brandt, 1987). The family no longer fulfilled the basic economic functions of earlier periods, instead it was a private sphere given over to motherhood, childhood and domesticity. In the last years of the 19th century, trends appeared that seemed to threaten the ideal of the family. There was a growing tendency toward later marriages and smaller families and a rise in the number of divorces (Brandt, 1987). Women’s rights to sexual pleasure were also being acknowledged, affecting the polarity of chaste wife and prostitute. Medical practitioners began to focus on the health of the family, viewing it as a palatable professional domain. As a result, VD was construed as a special danger to the family. Fears about the urbanised, industrialised and secularised world were symbolised by the venereal diseases. They were the signs of degeneration, a ‘family poison’, which could end marriages, cause sterility and infect offspring. In the USA, venereal diseases were seen as proof of infidelity and by the start of the 20th century, courts recognised the introduction of VD into a marriage as viable grounds for divorce (Brandt, 1987). Some states made premarital testing compulsory (Brandt, 2000). At the Australasian Medical Congress in 1909, Professor Allen, President of the Congress cited that the main mortality of children from ‘slight causes’ was due to inherited syphilis. In order to protect them, he argued that syphilitics should wait the recommended period of five years – subject to no symptoms during the last two years – which Professor Gaucher, Fournier’s successor had advised (Allen, 1909). Furthermore, he argued that the prevalent marriage laws for syphilitics were not administered with adequate firmness and that this was not an acceptable arrangement.

Anxieties about cities and industrialisation were linked with VD and illicit sex. One interpretation is that industrialisation had lessened the individual workload for survival, leaving people with more leisure time outside work. This helped to lift the sexual ‘repression’ of non-reproductive sex. Explorations of sexual pleasures were confined to after-work periods, but could be exploited by the leisure industry (Marcuse, 1972, as cited in Turner, 1991). Medical interpretation had become infused with cultural expectation. European and USA physicians viewed syphilis as mirroring cultural deprivation. Its prevalence mirrored existing levels of filth, poverty, malnutrition and overcrowding in cities (Engelstein, 1987). Material excesses, exposure to damp and cold, want of cleanliness and recklessness to consequences were other examples of urban life that were considered to make infection more potent

(Cooper, 1895). Rural life was seen as being healthy, rich with social values, strong family ties and as a result, uncommon occurrences of venereal disease. Urban centres, meanwhile, were the negative results of modernisation. Family and social values were weakened. Improved transport meant people moved around more often, thus coming more into contact with disease. Urban life also attracted immigrants. In the USA, VD became synonymous with incoming ethnic groups. Venereal diseases were depicted as being rampant amongst immigrant groups and because the bulk of prostitutes were also foreign born, the blame of VD fell on the shoulders of the 'other race' (Brandt, 1987). Cities were full of single men and women and in a vacuum of traditional norms, sexual encounters were frequent and illicit. Sexual encounters in the city were a matter of choice not a reproduction obligation. This emphasis on sexual contact being a matter of choice helped move the control of VD from state regulation to self-regulation.

For public health reformers, urbanisation represented dirt, disease, squalor, and moral corruption and contained the political and cultural threat of the urban working class (Mort, 2000). This urban disorder became engraved into sexual immorality and lower strata of societies were blamed for such disorder. Medics expressed greatest concern about working class women, whom they believed could be more easily led astray. Among the more serious dangers that an urban working class environment provided were sexual relations outside of marriage, dangers that occurred as the result of indulgence in visiting dance halls and other forms of entertainment (Mort, 2000; Weeks, 1989). Conditions of factories and slums were also cited as these helped to lead women into prostitution. Focus on the working class woman kept the prostitute as the agent of disease. She was portrayed as threatening the genetic patrimony of the dominant classes (Corbin, 1987). She was the bearer of syphilis who infected the male bourgeoisie and indirectly spread the disease to his wife and future children. The prostitute may no longer be the subject of regulation but she was now part of the process of degeneration. She embodied syphilis's threat to annihilate the bourgeoisie. Some doctors spoke of the 'puzzling' question of why for every one case of syphilis in women, there were 50 cases in men (Marion Sims, 1883). This placed the prostitute firmly in the centre of the network of transmission.

At the same time, European physicians sought to invoke the threat of non-venereal contagion to deter the middle classes from having casual contact with the unhygienic poor (Engelstein, 1987). Syphilis was "inherent in dirty cups, towels and toilet seats" (Engelstein, 1987:173). It is now known that syphilis and gonorrhoea are almost never communicated in non-sexual ways, but it seems that the physicians were trying to reduce the stigma of venereal disease (Brandt, 1987). As the 20th century dawned and discourse moved from centring the prostitute as the agent of disease to the man, who conveyed the disease to his family, non-venereal transmission came part of the discourse on the 'innocents'. These 'innocents' included not only wives and children of infected men, but medical and nursing personnel who had treated sufferers and those who had shared a cup or an innocent social kiss with a syphilitic (Hall, 2001). Interestingly, non-venereal spread of syphilis was considered the most common method in Russia in rural areas. There it was depicted as the disease of the community, whereas in cities, it was the disease of the individual. Engelstein (1987) speculates that the transmission could have been possible as conditions were similar to those of Bosnian communities and Bedouin villages of Syria. There houses were crowded, different notions of privacy prevailed and traditions of shared drinking

vessels and communal eating may mean that syphilis could be transmitted through vessels conveying infected fluid (Engelstein, 1987). It is also possible that the non-venereal strands were really those of other sexually transmitted infections, which had not yet been identified. Either way, emphasis on the non-venereal spread contains the future spectre of late 20th century, where viral infections and HIV were portrayed as often being non-sexually transmitted.

'Magic Bullet', 'Dying Diseases' and AIDS - 20th century.

The 20th century saw a range of major medico-scientific developments in relation to venereology. Within the first 20 years, the Wassermann diagnostic for syphilis was developed (1909), Salvarsan or the 'magic bullet' offered the first real cure (1909) and the use of antibiotics seemed to finally combat the diseases. Other sexually transmitted infections were identified and the 1980s endured the pandemic of HIV/AIDS. The century also saw two major world wars, which required campaigns to control VD in military and civilian populations and the development of the GUM clinic system in Britain and Ireland.

With VD rendered a civilian and not a military problem in Britain, regulation programmes were not deemed the best method of control (Mort, 2000). Sex had been defined as an individual's choice, so self-regulation was hailed with emphasis being placed on the individual taking responsibility for his or her sexual health, and hence helping to protect the larger society. Medical, state and voluntary sectors combined to ensure that VD treatment was available to everyone irrespective of background and the treatment was anonymous and cases reportable for surveillance. No such system was set up in the USA, due to a division between public health advocates and physicians since the start of the 20th century. The trustees of voluntary hospitals throughout Europe and the USA in the 19th and early 20th centuries were notorious for denying treatments to VD sufferers on moral grounds. Physicians wanted to make beds available for VD patients as they viewed hospitals as the best place for treatment but boards of health wanted to provide outpatients clinics. Physicians refused to pass on their scientific knowledge to the public health 'social hygiene' clinics and since then, physicians tended to treat patients in private, with the failure to report cases of STIs, an on-going nemesis of STI control (Brandt, 1987). The US government did attempt a regulation programme similar to that of the Contagious Diseases Acts. More than 18,000 women were suspected of prostitution and held against their will in state run reformatories, until it was determined that they were not infectious (Nelkin et al, 1991). This was the largest quarantine in American history (Nelkin et al, 1991).

By the end of the 20th century, STIs were no longer a punishment for sinful behaviour and neither were they a crime against health, instead they placed the individual's behaviour against the social norm (Herzlich & Pierret, 1987). The prostitute remained an agent of disease, although she was also considered a victim. At the turn of the century, the role of male sexuality entered the discourse on venereal disease. He was depicted as either the 'debauched aristocrat', a deviant form of masculinity associated with decadence and disease or the promiscuous male who wilfully subjected his innocent family to the woes of the diseases (Davidson & Hall, 2001). Furthermore, at the onset of the First World War, the threat of the professional prostitute was diminished as a new source for concern was identified, that of the 'amateur' prostitute, or the promiscuous girl who gave sex for free. This 'amateur' embodied all

the social fears about the rising tide of immorality, the increase in illegitimate births and changes in women's status (Mort, 2000). Single young sexually active women were targeted as bearers of disease. Incidentally during the wars, the professional prostitute was portrayed as being a safer option than the 'amateur' or girlfriend. Prostitution had declined by the First World War, as Hyam (1990) states, it had found its alternative in increasingly complaisant girlfriends, protected by contraception. After the First World War, availability of birth control and changing attitudes led to an increase in premarital sexual intercourse, a trend that progressed throughout the 20th century. Prostitution became superseded by casual sex and prostitutes had become just one of the defined 'high risk' groups. Since the mid 1960s, incidences of STIs have been officially and medically viewed as a reflection of sexual promiscuity in the population (Evans, 2001). Main social groups seen to be responsible are teenagers, immigrants, asymptomatic promiscuous women and homosexuals.

Some continuities from 19th century medico-moral discourse survived right through the 20th century. Racial associations have endured, with European concepts of disease being unremittingly transferred to overseas. Arrival of Caribbean immigrants in Britain after 1948, sparked off many connections between ethnicity and spread of sexually transmitted infections (Davidson, 2001). Black-Caribbean groups in Britain continue to be one of the most studied. On the issue of class, inequalities can be identified but such findings no longer reflect the social anxieties about urban working classes. Urbanisation remained but this time in relation to its alienation effects and abundance of drugs and alcohol. It was also the centre of attraction for a media obsessed with sexual permissiveness and gratification (Davidson, 2001). Discussions on sex education, which were prominent during the 1990s in Ireland, have their roots in the discussions on family health at the turn of the 20th century. Medics had called for sex education, blaming the spread of VD on ignorance and prudishness. They argued that it was the citizen's moral duty to remain chaste and healthy and he or she needed to be given information of how to protect oneself from infection. Attempts were made to make condoms more acceptable, which coincided with changes in attitudes to premarital sex and sexual pleasure in marriage (Tannahill, 1980). A number of organisations were set up to distribute information. One example is the American Society for Sanitary and Moral Prophylaxis founded in 1905. It contended that parents should teach their children about sex, although members frequently asserted that most parents were incapable of this task. Some physicians expressed concern that sex education would encourage 'impure thought'. Such arguments continue to be thrown into the public arena today despite the passing of nearly one hundred years.

In 1915, using the evidence presented to the Royal Commission on Venereal Disease, a pamphlet entitled *Campaign Against Syphilis* was published and circulated in London. It was moralistic in tone, reflecting that of the period, but uncannily similar to some of today's preventive messages. Abstinence was considered the best way to combat to the disease (Giles, 1915). Sex education was called for to stop the ignorance that was leading men and women to suffer symptoms and reinfect others unwittingly, as "these diseases often hide themselves away, as it were, in the body, so that the infected men or women may honestly believe that they are quite healthy" (Giles, 1915:11). Giles (1915) also pointed out that the venereal diseases also greatly affected the middle and upper classes, moreover, men should no longer "treat it as a matter of course, as a thing to joke about" as they should have compassion for the

women they infect, whose “sufferings are more immediate, and out of proportion to theirs” (Giles, 1915:10). Giles acknowledged the apparent disproportionate rates of VD amongst the lower classes but argued that prostitution was often a necessary trade in order to offset the appalling social conditions of high rents and low wages. While he did not view social change as being possible, he did ask for a revision of the application of moral standards to the lower classes. Continuing from similar arguments in the 18th century, the pamphlet included a citation from Sir Thomas Barlow on the effect alcohol has in the spread of infections. “From first to last the influence of alcohol with regard to these venereal diseases is most disastrous. It is when young men, and men of various ages, are under the influence of alcohol, that they are often led into it and contract these things” (Barlow, as cited in Giles, 1915:15). Alcohol continues to be cited as a factor in the spread of STIs. In keeping with the medico-moral discourse of the time, the pamphlet states that VD is public responsibility as well as public risk. Giles (1915) asks not to blame those who indulge in impurity but that the fault falls on everyone. Prostitution is, he claims, an outward sign of “a hidden moral disease induced by false habits and corrupt ideals of life” (Giles, 1915:16). The whole society should be aroused by the fear of being infected and should do his or her duty to not spread the infection. Moreover, “this pamphlet was written before the declaration of war, whose importance, vast as it is beyond our capacity to estimate, is as nothing for our Empire compared with the importance of war against venereal diseases and all that lies behind them” (Giles, 1915:19). Despite an echoing of previous panics on ‘the Scourge’ being the worst threat to humanity, Giles ascertains that the Royal Commission on Venereal Diseases would not recommend legislation or the use of compulsion for the civilian population. Although reporting for the state, the Commission was aiming to reduce the stigma attached to the diseases and would advise to make modern treatments accessible to all, even the poorest, and would recommend a programme of education for the youth. It is apparent that the aftermath of the Contagious Diseases Acts existed well into the first 20 years of the 20th century.

In the 1990s, discussions about adolescent sexualities were rampant throughout Europe and the USA. While the adolescent was part of the discourse on VD at the turn of the 20th century, present concerns about adolescent sexual behaviours mirror those of the 1960s, when ‘sexual promiscuity’ and ‘permissiveness’ arose as the central explanatory concepts in medical and public debates (Davidson, 2001). The 1960s saw a shift in sexual mores in the USA and in Europe. Sexualisation of many facets of life occurred, notably advertising, mass media and other elements of consumer culture (Brandt, 1987). Teenagers can be defined as a socially marginal group who inhabit the dangerous moral space between childhood and adulthood. The term ‘teenage’ is socially constructed to allow wild and socially deviant behaviours but ones which are in need of policing (Thorogood, 2000). During the teenage years, sexuality is emerging, is unfixed and therefore requires influence. With all the changes occurring in the wider social sphere, the sexuality of adolescents was subjected to the public gaze. In 1964, a report on VD amongst teenagers suggested that there had been a vast increase in promiscuity among the young in Britain (Weeks, 1989). Throughout the ensuing decades, VD figures were treated as an index of rising promiscuity and immorality in the population. In Scotland, young girls were seen as the carriers of venereal disease. “The potent image of asymptomatic promiscuous girls as ‘reservoirs of infection’ haunting cafes, pubs, cinemas and dances halls was widely projected in the media and in public health literature” (Davidson, 2001:222).

However attitudinal studies done at that time, suggested that most adolescents did not differ from their elders. They were more conservative than permissive (Davidson, 2001; Weeks, 1989). Premarital sex had been occurring throughout the 20th century and there was not any evidence to suggest that the change in sexual mores was related to increases in sexually transmitted infections. Michel Schofield pointed out that in 1965, the odds of a girl aged 15 to 19 getting a venereal disease were 1 in 1000 (as cited in Weeks, 1989). Nevertheless, calls for sex education through the familial framework were made, sparking off once again a debate about the capability of parents advising children and whether sex education would encourage more promiscuous behaviours. The rise in rates of STIs in Britain and the USA were more likely to be the result of failures in the provision of STI services. After the Second World War, STIs were considered 'dying diseases' and there followed medical indifference, administrative neglect and lack of state funding and interest (Hall, 2001; Brandt, 1987). This situation changed with the onset of AIDS.

HIV/AIDS has continued the social historical cycle of sexually transmitted infections. Emerging at a time of a herpes epidemic in the USA, HIV/AIDS had to grapple with being stigmatised, being the disease of the marginalized and the promiscuous and embodying societal fears about sexuality in an era of new reproductive technologies, child sex abuse and decadence. It highlighted the unfinished revolution in attitudes to homosexuality (Weeks, 1989). Heterosexuality continued to be viewed as the normative outcome of sexual development – an outcome that is socially produced through institutions, labour market and ideology (Dunne, 1997). This production places all other sexualities as deviances from the norm, including any deviations from the prescription of passive female heterosexuality. Women, adolescents and ethnicity were terms frequently applied in HIV related discussions. Medics returned to the forefront of public discourse and the 'Cinderella' service of genitourinary medicine once again had a major role to play in STI control, this time in public health prevention strategies. In Ireland, the opinions of genitourinary specialists and other consultants on the rising rates of STIs routinely featured in journalistic reports. Such engagement of medical authority appears to be unique in a time when medical expertise was being diminished by the rise in influence of the media, lay organisations and health service managers (Abraham & Lewis, 2002). By the end of the 20th century, HIV/AIDS and other STIs were incorporated into the wider notions of sexual health. A new discourse on risk and risk societies had also emerged in Britain (Turner, 1995), although such notions did not appear within the Irish public discourse. Instead, the media reflected views from medical professionals in the field of AIDS and STIs and from religious leaders on perceived changes in sexual mores in Ireland. Thus continuing the long tradition of medico-moral politics on sexually transmitted infections in the British Isles.

Before leaving the history of STIs in the 20th century, it is worth mentioning feelings of 'fin de millennium', which have been argued to affect notions of sexuality. Likening the feeling to that of the end of the 19th century, Weeks (2000) has pointed out similarities in issues that have arisen in public discourse. The late 19th century saw beliefs about the decline of the family, the first wave of feminism, the rise of the 'new woman', invention of the homosexual and the syphilis epidemic (Weeks, 2000). The late 20th century, saw beliefs about the decline of the family, the second wave of feminism, the liberalised woman, lesbian and gay politics and AIDS epidemic (Weeks, 2000). Furthermore, western societies were seen as being globalised, de-

traditionalised and urbanised, not unlike the industrialisation, secularisation and urbanisation of the late 19th century western societies. Both centuries ended with fears about the breakdown of moral and community values. At the end of the 20th century, the media in western societies proclaimed a rise in rates of crime, increased rates of teenage pregnancies and augmented rates of sexually transmitted infections. All these were used to point to societies that were becoming disordered. While Weeks (2000) further argued that feelings of 'fin de millennium' faded in Britain by the turn of the 21st century - due to individuals continuing their day to day lives despite concerns of churches and state on issues of sexuality - Ireland can be argued to have experienced a similar process. This was reflected not only in the media stories on rising rates of STIs and teenage pregnancies but also contained a moral panic on child sexual abuse (McAlinden, 2000). These feelings were amplified by the rapid changes in sexual politics in the early 1990s, which further liberalised Irish sexual attitudes. As a western society, Ireland is influenced by national and international forces.

Conclusion:

When examining STIs, sexual behaviours and attitudes in relation to Ireland, it is essential to take into account how STIs are historically and socially perceived within Europe and the USA. Medical responses to STIs have been shaped by moral assumptions about the sexual behaviours of those infected and these responses sequentially affect the public attitudes. The social meanings attached to diseases are important as the way we interpret illness affects how we will respond. These interpretations have influence over the perception of STIs in Ireland. Connotations of race, prostitution, class, adolescent and sexually liberated woman are prevalent within Irish public discussions and STIs are attached to socially deviant behaviours.

Studying the social history of the infections is of use to the sociologist in two ways – the devising of sexual health promotion campaigns and the study of sexuality. By taking into account the past efforts to combat the infections, sociologists can use the knowledge to break the cycle of morality, sexuality and medicine in order to devise new more effective prevention campaigns. Instead of viewing the infections as the consequences of deviant behaviours by socially devised 'high risk' groups, it would be more beneficial to look at why individuals risk STIs in their sexual encounters. In other words, we need to look at the infections themselves rather than viewing them as outcome measures of changes in sexual mores. Sexually transmitted infections occur within the governing social norm as well as in the 'high risk' categories. They are not solely the disease of the deviant, but diseases that can affect all humans. In relation to the study of sexuality, the socio-historical analysis of STIs and its relationship with sexuality reveals that sexual risk taking has always occurred, albeit amongst a minority. Western societies like Irish society have had mixes of sexual behaviours throughout history, although the actual rates of sexual activity amongst different groups – for example, adolescents – may vary across time. Additionally, the study of how sexual discourse in the past has been influenced by social forces raises the question of how current discourse surrounding sexuality is being shaped. In chapter 8, the influence of secularisation and mass consumerism on late 20th century Irish sexuality is discussed briefly, though Hawkes (1996) provides a more detailed analysis.

Unfortunately, we do not have details on why Irish individuals risk exposure to STIs in their sexual encounters. We do however have cross-sectional data on Irish sexual attitudes and behaviours from the ISSP (1994) data set. This can inform us about the proportion of the population who are engaged in 'high risk' sexual behaviours. Although not all those who attend GUM clinics have an STI, the majority are likely to perceive themselves at risk and have been involved in some form of 'high risk' behaviours. Indeed, Wellings et al (1994) found a close association between the risk-taking sexual behaviours in their cross-sectional survey in Britain and the probability of GUM clinic attendance. By utilising the ISSP (1994) data set, we can determine the proportion of the population who undertook forms of 'high risk' behaviour in the mid 1990s, i.e. during the period that the reported rates of STIs were increasing. This proportion can be viewed as likely candidates for attendance at GUM clinics. Through the analysis we can determine if 'high risk' behaviours are concentrated within 'core' groups or are distributed across the Irish population. We can also identify the factors that are associated with multiple partnerships. This should provide information on the types of individuals who are risking exposure to STIs in Ireland.

Chapter 5: Who's at Risk? Irish Sexual Behaviours and Sexually Transmitted Infections.

The relationship[s] between many aspects of lifestyle and health have been studied but sexual behaviours is a notable exception where little work has been undertaken.

(Wellings et al, 1994:275).

Introduction:

While it has been argued that the reported rates of STIs are not the direct outcome of the proportion of 'high risk' behaviour in a population, undoubtedly, individuals' risk-taking behaviours do affect the spread of the infections. Irrespective of sexuality, epidemiological studies have shown that the probability of acquiring STIs increase with the number of sexual partners with whom one has unprotected sexual intercourse (Liljeros et al, 2000; Wellings et al, 1994). Sexually transmitted infections are spread through sexual interactions between individuals and the greater the number of people an individual has sexual relationships with, the greater the likelihood of coming in contact with sexually transmitted infections. Utilising the appendix of the ISSP 1994 dataset on sexual behaviours, we can assess an individual's exposure to multiple partners. This estimated risk provides information on the potential risk of exposure to sexually transmitted infections. Because the measure does not include the intervening effects of contraceptive usage or partnership characteristics, it is an over-representation of potential risk. This however is useful to our study as it can tell us the maximum proportion of a population engaging in 'high risk' behaviour and we can thus derive whether the increasing rates are linked to a growing proportion of the population engaging in 'high risk' behaviours or if STIs are largely confined to a minority (e.g. 'core' groups).

The chapter comprises of four sections providing a depiction of the nature of sexual partnerships in the Irish population. The first section is merely descriptive, illustrating the number of sexual partners the respondents have had within three measures of time units, namely the last 5 years, the past year and since their 18th birthday ('lifetime' partners). While these data cannot provide accurate estimates of the numbers at risk of contracting STIs, this information can provide a first step towards addressing this public health issue (Kost & Forrest, 1992). It is intended that the time span of five year (roughly 1989 to 1994) would give some indication of the numbers of individuals exposing themselves to the potential risk of STIs within the very period of escalating rates. The second section is concerned with the exposure to 'high risk' behaviours, such as homosexual and bisexual behaviours and sex with a prostitute or an anonymous partner. In previous studies, when controlling for the sexual partner being infected, concurrent relationships were also found to yield a higher risk of STIs than sequential relationships (Laumann et al, 1994). Unfortunately we are unable to derive from the data any information to support the presence of concurrent relationships. Even where respondents were married and were stated as having two or more partners in the last year, it is difficult to determine if these relationships were concurrent as we do not know the time frame of marriage.

However, we do have information on extramarital affairs. It can be argued that a married individual who is having sex with someone other than their spouse, will recruit their partner from outside their social circle of acquaintances in order to minimize the chances of being discovered. Laumann et al (1994) in their study on the sexual behaviours of the USA population argued that this action increases the individual's risk of STIs more than if the individual was single and had indulged in a series of short-term monogamous relationships. A limitation with this dataset is that the size of the subpopulation of homosexuals and bisexuals is too small to carry out any significant differential analysis¹. Therefore, this section has to be descriptive and devoid of attempts to determine sexual linkages as possible routes of sexually transmitted infections.

In the third section, a logistic regression analysis is employed to yield the combination of predictor variables that affect the likelihood of having multiple partners within the time frames of one year and five years. Multiple partnerships are defined as having had two or more sexual partners in the last year (Kost & Forrest, 1992). Coetzee & Mathews (1998) found that STIs tended to be prevalent in young, unmarried individuals. Magnus (1998) also concluded that young, non-cohabiting city dwellers constituted one of the groups that keep STIs flourishing. As discussed in previous chapters, age does have an effect on the prevalence of STIs, with those aged between 20 and 30 reporting the largest proportion of rates of the infections within Ireland and across western societies. This is also the age group who are sexually active amidst the changes that have occurred in sexual politics and the wider Irish sexual culture during the 1990s. By dividing the sample into those between 18 and 30 and those over the age of 30, we can focus on this group of people and compare their behaviours with the rest of the population. Through the use of the ISSP dataset, we can attempt to predict if membership of the younger age group does increase likelihood of having multiple partners and identify what other conditions influence the accumulation of two or more partners within a stated time frame.

In the absence of information on contraceptive practices, patterns of sexual behaviour, characteristics of sexual partnerships and numbers of infectious partners, we cannot directly determine the risk of exposure to a potentially infected person for an Irish individual. We can however, estimate the probability for an individual encountering a sexual partner who has multiple partnerships within the same period of time. Since multiple partnerships is an important feature of STI transmission, we can infer from the estimate an approximate likelihood of a sexually active Irish individual encountering a potentially infected partner. This estimate is calculated in the final section of this chapter.

Data and Methods:

The data on Irish sexual behaviours is taken from the 1994 International Social Survey Programme (ISSP) module on Family and Changing Sex Roles, although the focus here is on the appendix of questions on sexual behaviours. This appendix was collected through postal questionnaires. According to Aral and Peterman (1996),

¹ One problem with using a randomised sample for sex research is that the homosexual population tends to be underrepresented. As O'Connell Davidson & Layder (1994) have argued, the homosexual population is not geographically dispersed across a nation, as homosexuals tend to live in cities where there are cohesive gay communities.

responses by written questionnaires, which are anonymously returned by post, is a reliable method for collecting valid sexual behavioural data. Compared to face-to-face interviews, it minimises embarrassment, reassures anonymity by providing information on sensitive issues and gives people time to recall their number of sexual partners. Three measures of multiple partners are used – number of sexual partners in the last year, over the past 5 years and ‘lifetime’ partners. This last measure was formulated by adding together the variables ‘number of male sexual partners since 18th birthday’ and ‘number of female sexual partners since 18th birthday’. For the logistic regression, the first two sexual partner measures were recoded into a binary response variable of those who had one sexual partner in the time period (of either the last year or the past five years) and those who had two or more partners. Although, attendance at religious services is only one measure of religiosity, in relation to sexual behaviours, it can be assumed that attendance at religious ceremonies would bring individuals into contact with the religious institution’s teachings on sexual matters. Thus, it can have an external influence on behaviours.

Missing Data:

One problem with the Irish component of the ISSP dataset is the large proportion of people who did not respond to the sexual behaviour questions. Out of 938 respondents, almost half (46%) refused to answer the sexual behaviour questions. This provides a large proportion of missing data, which subsequently affects the conclusions drawn from the analysis. While the survey was carried out by means of face-to-face interviews, the questions on sexual behaviours formed an appendix, which was left with the respective respondents to fill out in private. Completed questionnaires were then returned by post to the research body conducting the Irish component of the ISSP survey². It is thus very likely that individuals just simply did not bother returning the appendix. Nevertheless, since the non-response rate is so large, it is possible that the analysis of risk behaviour (i.e. the number of sexual partners during a specific time period) could be biased. Individuals who discuss their sexual behaviours may be different from those who do not.

Although Peruga, Kofie and Martinez (1993) found no association between non-response to answer sex behaviour questions and socio-demographic questions (with the exception of levels of education), the absence of questions on risk taking behaviours does mean that the only way to distinguish a pattern of non-response or expression of unease about sexual behaviour questions is to examine the ‘non-response’ group by their demographics. Indeed, some variation was seen to have occurred between those who responded and those who did not when comparing them by categories of some of the demographic variables. As education level increased from no education to university degree, the non-response rate decreased from 50% to 30.3%, while 55.7 % of those in rural areas did not respond opposed to only 38.4% of those in urban areas. However on most accounts, difference between those who responded and those who did not were small. The age groups of 31 to 40, 51 to 60 and 61 to 70 years all had a non-response rate of circa 45%. A similar non-response rate was also found amongst the classifications of marital status. In relation to gender, both sexes were equally likely not to respond – 47.1% of males and 45.7% of females.

² Information obtained from Dr. Tony Fahey, ESRI, Dublin, who was involved in the project.

Table 1.
Table of Results from Logistic Regression Analysis for predicting the variables associated with the log-likelihood of non-response to sexual behavioural questions.

	Model I		Model II		Model III		Model IV		Model V		Model VI	
	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.
Reached or completed third level education	-0.557***	0.211	-0.383*	0.217	-0.461**	0.222	-0.372	0.23	-0.366	0.232	-0.39*	0.233
Reached or completed secondary school level	-0.075	0.164	-0.008	0.167	-0.065	0.171	-0.009	0.175	0.024	0.178	0.001	0.179
Reached or completed primary school level (Base)	0		0		0		0		0		0	
Reside in an urban area			-0.678***	0.145	-0.712***	0.147	-0.71***	0.147	-0.71***	0.148	-0.771***	0.151
Reside in a rural area (Base)			0		0		0		0		0	
Premarital sex is not wrong					0.254*	0.152	0.324*	0.159	0.324*	0.159	0.191	0.17
Premarital sex is wrong (Base)					0		0		0		0	
Aged between 18 and 30 years							-0.295	0.19	-0.39*	0.216	-0.441**	0.218
Aged 31 and older (Base)							0		0		0	
Single and never married									0.194	0.19	0.114	0.193
Separated, divorced or widowed									0.19	0.254	0.174	0.256
Married or cohabiting (Base)									0		0	
Never attend religious services											0.327	0.371
Attend religious services once a month to once a year											0.467**	0.194
Attend religious services once a week or more (Base)											0	
- 2ll	1118.907		1096.839		1094.042		1091.62		1090.246		1084.284	
Model Chi²	8.194**		30.263***		33.06***		35.482***		36.856***		42.818***	

N = 435

*** = significant at 0.005 level; ** = significant at 0.05 level; * = significant at 0.1 level

Using a logistic regression, the log-likelihood of non-response to the sexual behavioural questions was calculated using level of education reached, area of residence, attitude to premarital sex, age group, marital status and religious attendance. The variable of gender is not included, as it was not shown to be a confounding factor. Apart from inclusion of attitudes to premarital sex, the predictor variables are the same as those used for the logistic regressions on the likelihood of multiple partners. The reason behind the utilisation of the variables was that if there was a bias in the type of person who responded to the questionnaire, it was important to establish how likely members of the 'non-response' group were to have multiple partners, using the characteristics associated with the probability of that behaviour. If the 'non-response' group consisted of mostly young, single urban dwellers then the chances are that the risk assessment would be inaccurate, as the proportion of 'high risk' takers is too small. As it transpired, it was largely the older age groups who were married who declined inclusion. This of course means that those who do have multiple partners may actually be a much smaller percentage of the sample, resulting in a possible over-estimation of multiple partners. However, given that the numbers of people with multiple partners are so small, it is not necessarily a bad thing to have a small over-representation of those with multiple partners. Not only does it help the statistical analysis in terms of sample size, but it can also help predict maximum risk levels for the population.

The results of the regression analysis on likelihood of non-response are shown in Table 1. Six models are presented, accumulating in what is considered the 'best-fit' model. Unstandardised logistic regression coefficients (B) and their standard errors are reported rather than odds ratios. This is because standardised logistic regression coefficients are better for evaluating the strength of the influences of the independent variables on the dependant, relative to one another (Menard, 1995). Because log-odds are centred around zero (i.e. no effect), log-odds are easier to visualise than odds ratio. In odds ratio, the use of 1 equalling no effect makes values between 0 and 1 difficult to interpret (Miles & Shevlin, 2001). Positive log-odds represents a higher log-likelihood of having one or more partners than the based category. Negative log-odds represent a lower log-likelihood. Significance levels of 0.005, 0.05 and 0.1 are used, with reference given to those that were just over the 0.1 level. Since the regression models are being used here for exploratory analysis, the emphasis is not on determining causality, rather the interest is to find a set of predictors that can accurately predict the likelihood of two or more sexual partners. Therefore, 0.05 can be deemed too low and rigid for exploratory research as it can often exclude important variables from the model (Menard, 1995). Because of this, a higher significance level of 0.1 is employed.

Throughout the models, area of residence is a strong predictor of the log-odds of non-response. Even when adjusting for all the other variables, those living in urban areas had significantly lower log odds of non-response than those in rural areas. This could be due to a number of factors. Firstly, those living in rural areas may not be as forthcoming about discussing sexuality. Evident features of gossip in rural parts can make people distrustful about speaking about personal matters. They may also not possess the blasé attitude of urban dwellers towards sexuality, a feature that can be associated with the direct contact with sexualisation of culture in large towns and cities or with city life in general. Secondly, access to a post office may be limited for some people, especially if they are elderly or live in a sparsely populated area. This

would inhibit their return of postal questionnaires. Finally, rural areas are considered to hold traditional values and beliefs. This undoubtedly would contribute to reluctance to discuss private, sexual matters, especially given the Irish social history of sexual morality.

Similar to the findings of Pergua, Kofie and Martinez (1993), level of education reached did have an effect on the likelihood of non-response. Without controlling for other variables, those who had acquired third level education or more had significantly higher odds of answering the questions on sexual behaviours than the base category of those who had not progressed further than primary school. Completion of the questionnaires required written responses and perhaps, some respondents with lower educational levels, did not respond on the basis that either they were uncomfortable expressing themselves in the written word or they did not comprehend the confidentiality and nature of the survey process. The significance and size of the effect of education level did falter as additional variables were added through the ensuing models. It is not surprising that adjusting for the effects of other demographic variables would have changed this variable's ability to predict the log-likelihood of the response outcome. Education is influenced by a number of factors and notably in Ireland, education level is affected by age group. Over the past two generations the majority of people have moved from only reaching primary level of schooling to attaining secondary school level. A similar effect has been seen in sex surveys carried out in Europe, where younger generations are better educated (Sandfort et al, 1998). This of course means that a large proportion of those in the baseline category of primary level of education will be in an older age group. In relation to sexual behaviours, this is not detrimental to the analysis. Older age groups are on the whole more likely to have had only one sexual partner in the last year or five years. While their exclusion does affect the response rate (and perhaps numbers of 'lifetime' partners), the implications would have been far worse, if it had largely been the younger and theoretically more sexually active age groups that were missing.

Age group membership did have an effect, especially when adjusting for the other effects of marital status and religious practice. Those under the age of 30 had lower log odds of non-response to the sexual behaviour questions (-0.39 log odds in Model V and -0.441 log odds in Model VI). Furthermore, when expressed as odds of non-response and controlling for educational level, area of residence, marital status, premarital attitudes and religious practice, being under the age of 30 means that you are 0.643 times as likely not to respond (i.e. 36% less likely to refuse than the older age group). As mentioned earlier, it is better for the analysis that it was the older group and not those under 30 who were more likely not to respond as the focus is on the characteristics of this group. It is worth pointing out that those who held beliefs that premarital sex was not wrong were less likely to return their questionnaires than those who maintained that premarital sex was morally wrong. The influence of this variable was explained away by the addition of the religious variable in Model VI, where those who infrequently attended religious services were more likely to decline response than the base category of those who were religious attendees. While the effect of attitudes to premarital sex in Models III, IV and V suggest the exclusion of those who may have contributed to our group of having two or more sexual partners, links drawn between attitudes and behaviour are inconclusive. Furthermore, the effect of those who infrequently attend church when controlling for all other factors

can be argued to suggest a tendency of non-committal. In other words, the respondents were just not bothered about returning their responses.

Overall, it can be surmised that while a large portion of data is missing, we can still carry out our inquiry. It is necessary though to view the results mindful of the following observations. Firstly, in sex surveys, there is always the danger that those who responded are those who are more comfortable about talking about sexual behaviours. In relation to our analysis, this means that we may be establishing a difference that is larger than it should be between the behaviours of those with multiple partners and those who do not. It is possible that the missing group of respondents may have had multiple partners and their inclusion would have helped the effects of the predicting variables for multiple partners. Secondly, while the output from the logistic regression suggests that those who refused were from rural areas, were older and were religious - all of which indicate a tendency to have had only one partner within the specified time frames - it is possible that earlier in their sexual careers, they had indulged in multiple partners and as a result, we have lost information on the pattern of sexual activity across generations.

Risk-taking and Multiple Partners:

A good measure of the nature of people's relationships is the number of sexual partners they have within a specific time. Along with sexual orientation, age, social status and other demographic variables influencing partner choice, number of partners per unit time is a long established measure of risk behaviour in sexual behaviour surveys (Kretzschmar, 2000). It is an adequate indicator of an individual's exposure to STIs, including HIV (Wellings et al, 1994; Peruga, Koife and Martinez, 1993). Wellings et al (1999) found that the likelihood of GUM clinic attendance increased markedly with increasing numbers of heterosexual partners. Over one in seven who had five partners in the last five years had attended a clinic in that time. The rate of spread of STIs in a population does depend on the positions of individuals in the sexual network and the timing of their sexual partnerships. Those with multiple partners occupy more central positions in the sexual network than those who have one sexual partner, even if the latter has had greater frequency of sex (Aral & Peterman, 1996). These connections put the individuals at risk of infection and this aids the spread of sexually transmitted infections. It is difficult to assess from survey data, the extent to which those with many partners mix with those with few partners (Wellings et al, 1994). However, the measure of multiple partners provides a good starting point for assessing the extent and type of sexual risk behaviours in the Irish population.

The risk of acquiring STIs does involve a number of sexual behavioural variables. These include whether or not a sexual partner is infected, condom usage, type of sexual partnership (e.g. casual or regular) and the type of sexual practices used. However, numerous studies have shown that the risk of infection positively correlates with the number of sexual partners with whom an individual has unprotected sex (Jonsson et al, 1997; Wellings et al, 1994; Gisecke et al, 1992). Renton et al (1997) estimated that if 'lifetime risk of STI acquisition' is defined as having more than two lifetime partners, then about 50% of males and 40% of females in Britain are at risk. In the USA, it was argued that people with two to four lifetime partners have 3 to 5% chance of being infected with a bacterial STI, while those with over 20 partners have between 28% and 35% likelihood (Michael et al, 1994). It is due to this effect of

having at least two sexual partners on the risk of STIs that the variables for the number of sexual partners in the last year and five years have been categorised into those with one sexual partner and those with two or more sexual partners.

Irrespective of whether condoms are used or not, having multiple partners does increase risk of exposure to STIs for an individual. Firstly, the more partners a person has in a specific time unit, the more likely it is a non-monogamous relationship (Michael et al, 1994). Relationships tend to be casual, short-term or 'one night' stands. There is a strong correlation between those with several partners and the likelihood of paid sex and casual alcohol fuelled encounters (Michael et al, 1994). This of course leads to a decreased usage of condoms. There is also evidence that people with many sexual relationships engage with others who are also in non-monogamous relationships. Since sexual partnering occurs within tightly circumscribed social settings such as geographical proximity, they involve people of the same social network or with similar characteristics (Mai et al, 2000). Hence people with multiple partners relate to others of similar disposition. This greatly increases the chances of acquiring a sexually transmitted infection.

Secondly, people with multiple partners over a twelve month period are more likely to have concurrent relationships or overlapping relationships. Concurrent relationships are more conducive to the spread of STIs than a series of sexual relationships with single partners known as serial monogamy (Overseas Development Administration, 1996; Aral & Peterman, 1996). Serial monogamy can facilitate the spread of STIs, since the incubation period of some infections can last a few weeks. However, according to Barlow (1979) a period of 6 weeks between sexual partners reduces the likelihood of transmission, as this gives people time to show signs of infection. In the case of concurrent relationships, one relationship may be ending while another is commencing, thus allowing the infection to be spread before the symptoms can appear. Additionally, concurrent relationships may consist of one regular sexual partner supported by a secondary sexual partner, casual sex, 'flings' or paid sex. Concurrent relationships have also been demonstrated to be devoid of condoms usage (Mai et al, 2000). All of these add to the risk of exposure to sexually transmitted infections.

Multiple Partnerships in the Last Year and Five Years:

When looking at sexual behaviours, it is important to collect data on a few different time periods in order to capture variability in sexual behaviours. There is unfortunately a recall bias inherent in sexual behavioural data – the longer the period, the more difficult it is to recall accurately the number of sexual partners. However, the measures of sexual partners in the last year and last five years should be fairly reliable. Table 2 illustrates the number of sexual partners in these two periods of time by the social characteristics of gender, age, group membership, religious attendance, education level, area of residence and marital status. Gender is included here, as previous research has indicated a variation in responses between the sexes with males reporting a higher mean and median numbers of sexual partners than females (Wellings et al, 1994; Fitzpatrick et al, 1992). This could be due to the tendency of males to boast about their exploits while women become coy about revelations. Individuals can have partners who are outside the sampled population (e.g. abroad) or are under represented (e.g. prostitutes) and this would affect the response rate

(Wellings et al, 1994). However, in terms of the measurement of one sexual partner versus two or more, the response rates are very similar. The majority of males and females have reported one sexual partner within the last year and five years.

Within age groups, those under the age of 30 were just as likely to have one sexual partner as those over 30 years for both time periods, although a larger percentage of the younger age group had two or more partners. This is expected as those of the younger age group are at the start of their sexual career³ and are more likely to sexually experiment with a number of sexual partners. There is a small difference between males and females of the lower age group, with 77.3% of females between 18 and 30 reporting one sexual partner in the last year while 61.7% of women reported one sexual partner in the past five years. This is 3.5% and 17.5% higher than reports from males for the same periods. Lear (1997) had a similar finding amongst a US college population. Despite younger age groups being more likely to sexually experiment, women tended to be more conservative and more careful in contraceptive practices. People who regularly attend religious services (i.e. at least once a week) reflected the expected conservative pattern with the vast majority reporting one sexual partner in the last year and five years (94.4% and 88.1% respectively). Small percentages did report having two or more partners, which is not surprising, given that the religious measure is one of attendance not devotion per se. In Ireland, church attendance can be described as a social outing as much as a religious practice, with many families and friends routinely attending out of habit. In relation to those who categorised themselves as married or living as married but reported two or more partners in the past year or five years, it is difficult to assess concurrency when we do not know the date of marriage nor the timing of these partnerships. Nevertheless, this group does include those who have had extramarital affairs so we cannot overlook the possibility that these are individuals who are potentially at risk of sexually transmitted infections.

Similar to other sexual behavioural surveys, such as Wellings et al (1994), an extreme skewness of distribution occurs in relation to the reported number of partners. The vast majority of respondents only report one sexual partner with a few extreme points or outliers reporting several. This of course affects the mean and variance of the number of sexual partners and as a result, there is common tendency amongst sexual behavioural surveys to report median number of sexual partners. Unlike, other types of social surveys, 'outliers' cannot be readily ignored or dismissed as errors. Within the population there is a minority who frequently change sexual partners. These form a 'core' or 'high risk' group. The extreme skewness of the distribution in this sample lends support to the existence of this group within the Irish population. This small part of the population contains a high rate of partner change and its associated risk behaviours, which place the individuals at risk of acquiring or transmitting a sexually transmitted infection. Unfortunately, we cannot assess their mixing pattern. There is some evidence from other sexual behavioural research to suggest that individuals do move between 'high risk' sexual activity groups and low risk groups (Kretzschmar,

³ The life course of sexual activity and lifestyle of an individual can be termed a sexual career. Generational effects and secular trends aside, most individuals' sexual careers undergo a similar process (Welling et al, 1994). There is an initial experimental phase with a number of partner changes. Then there is the establishment of a long term and committed relationship (e.g.: marriage). Later in life, there can be separation, divorce and widowhood, which result in either sexual abstinence or new relationships.

2000). Certainly people move from high risk sexual activities to low risk over their sexual careers. However, in relation to the transmission of STIs, the degree to which those with a high rate of partner change mix with those with a low rate within a specific period of time is of importance to the pattern and spread of sexually transmitted infections in a population. Giesecke et al (1992) has suggested that high-risk individuals choose similar high-risk partners, more often than is predicted by chance. If this is the case for the Irish population, then the increase in reported rates is reflective of this minority rather than changes in high-risk behaviour for the whole population. Indeed, given that the majority of the young age group have had only one sexual partner in the last year, it is very possible that at that period when the rates were increasing, it was not changes in sexual practices amongst the young that were contributing to the augmentation.

Due to the huge value publicly placed on chastity in Irish social history, it is worth mentioning those who did not have any sexual partners within the past year or five years. Overall 13.5% (127) of respondents reported having no sexual partner in the last five years while 15.2% (143) claimed to have abstained in the last year. In relation to lifetime partners, 30.6% responded that they had not had any male sexual partners since their 18th birthday, whilst 29.3% reported a lack of female sexual partners. Out of those under 30, 16.7% did not have a sexual partner in the last year compared to 14.3% in the last 5 years. Given the tradition of chastity, this rate is not as high as would be expected amongst those who are unmarried and does reflect a generation of Irish people who do not subscribe to traditional views of Irish sexuality.

‘Lifetime’ Partners:

In relation to the third measure of sexual partners – the number of lifetime partners since 18th birthday - the median number of sexual partners for all respondents was 1 partner (Mean number of partners was 3.66 and the standard deviation was 5.03). Overall, the number of sexual partners ranged from 1 to 30 lifetime partners. Variation did occur between the sexes for the different age groups (See Figure 1). The median number of partners peaked for males in the 31 to 40 years age category (4.5 partners), while it was earlier for females (2 partners), perhaps indicating a difference in female sexuality post feminism when compared to the previous generations. Median numbers of partners were higher for males until the 51 to 60 category when the median fell to one. These older age groups would have been in the early stages of their sexual careers before the social and economic changes in modern Ireland, when Irish chastity was valued, and this may be reflected in their behaviours. When viewing age groups without gender segregating, those who are aged between 18 and 20 reported a median of 2 and a range of 1 to 20. Those 21 to 30 years had a slightly higher median of 3 and a range 1 to 30. The age group 31 to 40 also had a range of 1 to 30 sexual partners but the median number decreased to 1 sexual partner. A similar pattern was seen in the 41 to 50 year old age group, while the 51 to 60 age group’s maximum number decreased to 18 sexual partners. The 61 to 70 year olds again reported a median of 1 but had a range of 1 to 20, while those 71 and older had a median of 1 and a range of 1 to 10. The variation in number of lifetime partners is not surprising. Despite claims that younger cohorts are more sexually active, one would expect to see sexually active individuals in all age groups. As previously argued, the past sexual morality does not mean that all individuals were prudent.

Table 2

(1) Sexual Partners in the Last Year

Social Characteristics	Number of Sexual Partners (%)		Total
	1 partner	2 + partners	
Gender	318 (89.1%)	39 (10.9%)	357
Male	144 (86.7%)	22 (13.3%)	166
Female	174 (91.1%)	17 (8.9%)	191
Male (18 – 30 years)	31 (73.8%)	11 (26.2%)	42
Male (older than 30)	113 (91.1%)	11 (8.9%)	124
Female (18 – 30 years)	34 (77.3%)	10 (22.7%)	44
Female (older than 30)	140 (95.2%)	7 (4.8%)	147
Age Group (18 – 30 years)	65 (75.6%)	21 (24.4%)	86
Age Group (older than 30)	253 (93.4%)	18 (6.6%)	271
Those do not attend church	11 (68.8%)	5 (31.3%)	16
Attend church between once a year and a few times a month	68 (80%)	17 (20%)	85
Attend service once a week	235 (94.4%)	14 (5.6%)	249
Those who reached university level of education	71 (84.5%)	13 (15.5%)	84
Secondary School level	184 (88.5%)	24 (11.5%)	208
Primary level or less	62 (96.9%)	2 (3.1%)	64
Live in urban area	196 (86%)	32 (14%)	228
Live in rural area	122 (94.6%)	7 (5.4%)	129
Single, never married	43 (62.3%)	26 (37.7%)	69
Separated, divorced or widowed	7 (70%)	3 (30%)	10
Married or living as married	266 (96.4%)	10 (3.6%)	276

Table 2 Cont'd

(2) Sexual Partners in the Last 5 Years

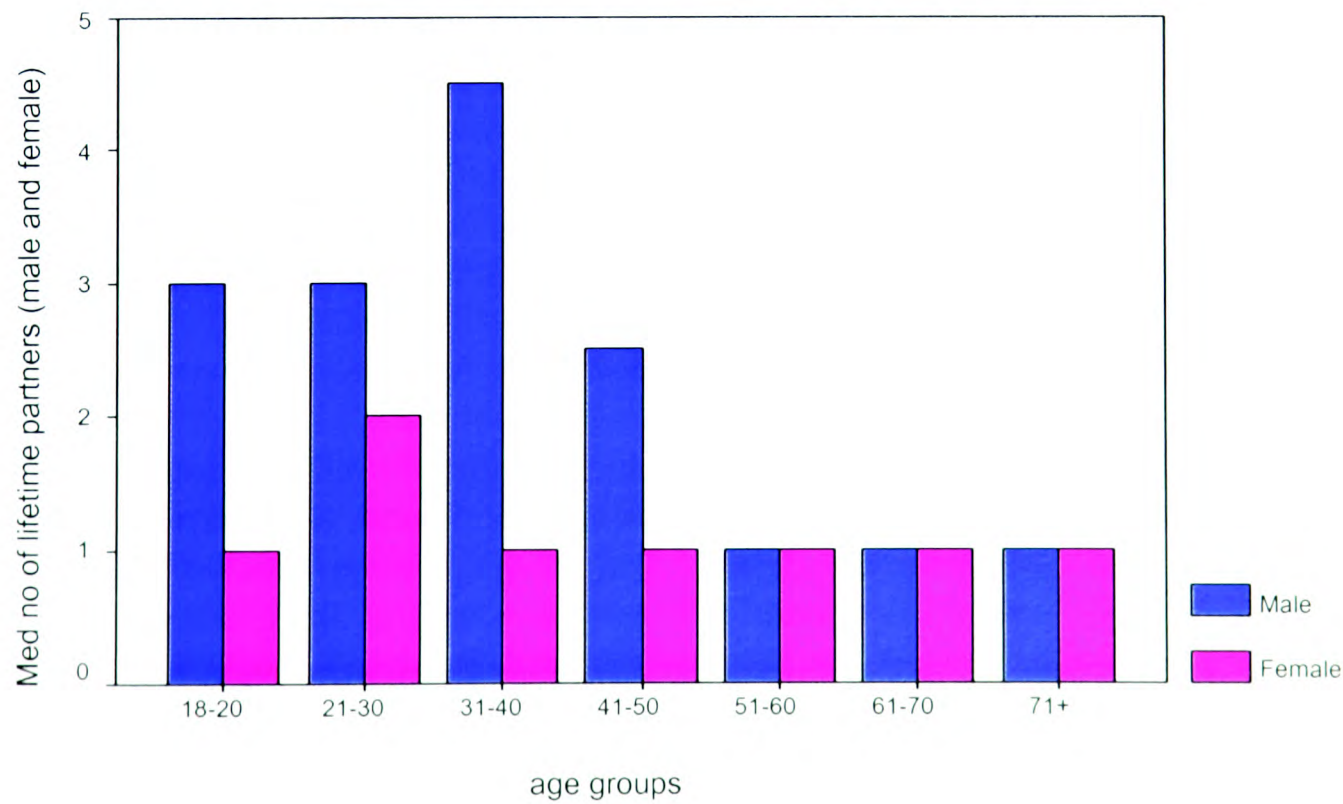
Social Characteristics	Number of Sexual Partners (%)		Total
	1 partner	2 + partners	
Gender (Total)	295 (80.6%)	71 (19.4%)	366
Male	128 (75%)	42 (24.7%)	170
Female	167 (85.2%)	29 (14.8%)	196
Male (18 – 30 years)	19 (44.2%)	24 (55.8%)	43
Male (older than 30)	109 (85.8%)	18 (14.2%)	127
Female (18 – 30 years)	29 (61.7%)	18 (38.3%)	47
Female (older than 30)	138 (92.6%)	11 (7.4%)	149
Age Group (18 – 30 years)	48 (53.3%)	42 (46.7%)	90
Age Group (older than 30)	247 (89.5%)	29 (10.5%)	276
Those do not attend church	10 (58.8%)	7 (41.2%)	17
Attend church between once a year and a few times a month	60 (67.4%)	29 (32.6%)	89
Attend service once a week	223 (88.1%)	30 (11.9%)	253
Those who reached university level of education	58 (68.2%)	27 (31.8%)	85
Secondary School level	164 (80.4%)	40 (19.6%)	204
Primary level or less	72 (94.7%)	4 (5.3%)	76
Live in urban area	182 (76.8%)	55 (23.2%)	237
Live in rural area	113 (87.6%)	16 (12.4%)	129
Single, never married	25 (33.3%)	50 (66.7%)	75
Separated, divorced or widowed	16 (80%)	4 (20%)	20
Married or living as married	252 (93.7%)	17 (6.3%)	269

Variations of sexual behaviours have always occurred within generations and will continue to do so.

All outliers were checked for potential errors in data entry. The only outlier of concern was a 19 year old male, who claimed that he had 20 partners since his 18th birthday yet mentioned only 1 sexual partner in last 5 years and 1 in last year. It is unlikely that he acquired 18 of these partners by the age of 14, however it is worth noting that when dealing with responses on sexual behaviours, people are very subjective in defining sexual partners. Many people discard ‘one night stands’ as sexual partnering, so it is possible that this respondent may have used this premise and only considered one sexual partner as being a regular sexual partner.

Given that lifetime numbers of sexual partner are aggregates, we would expect the number of partners to increase over an individual’s lifetime. In Figure 1, the median number of partners for males is greater for those under 50 than over. In relation to women, the median number of partners is higher for those under 30, thus suggesting a pronounced generational difference. This finding contrasts with that of Wellings et al (1994) whose study on British sexual behaviours displayed a more even distribution of numbers with multiple lifetime sexual partners across the generations. In relation to the accumulation of sexual partners over a lifetime, recall bias can affect the results, as the older generations have to remember number of sexual partners for a longer interval of time than the younger age groups. However, we would expect individuals to remember if they have had more than one lifetime sexual partner. Those under the age of 30 have had less time to acquire their sexual partners, yet they have accumulated a higher median than those over 30 years. It suffices to say that there is a difference between the younger and older age groups in terms of number of sexual partners accumulated over a lifetime. However, despite this evidence of generational differences, the majority of those under the age of 30 report only one sexual partner in the last year and five years. Hence, it can be concluded that only a minority indulge in multiple partnerships.

Figure 1
Median number of lifetime partners By Age Group and Gender.



‘High Risk’ Groups.

This section focuses on the risk behaviours associated with spread of STIs including homosexual and bisexual behaviours, prostitution and concurrency. Kretzschmar (2000) has argued that when looking at sexual transmission of diseases, it is important to distinguish between homosexual and heterosexual behaviours. Homosexuals have long been recognised as a ‘high risk’ group in terms of STIs and AIDS. When looking at behaviours it is important to distinguish between those who identify their sexuality as homosexual and those who have experienced homosexual activities. Irrespective of sexual identity, people can be engaging in both homosexual and heterosexual transmission of STIs (Wilton, 2000). Evans et al (1998) argue that risk of heterosexual spread of HIV is increased by the combination of heterosexual and homosexual intercourse by homosexual and bisexual men. Self-classification of sexuality does not accurately reflect sexual behaviour nor does it recognise the full potential for heterosexual spread of STIs by homosexual and bisexual men. Evans et al (1998) found in their studies that over 50% of homosexual men reported previous heterosexual intercourse.

According to Richardson (2000), it is possible to define homosexuality in survey data. Homosexuality can be used to describe those who only engage in sexual activities with their same sex within a specific period of time and the term bisexual can be used to refer to those who have had sex with both men and women within the same time period. In relation to this sample, sex of life-time partners is considered the best measure of homosexuality, bisexuality and heterosexuality. It is possible that some homosexuals have reported sexual partnerships with the opposite sex before ‘coming out’ so in terms of STI transmission, bisexual behaviours is of more importance when measured in the time periods of the last year or past five years.

Homosexual Behaviours.

Similar to Wellings et al (1994) in their national study on sexual behaviours in Britain, the majority of respondents in this sample have experienced exclusively heterosexual behaviours. Moreover, those with multiple partners were found in this heterosexual population. Only 21 respondents reported homosexual behaviours – 4.1% of those who had exclusively male partners since 18th birthday were men and 6.1% of those who had only female partners since 18th birthday were women. This low percentage reflects what has been found in other European sexual behavioural surveys. Out of 5 surveys done on USA, Denmark, France, UK and Sweden on aspects of sexual orientation and behaviour which are related to risk of HIV/STIs, lifetime homosexual behaviour was reported to be less than 7%, with rates of past year same gender sexual contact of between 1% to 3% (Dunne et al, 1994).

Overall the number of lifetime partners that homosexuals had were quite small, with only one male in his 60s reporting 9 male sexual partners, while 4 women between the ages of 41 and 60 also reported having had 9 lesbian partnerships. In the younger age group of those under 30, only one woman reported 6 female relationships, the others - 2 males and a female - had one, two and one partners respectively. When looking at sex of sexual partner in the last year, again the proportion of homosexual and bisexual behaviour is very small, thus indicating that perhaps transmission of STIs in the Irish population may be more affected by heterosexuals with multiple partners. Indeed, the

largest proportion of reported STI rates consists of ano-genital warts, an STI which is associated with heterosexual coupling. Within the last year, only 3.2% of males under the age of 30 and who had one sexual partner reported homosexual experience. In the older age group of males aged 31 and older, 2.7% of those who had one sexual partner in the last year had homosexual experiences. Only one female had a same sex partnering in the last year. She also reported having two or more sexual partners. Interestingly, two males and 3 females who reported having only one sexual partner claimed to have had sexual experiences with both sexes. While this could be an error in data entry, again it should be reiterated that people are subjective in their definitions of sexual partners and activities. It is possible that the respondents may consider themselves heterosexual and therefore do not consider the homosexual encounter as a sexual partnering (or vice versa). Moving between sexual groups would help increase the risk of exposure to an STI for the individual.

Prostitution.

Only a tiny number of respondents reported having used paid sex. None of the females reported being involved in prostitution since their 18th birthdays⁴. Only one male under the age of 30 and who was also unmarried, reported having used a prostitute. Another 7 were aged between 31 and 40 and 4 were between 41 and 50 years of age. The majority of these older men were married (9 respondents). As seen in Table 3, no one reported use of paid sex in the last year, hence indicating that the use of prostitution may not have placed them in contact with a high risk group within that year, but their reported past experience reveals that they have taken risks in being potentially exposed to sexually transmitted infections. Furthermore, given that the majority are married and of older age groups, it is conceivable that the respondents have placed both themselves and their wives at risk.

Concurrency.

Table 3 provides information about the types of sexual partners the respondents engaged with over the past year. This can reveal a little about the possibility of the existence of concurrency. Moreover, it can indicate the number of people who engage in sexual intercourse outside regular sexual partnerships, thus exposing themselves to a greater likelihood of encountering a sexually transmitted infection. While looking at those who claimed to have had only one sexual partner, the majority had sex with their regular sexual partner. One male did use a prostitute, while others had sex with a close friend, neighbour, co-worker or casual date. While the males themselves may have had only one sexual partner, their choices of partners reveal a possible exposure to a ‘high risk’ individual. The females were more conservative, with only 5 women having sex with a close friend and another woman having a casual date. In relation to those who had two or more sexual partners in the past year, again the majority had regular sexual partners, though admittedly a smaller percentage when compared to those with just one sexual partner. Expectedly, a proportion of those who had a regular sexual partner also reported having sex with close friends (68% or 17 respondents), a casual date (12% or 3 respondents) or a neighbour or co-worker (4% or 1 respondent). Interestingly, out of those who mentioned having only one sex partner in the last year, 1 male and 2 females over the age of 30 answered that they

⁴ It is possible that there is a social desirability bias with female responses.

Table 3

(1) Type of Sexual Partner in the Past Twelve Months For Those with One Sexual Partner.

<u>Males</u>	<u>Aged 18 to 30</u>	<u>Aged 31 and older</u>
Regular Sex Partner	25 (83.3%)	107 (96.4%)
Close Friend	2 (6.5%)	2 (1.8%)
Neighbour/co-worker	0	2 (1.8%)
Casual Date, pick up	3 (9.7%)	1 (0.9%)
Other partner was paid	1 (3.2%)	0
Other type of partner	0	0
<u>Females</u>	<u>Aged 18 to 30</u>	<u>Aged 31 and older</u>
Regular Sex Partner	31 (96.9%)	132 (97.8%)
Close Friend	1 (2.9%)	4 (2.9%)
Neighbour/co-worker	0	0
Casual Date, pick up	0	1 (0.7%)
Other partner was paid	0	0
Other type of partner	0	0

(2) Type of Sexual Partner in the Past Twelve Months For Those with Two or More Sexual Partners.

<u>Males</u>	<u>Aged 18 to 30</u>	<u>Aged 31 and older</u>
Regular Sex Partner	6 (60%)	8 (72.7%)
Close Friend	8 (72.7%)	6 (54.5%)
Neighbour/co-worker	2 (18.2%)	0
Casual Date, pick up	0	4 (36.4%)
Other partner was paid	0	0
Other type of partner	0	0
<u>Females</u>	<u>Aged 18 to 30</u>	<u>Aged 31 and older</u>
Regular Sex Partner	6 (60%)	5 (71.4%)
Close Friend	3 (30%)	6 (85.7%)
Neighbour/co-worker	1 (10%)	0
Casual Date, pick up	4 (40%)	0
Other partner was paid	0	0
Other type of partner	0	0

had other partners whom they classified as close friends. One male over the age of 30 also said that he had another partner who was a neighbour or a co-worker, while another male under the age of 30 had a casual date. Again this could be an error in data entry or it could reflect people's subjective views of what constitutes a sexual partner. The latter does have consequences for the spread of STIs if people are overlooking certain sexual experiences and not considering them as potential risky situations for acquiring or transmitting infections.

An indicator of potential concurrency is participation in extramarital affairs. Although respondents have stated that they are married and have had one sexual partner in the last year and five years, it is possible that they may not be having a sexual relationship with their spouse. Despite also not possessing any knowledge of the nature and duration of the extra-marital affair, we can assume possible concurrency. Eighteen men (7.7% of all males) and eight women (3.7%) had been involved in an extramarital affair. All males were aged 31 and over, while two women were less than 30 years of age (the youngest of which was 28). With the exception of one person who had never been married, all respondents who had been involved in an extramarital affair had been married, with two men and one woman now widowed. None of the respondents classified themselves as separated or divorced, thus indicating that the marriage had continued in spite of the affair. All respondents, except for one person, lived in urban areas with between three and seven people in their households, thus suggesting offspring.

Sixteen of those respondents cited only one sexual partner in the last year, thus indicating that the affair may have happened some time ago. The other ten had between 2 and 100 partners and all cited having one regular sexual partner. It is probable that concurrency of partners occurred. None of them had paid for sex or had casual sex, but eight of the sixteen (50%) had sex with someone they had termed as a close friend, perhaps alluding to a mistress or other secondary sexual partners. These partnerships would have run for a specific period of time during which those individuals may be exposing themselves to risk of infection. Furthermore, the indulgence in extramarital affairs helps to link high-risk partners with low risk sexual partners by providing a channel for the transmission of STIs from core groups to low risk groups.

'High Risk' Groups and Spread of STIs.

While details of the sexual partnerships are scant, it is still possible to infer that a small minority or 'core' group of multiple partners may be placing themselves and others at risk of sexually transmitted infections. Homosexual and bisexual partnerships in this sample are too small in number of partners to support a hypothesis of homosexual behaviours in this population fuelling the rise in rates of sexually transmitted infections. Instead, it appears to be the heterosexual majority that are at risk through the use of multiple partners within a specific time and the risk factors associated with these behaviours.

Using the discrete numbers of those who had multiple partnerships in the past year, an attempt can be made to estimate the maximum percentage of people in this sample who could be infected. This calculation assumes that no condoms are being used and that all the sexual partners of the respondents had some form of sexually transmitted

infection. While this is not an accurate reflection of sexual practices in a population, it can help to assess the maximum level of infection for this group of people. Out of 503 respondents to the sexual behavioural questionnaire, 345 provided information to the questions on the number and type of sexual partners in the past year. Thirty-eight respondents had two or more sexual partnerships, 307 reported one partner. Out of the former group, 17 of those with a regular sexual partner also had sexual intercourse with a close friend, 1 had sex with a neighbour or co-worker and 3 had casual sex. Amongst those who claimed to have one sexual partner and stated as having a regular sexual partner in the past year, 3 had sex with a close friend, 1 had sex with a neighbour and 2 had casual sex. It is possible that the respondents had classified their one sexual partner as both a regular and one or more of the other categories or they may have different interpretations of what constitutes a sexual partner. Either way, these 6 people have placed themselves at risk of possible infection. Adding the 6 to the 21 of those who admitting multiple partnerships in the past year, we have 27 potentially infected people, who form a 'high risk' or core group.

If all these people had slept with infected individuals with no use of condom usage, then 7.8% of those who answered all the questions on sexual partners in the last year could be potentially carrying sexually transmitted infections ($27/345 \times 100$). Expressed as a percentage of the entire population ($27/938 \times 100$), at least 2.8% of this sample have exposed themselves to the potential risk of STIs when not controlling for condom usage and likelihood of partner being infected.

What Factors Influence the Likelihood of Having Multiple Partners?

A series of logistic models was constructed in order to examine the effects of age group membership, area of residence, level of education religious attendance and marital status. Only demographics were included as these variables were found in other studies to be strongly correlated with sexual behaviours (Sandfort et al, 1998; Wellings et al, 1994; Hendry, 1993). Furthermore, the causal direction is clear, unlike the relationship between sexual attitudes and behaviours (See Chapter 8). When run in single models, all variables were shown to have an effect on the log-odds of two or more partners for both time periods and were significant at 0.005 and 0.05 levels. Although previous studies such as the Kinsey Reports of 1948 and 1953 found variations of sexual behaviours between socio-economic groups (Weinberg, 1976), the self labelled social class membership, personal income and occupation were not confounding variables for the number of partnerships over the past year or last five years. Hence, the effects of the socio-economic variables on sexual behaviours will be omitted here. Gender was also not used in the analysis, as it also was not found to be a confounding variable. This is an interesting finding as previous sex surveys have suggested that while roughly the same proportion of men and women claimed one partner, in relation to two or more partners, men were more likely to overestimate their number of sexual partners while women underestimated the number of theirs (Wellings et al, 1994; Hendry et al, 1993). It is possible that the effects of gender differences are being hampered by missing data or there may really be little difference between the genders in Irish sexual culture.

By examining the effects of the demographic factors simultaneously, it is possible to characterise those who reported two or more sexual partners in the last year and the last five years. Table 4 and 5 show the results of the combined models for predicting

Table 4.
 Combined Models for Predicting Likelihood of Having Two or More Partners in the Last 5 Years.

	Model I		Model II		Model III		Model IV		Model V	
	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.
Under 30 years old	2.112****	0.299	1.894****	0.312	1.849****	0.313	1.697****	0.322	0.319	0.449
31 years and older (Base)	0		0		0		0		0	
Reached or completed third level education			1.153*	0.603	1.11*	0.605	1.003♦	0.616	0.659	0.695
Reached or completed secondary school level			0.815♦	0.567	0.811♦	0.569	0.804♦	0.574	1.001♦	0.633
Reached or completed primary school level (Base)			0				0		0	
Reside in an urban area					0.473♦	0.345	0.315	0.357	0.215	0.418
Reside in a rural area (Base)					0		0		0	
Never attend religious services							0.595	0.6	0.125	0.727
Attend religious services once a month to once a year							0.731**	0.338	0.106	0.417
Attend religious services once a week or more (Base)							0		0	
Single and never married									3.358****	0.476
Separated, divorced or widowed									1.639**	0.655
Married or cohabiting (Base)									0	
- 2II	288.83		284.620		282.674		277.942		213.292	
Model Chi²	52.555****		56.765****		58.712****		63.443****		128.093****	

N = 356

**** = significant at 0.0005 level

*** = significant at 0.005 level

** = significant at 0.05 level

* = significant at 0.1 level

♦ = just over 0.1 level – Model II (0.136); Model III (0.17 and 0.154); Model IV (0.103 and 0.161); Model V (0.114)

Table 5
 Combined Models for Predicting Likelihood of Having Two or More Partners in the Last Year.

	Model I		Model II		Model III		Model IV		Model V	
	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.	B.	S.E.
Under 30 years old	1.554****	0.363	1.4****	0.378	1.333****	0.38	1.088**	0.394	-0.444	0.533
31 years and older (Base)	0		0		0		0		0	
Reached or completed third level education			0.99	0.817	0.912	0.818	0.626	0.834	-0.05	0.899
Reached or completed secondary school level			0.908	0.77	0.891	0.771	0.798	0.778	0.714	0.826
Reached or completed primary school level (Base)			0		0		0		0	
Reside in an urban area					0.745*	0.45	0.477	0.468	0.292	0.513
Reside in a rural area (Base)					0		0		0	
Never attend religious services							1.409**	0.652	1.412*	0.737
Attend religious services once a month to once a year							0.992**	0.419	0.695♦	0.475
Attend religious services once a week or more (Base)							0		0	
Single and never married									3.064****	0.589
Separated, divorced or widowed									2.444***	0.805
Married or cohabiting (Base)									0	
- 2ll	213.218		211.327		208.291		200.796		166.305	
Chi²	18.049****		19.94****		22.976****		30.471****		64.962****	

N = 347

**** = significant at 0.0005 level

*** = significant at 0.005 level

** = significant at 0.05 level

* = significant at 0.1 level

♦ = just over 0.1 level – Model V (0.144)

the likelihood of having two or more partners in the last five years and the last year. Similar to the regression models on likelihood of non-responses, unstandardised logistic regression coefficients (B) and their standard errors are reported rather than odds ratios. In addition, this regression analysis is also exploratory, so significance levels of 0.1 and reference to those just over this significance level will again be made. No interactions are included as none of them brought any explanatory or specification power to the models.

Age Group Membership.

Both tables reveal that age group membership does have an affect on the log-likelihood of having two or more partners within a certain time frame until adjusting for marital status, when the effect disappears⁵. Throughout Models I to IV on both tables, those who are between 18 and 30 years have higher log odds of multiple partners in the last year or five years than those who are 31 and older. Without controlling for the other five independent variables, membership of the younger age group increases the log odds of having two or more partners by 1.6 times for the last year and doubles the log-odds when compared to the other age group for the period of

five years. These log-odds decrease when adjusting for the effects of the other variables indicating intervening variables. When the log-odds fall to near zero in the final models, this is not unexpected given that one would expect marriage to diminish the likelihood of having multiple partners. Similar to the findings of Wellings et al (1994) and Kost & Forrest (1992), irrespective of age, those who are single are more likely to have multiple partners than those who are married. People of all ages respect the monogamous union of marriage. When taking age, area of residence, educational level and religious attendance into account, single never married people have higher log-odds of 3.358 times to have had two or more partners within last five years compared to those married or living as married and a higher log odds of 3.064 times for the last year. People who are separated, divorced or widowed also significantly had higher log-odds of having multiple partners than those who were married (despite presence of extramarital affairs). Merryn Gott et al (2000) have pointed out that relationship patterns are becoming more flexible in later life in western societies with many people actively seeking sexual partners post-marriage. This is reflected in the positive log-odds of 1.69 for having multiple partners over the last five years and 2.444 for the last year.

Education.

In spite of the level of education being significant when used in a single model for predicting log likelihood of two or more partners within the last year or five years, it does not add to the explanatory power of Model II in Table 5. Its addition only reduces $-2 \log$ likelihood by 4.21. When predicting log-likelihood of having two or more partners in the last five years, education did display an increase of 1.153 in log odds when controlling for age (Model II in Table 4). It is possible that the effect of

⁵ Model V is also the 'best fit' model for both time period, with a difference in $-2\ln$ from the first model of 46.913 for last year and 75.538 for the five year period. Thus indicating that the addition of variables provide an improvement in the predictive power of multiple partnerships for both time frames. Changes in the Model Chi-square for each new block added in the models were significant at the 0.0005 level, showing improvement in chi-square for each additional degree of freedom.

educational level reached may have higher significance with a larger sample. In Model V, those who reached or completed secondary school level had higher odds of 1.001. This is in keeping with previous research which found that despite age, the higher the level of education, the more liberal the attitudes to sexual behaviour and the greater the possibility of multiple partnerships. Lear (1997) found that unlike those who did not attend university, college populations frequently partook in risk-taking sexual behaviours, such as alcohol fuelled sexual encounters and multiple partners. Thus over the longer period, those educated at secondary school and higher have higher log odds to have accumulated more partners than those who attended just primary school. The effect of educational level reached does lose significance for the time period of five years when attendance at religious services and marital status are controlled. Thus showing that in Ireland, the liberalising effects of increasing educational level is compromised by religious devotedness and adherence to marital vows or long term monogamous commitment.

Area of Residence.

Area of residence was added to the third model in both tables to see if living in an urban area provides greater opportunity to engage in multiple partners. We would expect the greater availability of sexual partners and more secularised outlooks of urban areas to increase the log-odds of multiple partners when controlling for the other variables. For the last year, the log-odds of multiple partners was increased by 0.76 times while for the last 5 years, the log odds were increased by 0.5 times. Both log odds are small and hover around the 0.1 level of significance. When controlling for age group membership, residence in an urban area increases log likelihood of multiple partnerships. This effect may be found to be more significant in a larger sample. Since the effect disappears once the impact of religion was controlled for, it is possible that those living in urban areas had higher log odds of multiple partners because they had larger numbers of those who did not attend or infrequently attended religious services than the rural areas.

Religious Attendance.

Religious attitudes (which can be derived from attendance at religious services) have an effect on the possibility of sexual risk-taking within the shorter period of one year. Religious attendance has a significant effect at the 0.05 level on the number of sexual partners in the last year when controlling for age group membership, area of residence and education level reached (Model IV). Those who do not attend church services have higher log odds of 1.409 of having two or more sexual partners in the last year than those who attended regularly. Furthermore, those who attended infrequently – that is between a few times a month and once a year – also increased the log-likelihood of multiple partners by 0.992 times. Despite age, area of residence and educational level reached, those who regularly attended religious services were more likely to have more conservative sexual behaviour – i.e. did not have two or more sexual partners in the last year. This is not an unusual finding. The majority of the Irish population are practising Catholics so one would expect either one sexual partner or no sexual partners if the Church teachings were being followed. Religious attendance still has a small level of significance when marital status is controlled for, indicating the old connection between Christianity, sex and guilt perhaps holds true.

Those who do not adhere to religion have accumulated more partners due to fewer preoccupations with monogamy or marriage than those who regularly attend church.

Religious attendance is not as strong a predictor in the models for log-odds of having two or more partners in the last five years. Those who never attended did not have significantly higher log-odds than those who attended regularly. When controlling for age, area of residence and education level, those who attended services infrequently did have slightly higher log odds of multiple partners than those who did attend regularly (0.731). Erratic attendances could be symptomatic of family obligations rather than personal beliefs and so would display higher odds of multiple partners than those who attended church regularly. The sporadic attendance at church could mean an inconsistency in beliefs and values that spill over into sexual behaviours and lifestyles. In relation to the absence of significant differences between those who attend religious services regularly and those who never attend, the effect of religious attendance could be comprised by favourable premarital attitudes. People may be religious but may maintain that monogamous relations before marriage are fine. Whelan & Fahey (1994) have observed that the strong adherence to traditional religious beliefs and practice amongst Irish Catholics is not an obstacle to the widespread practice of contraception and sexual activity before marriage. On the other hand, people may not practise religion but are influenced culturally to seek monogamous relationships. Irish people would be influenced by the overall trend of premarital sex and cohabitation in the western world. Here the emphasis is still on long-term emotional partnerships with a sexual component but it no longer needs to be restricted to the marital union. This could result in the lack of differentiation between those who never attend and those who attend regularly. This would mean that the two or more sexual partners in the last five years represent serial monogamous relationships rather than short term flings.

Discussion.

The main purpose of the models was not just to explore what best predicts multiple partnerships but to find out if the age group of the under 30s (which accounts for the biggest proportion of STIs) are likely to engage in risk-taking sexual behaviours. When taking into account area of residence, education level and religious practice, the younger age group do display a higher likelihood of multiple partnerships than the older age group. It is not surprising that in the final and best-fit model for both time frames that marital status would have such a big effect. We would expect those who have never married and those separated, divorced or widowed to have higher log-odds of multiple partners than those who are married. Given that age ceases to be significant in the final models of Table 4 and 5, it can be surmised that both age groups observe the sanctity of marriage. Sexual intercourse is not age specific and the larger numbers of reported rates of STIs from under 30s could simply reflect the larger proportions of them being unmarried than the older age group. Additionally, there has been an increase in the age at first marriage in Ireland since the 1970s (see Chapter 7). This means that those under the age of 30 are on average remaining single for a longer period than the preceding generations. In doing so, they are increasing their likelihood of multiple partnerships and thus increasing their potential risk of exposure to STIs.

Age at First Sexual Intercourse.

One of the reasons given for the greater likelihood of multiple partners amongst those under the age of 30 is the debatable decrease in age at first intercourse. This acts as a marker of sexual activity as the longer the period of risk sexual activity to the formation of a stable relationship, the greater the probability of multiple partners (Giesecke et al, 1992). In other words, the longer the gap between sexual maturity and emotional capability of a stable relationship, the more likely individuals are to engage in casual and short-term relationships. In relation to STIs, the earlier the age of first sexual intercourse, the greater the number of sexual partners and the higher the incidence of HPV lesions on the cervix (Edwards & Carne, 1998a).

Although not substantiated, there are suggestions that age of sexual maturity has lowered over the past 20 years (Adler, 1995). Unfortunately, there is no information in regards to age at first intercourse in Ireland either in terms of longitudinal data or as a cross-sectional sex survey. The ISSP (1994) dataset also did not include it as a question. Durex, the condom manufacturer, undertook a sex survey in 1997 and reported that 50% of Irish respondents had sex before 16 (Inglis, 1998). This percentage appears to be overestimated. The Alliance (1998) surveyed 800 people in Cork city and though not randomly selected, the sample can provide a better insight into the age at first sexual intercourse. The majority of respondents did not have sexual intercourse until the age of 18 (70% of women, 55% of men). This compares to studies done on Wales, where average age of first intercourse for males was 17 (Davidson & Blakey, 1995) and in the UK, where respondents reported a mean age of 16 for boys and 17 for girls (Knox et al, 1993). WHO (2000b) reported median ages at first sexual experience for adolescents between 15 and 19 years old. Spanish had a median age of 18, while the Australians and Polish had a median age of 17 (WHO, 2000b). Similar findings can be seen in other European studies, for example, a sample of 758 Swedes reported median ages for first sexual intercourse of 16.4 for women and 17.1 for men (Giesecke et al, 1992).

Sandfort et al (1998) found a general trend in Europe of decreasing age at first sexual intercourse, especially for women. This rate did slow down for younger generations. Dunne et al (1994) argued that median age at first sexual intercourse did decline between the 1940s and 1970s but may not have changed since the early 1980s. It is possible that Irish teenagers withhold sexual intercourse until they have completed secondary school level. Given that a large proportion of secondary schools are segregated and the pressure placed on academic achievement, teenagers' exposure to sexual activity may be limited by time constraints and access to potential partners. This is speculative and overlooks the prevalence of manual, anal and oral sexual activities. Furthermore, claims about the lowering of age of first sexual intercourse since the 1980s and discussions about teenage sex are problematic, especially since that within the same period, issues of sexual abuse came to the fore of the public forum. Indeed, a cross-sectional study in Dunedin, New Zealand found that a large proportion of women who had experienced sex before the age of 14 had been forced (Dickson et al, 1998).

Returning to the relationship between age at first sexual intercourse and multiple partners, those in the younger age group with multiple partners may be suggestive of that casual period between first sexual experience and obtaining a stable relationship.

Being under the age of 30 and in the experimental stage of sexual careers does not necessitate an earlier age of first sexual intercourse. Until we have firm evidence of the relationship between decreasing age of first sexual encounter and likelihood of multiple partnerships, we can only conclude that the younger age groups in Ireland are more likely to accumulate more than one lifetime sexual partner than older generations and because a large proportion of them are unmarried, they also increase their likelihood of acquiring two or more sexual partners within a year or five year period.

How likely is an Irish Individual to be Exposed to a Carrier of Sexually Transmitted Infections?

It is possible to estimate the possibility of being exposed to the behaviour associated with the facilitation of the spread of sexually transmitted infections. As previously stated, the number of partners an individual has over a unit of time is an important factor in the transmission of a sexually transmitted infection. The greater the contact an individual has with multiple partners, the greater the risk of exposure to a potentially infected person. Since we cannot control for the impact of condom usage, the calculations show the risk of being in contact with possible carriers of infection via multiple partners and unprotected sex. The estimate can also tell us how closely connected individuals are in a sexual network. Liljeros et al (2001) argue that sexual networks are scale free, meaning that there is no well-defined boundary separating the 'high risk' group of multiple partnerships from other individuals. This means that all individuals are likely to meet a sexual partner who has had multiple partnerships. By estimating the probability of meeting an individual with multiple partners, we can determine that an increase in an individual's number of sexual partners over a unit period of time will increase possible exposure to STIs.

In establishing the risk of exposure to a channel of STIs, i.e. multiple partners, the estimate is based on the assumption that all sexually active people have equal chance of having a partner who is not monogamous in the last year. This provides a 'high risk' estimate for the population. Irrespective of age, all sexually active respondents in the data set were used for the calculations. Sexually transmitted infections exist in populations that have a heterogeneity of sexual behaviours. This diversity is determined by demographic attributes such as age, ethnicity, sex, sexual preference etc. (Morris, 1994). Furthermore, STIs can and do spread from 'core' groups to groups of low risk by taking advantage of high rates of partner change. All humans have various sexual strategies in choosing a partner but do not homogeneously bias in relation to age (Buss, 1994). If humans did restrict themselves to their own age group, STIs would not be spread to the younger age groups. Indeed, in order for adolescents to acquire an STI, one has to come in sexual contact with someone of an older age group, whose seniority exposes them to the infections (Knox et al, 1993). Furthermore, since the majority of respondents are heterosexual (and this is also true of the general population), the risk of encountering a sexual partner with multiple partners will be calculated on the assumption that all sexual encounters will be heterosexual. Separate estimates are made for males and females. The period used for the calculation was the last year, as number of sexual partners in this time frame play a greater role in exposure to STIs, as relationships are of a shorter duration than those over the past five years. Therefore, more sexual partners results in greater likelihood of casual encounters.

For the male population, we based their calculations on the number of male sexual partners reported by women for the last year. 174 women reported 1 sexual partner, 9 women reported 2, 5 women reported 3, 1 woman reported 4, 1 woman reported having between 5 and 10 partners while another woman reported having between 21 and 100. For these latter two women, we took the mid-points – 7.5 and 60 respectively. Since we are estimating the probability of meeting a sexual partner who has had multiple partnerships, we need to think in terms of sexual encounters. Therefore we multiple the number of reported sexual partners by the number of respondents. This calculates the number of new sexual encounters in the last year. Since 174 women reported only one sexual partner, this represents 174 sexual encounters with the opposite sex, 9 women reported having 2 partners so that makes it 18 new sexual encounters, 5 women reported 3 partners therefore there has been 15 separate sexual encounters, 1 reported 4 partners (4 new sexual encounters), 1 reported 7.5 (7.5 new sexual encounters) and one woman reported 60 (60 new sexual encounters). This gives us a total of 278.5 new sexual encounters for the past year. The next step in our calculations involves finding the fraction of all sexual encounters that involved a female with just one sexual partner and females who had two or more sexual partners. Thus, we divide the 174 sexual encounters that involved females with only one sexual partner by the total number of new sexual encounters (278.5) and we achieve a figure of 0.625. We then subtract this figure from 1 to get the fraction of total sexual encounters that involved females with two or more sexual partners in the last year and we get a figure of 0.375. This means that 62.5% of male new sexual encounters were with females who had 1 sexual partner, while 37.% of female new sexual encounters were with females who had two or more sexual partners.

To calculate the risk of exposure of a male to a woman who has had two or more sexual partners in the past year, we use the following equation:

$$P = 1 - (0.625)^n$$

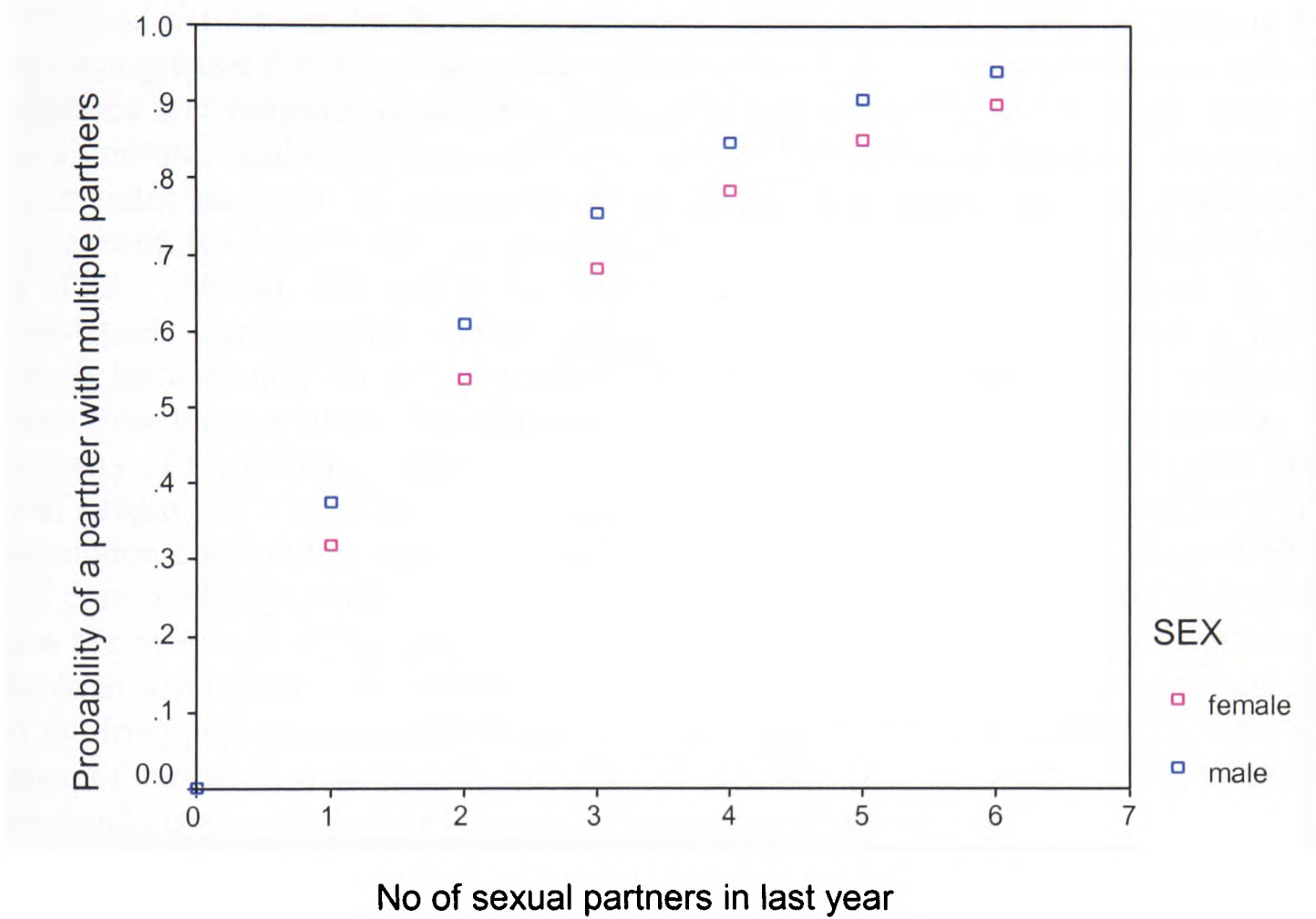
where n equals the number of sexual partners a male has had in the last year.

For a male who has had just one sexual partner, his probability of coming in contact with a woman who has two or more sexual partners is $1 - (0.625)^1$, giving us a probability of 0.375 that the female sexual partner will have had multiple partnerships that year. A male who has had two sexual partners in the last year has a probability of 0.609, i.e. $1 - (0.625)^2$, a male with three sexual partners has a probability of 0.756, a male with 4 has a probability of 0.847 and so on. It is apparent that as Irish males increase their number of sexual partners in a year, their likelihood of encountering a female sexual partner who has had two or more male sexual partners in the last year also increases. (Figure 2 displays the pattern of probabilities for each sex using the calculated probabilities). For example, a male with five sexual partners in the last year has a 90.5% chance that at least one of his sexual partners has had multiple partnerships. This is in direct contrast to males who have had just one sexual partner as they have only a 37.5% chance of having their relationship with a woman who has had two or more sexual partners in the last year. Therefore, they expose themselves to a greater likelihood of potential risk of STIs.

We replicated this method for Irish women, this time using the reported sexual partners by the male respondents for the last year. 144 males reported having one

sexual partner, 11 men had 2, 6 men had 3 sexual partners, 3 men had 4 and 2 males reported having between 5 and 10 partners (mid-point was 7.5). Numbers of reported sexual partners were again multiplied by the number of respondents giving us a total of 211 new sexual encounters involving males who had one sexual partner or had two or more sexual partners in the last year. Dividing the number of sexual encounters involving males with just one sexual partner by the total of new sexual partners (144/211), we got the figure of 0.682. Subtracting this from 1, we get 0.318. Thus, 68.2% of new sexual encounters in the last year involved males who had just one sexual partner, while 31.8% of new sexual encounters involved males who had two or more sexual partners.

Figure 2
Graph Displaying the Probability of Encountering a Sexual Partner who has had Multiple Sexual Partnerships by Increasing Number of Sexual Partners for the Last Year by Gender.



To calculate the probability that a female had contact with a male with multiple partnerships in the last year, we used the following equation:

$$P = 1-(0.682)^n$$

where n equals the number of sexual partners a female has had in the last year.

If a female has had only one male sexual partner in the last year, then her probability of coming in contact with a male who has had multiple partnerships is 0.318, i.e. $1-(0.682)^1$. For a woman who has had two sexual partners, then her likelihood of having a sexual partner who has two or more sexual partners is 0.535, i.e. $1-(0.682)^2$. If she has had three partners, then her probability of coming in contact with someone who has engaged in multiple sexual partnerships is 0.682. Similar to the calculations for the males, the probability of encountering a sexual partner who has had multiple partnerships in the last year increases as the individual increases her number of sexual

partners. So a woman who has had 5 sexual partners has a 85.2% chance of having a sexual encounter with a male who has had two or more sexual partners. Women who have had only one sexual partner, has a 31.8% chance of the partner having had multiple partners.

Taking into account the other influential factors, such as condom usage and whether or not the sexual partner is infected, the risk of acquiring a sexually transmitted infection would be much lower. However, we can clearly see that by increasing the numbers of sexual partners, an individual increases the likelihood of having a partner who has had multiple partners, thus increasing his or her risk of being exposed to an infected individual.

Conclusion:

Although the sample of the Irish population was small, we are able to establish individual risk factors for the potential risk of exposure to STIs. When controlling for the demographic factors of age group membership, level of education reached, area of residence and religious attendance, those who are unmarried are the most likely to have multiple sexual partners in the last year or five years. Because the majority of those under the age of 30 are unmarried (unlike the older age group), it is possible that this constitutes them as the age group more likely to be exposed to the potential risk of STIs. Sexual risk patterning does occur throughout the generations in the population. Certainly, the younger age groups are more likely to be exposed to STIs, simply because they are at the experimental stage of their sexual careers. However, those over the age of 30 demonstrated use of prostitutes and extramarital affairs. A minority of respondents displayed tendencies to risk-take in sexual behaviours. This is in keeping with studies on STI transmission, where only a small proportion of the population contribute disproportionately to the spread of STIs via high rates of STIs and partner change (Jolly et al, 2000). Sexual network analysis is needed to uncover how the infections are spread between individuals. In the absence of these studies on the Irish population, one can conclude that since only a small portion (a 'core' group) of the Irish population are indulging in multiple partnerships, the increasing reported rates of sexually transmitted infections owe their rise as much to other social mechanisms as to the level of sexual risk-taking in the population.

One factor that has helped to determine the increase in reported STI rates is the change in the sexual culture in Ireland. The last two decades of the 20th century marked a sudden growth in sexual permissiveness. Such a climate would encourage a greater openness about issues of sexuality and would ultimately aid people to come forward for treatment of STIs. It is thus necessary to explore the construction of Irish sexuality and its historical relationship with STIs. Such an investigation will provide the background to the comparative analysis of Irish sexual culture in the 1990s with other western nations, namely USA, Australia, Poland and Spain.

Chapter 6: What Sexually Transmitted Infections Reveal About Irish Sexuality.

Generally, speaking relations between men and women were very much what they are and always have been. One has only to read the 'Love Songs of Connacht', many of which were composed in the seventeenth century to realise that. They fell in love with all the romance and ardour of their forefathers and of their descendants. Some people were fickle, some constant; there were men without moral principles and women of easy virtue as there are today and there were just as certainly men and women of high character.
(MacLysaght, 1979:63).

Introduction:

Despite the popular belief that Irish people were morally conservative in sexual practices, STIs, illegitimate births and other sexual problems have always been prevalent in the Irish population. This implies that behaviours and attitudes exist in two separate spheres and that changes in public attitudes - such as the documented changes in sexual politics in the 1990s – may mean a more tolerant approach to sexual behaviours rather than changes in the behaviours themselves. Changes in sexual attitudes can result in public awareness of the diseases, which in turn leads to increased clinic attendances. Through the assertion of Irish 'sexual repression', STIs (with the exception of the CDAs) were denied as an issue for public concern until recently.

This chapter looks at the history of sexually transmitted infections, sexual behaviours and sexuality in Ireland. Irish medical practitioners were active participants in 19th and early 20th century venereology but their contributions are curiously absent from the historiography of venereal disease. Even in relation to Irish sexuality, there is a dearth of studies within sociology (Inglis, 1997) and any studies undertaken in related disciplines focus on the repression of the Irish by the Catholic Church and the after-effects of the Great Famine in the 1840s. This is a rather simplistic interpretation of Irish sexuality. Its construction would have also been affected by Victorian values, the Irish colonial status and its subsequent political and economic assertions. Furthermore, the emphasis on Irish sexuality has ignored the variety of sexual behaviours that have historically existed. Publicly, the Irish asserted a conservative religion based sexuality but privately, a variety of sexual behaviours were practised. In the vein of Foucault, it is more practical to view the 'repression' of Irish sexuality as a social classification, more specifically, an assertion of political identity. Irish sexuality had repercussions for the perception of incidences of sexually transmitted infections. When social anxieties about sexuality were raised, the rates of STIs reputedly increased.

The history of STIs in Ireland can inform us about Irish sexual behaviours and Irish sexuality and can reveal why STIs have received much attention on the pages of national newspapers, such as *The Irish Times* and *Irish Examiner*, in the late 1990s. This will be demonstrated through an examination of venereal disease in Ireland, Irish sexual behaviours and the growth and fall of sexual morality. Voices of medical

practitioners will also be analysed in order to conceptualise the prevalence of STIs in the Irish population and how they were viewed and controlled. This should help place the rising reported rates of the 1990s into a historical context of STIs and Irish sexual behaviours.

History of VD in Ireland:

The extent of venereal diseases in Ireland prior to the establishment of the official statistics in the mid 1940s is contestable. According to records of the Cork County Council, as compiled by Marnane (1986), the County Council in 1918 refused to provide health services for venereal disease partly because “medical men have informed us that no country in the world is more free from it” (Marnane, 1986:146). Many contemporary and modern authorities maintain that VD was not a serious problem in Ireland during the 19th century (Malcolm, 1989). It was seen as being virtually non-existent in rural areas and the incidence in Dublin was considered to be less than in comparable British cities (Malcolm, 1989). Throughout the 19th century, Ireland was predominantly a rural society and with the widespread equation of rural life and moral values through Europe in the latter years of the century, it is not surprising that such an assumption prevailed amongst Irish authorities. Because Ireland was part of the British Empire, contemporary commentators did sometimes include the Irish in their sweeping statements on the overall rates of venereal disease. Writing from Ireland, Barton (1868) spoke of the commonness of VD in the army and the navy and consistently refers to the British Isles as one country. Ireland’s inclusion as part of the British Isles - which were ruled by one government - does mean that national rates would be a rarity. However, if venereal disease was not as serious as in Britain, this surely would have been noted in the writings. The Irish did contribute forces to the British imperial army and a number of sizable garrison towns existed along the east and south coasts. When Britain implemented the CDAs, Ireland and not Scotland was subjected to the legislation (Malcolm, 1989). Such measures at least point to the perception that the troops were under threat from Irish prostitutes, especially since three of the Irish garrison towns were amongst the original eleven that were first targeted.

Although undocumented, there is no reason to believe that venereal disease has not existed in Ireland since the epidemic of syphilis in the 15th century. In the 19th century, its incidences and prevalence may have been as widespread as in the other European societies. While information on venereal disease is scarce, nevertheless there are a number of factors, which indicate that VD was considered serious enough to be monitored and controlled. Firstly, treatments and hospitals for VD had been established long before the Act of Union in 1800, reflecting the localised identification of the prevalence of the diseases. Secondly, at the time of the CDAs, Irish authorities and venereologists estimated high levels of VD throughout Ireland and by the First World War, venereology had been established as a discipline in Ireland, with the medical community actively engaged in the medical discoveries and medico-moral discourses of Europe. A medical interest in venereology can only really be substantiated if the medics had a population to observe. What had impeded the studies of VD and sexuality in Ireland from a socio-historical perspective were the political discourses on nationalism and identity, which endured right through the 19th century via the establishment of the Irish Free State in the 1920s to the economic boom of the late 20th century. Irish people were viewed as being ‘pure’ (Brown,

treatment for syphilis but pioneering orthopaedic treatments and teaching were also carried out on the very same premises (Fleetwood, 1983). By the 1870s, Ireland had the Westmoreland Lock Hospital for women, wards for men at Sir Patrick Dun's and Steeven's. There was a Lock hospital in Cork – also known as 'Queen's hospital' – which contained 46 beds and another hospital in Kildare, which had 42 beds (Meldon, 1914). Both these hospitals were closed after the repeal of the CDAs. Private hospitals sprung up from time to time such as the VD hospital on King Street, Dublin, in 1758. Lock wards also existed for periods in other hospitals, such as the South Infirmary in Cork city (O'Mahony, 1997) and Richmond Hospital in Dublin (West, 1859). There was a Fever and Lock Hospital opened in Limerick in 1781 but it was closed due to an outbreak of cholera in 1849 (Meldon, 1914). The provision of VD services was recognition of the need to treat a disease that was prevalent, especially given the existence of certain social and cultural factors known to assist the transmission of sexually transmitted infections.

Like other countries in the 18th century, population mobility was the norm (a factor that would have helped the spread of venereal disease). In the countryside, itinerant labourers, tinsmiths, beggars, storytellers, musicians and poets roamed freely and the rural practice of providing hospitality to travellers would have aided the spread of venereal diseases. The mobility of the population could have given rise to the female dominance in the family. Sweetman (1979) argues that mothers usually develop as dominant figures in societies where long absences of the male from the family becomes the norm. The role of the father diminishes of necessity at first and eventually this weakened position becomes part of a self-perpetuating cycle. Dublin was in its prime, peopled by nobility, gentry and wealthy merchants, however its splendour did not match the condition of the rest of the country. Poverty, famine and unemployment were rife and distress drove countrymen and women to the city in the hope of getting work (Widdress, 1972). Unfortunately, many had to turn to begging or prostitution. Prostitution was common in most large towns in Ireland throughout the 17th, 18th and 19th centuries (O'Mahony, 1997; MacLysaght, 1979). By the time the CDAs were introduced, prostitution was considered a major social problem. In Cork city, prostitutes were frequently attacked by disgruntled residents. Such acts included the burning of brothels, regular beatings and the occasional murder (O'Mahony, 1997).

The living conditions of the urban poor in Dublin and Cork certainly contributed to the rates of prostitution and disease (O'Mahony, 1997). Housing was cramped, damp and unsafe, sewage and clean water non-existent, streets were lined with rotting rubbish and diseases rampant. This situation was not helped by the characteristic unwillingness of lower classes to attend a hospital (Browne, 1989; O'Brien, 1982). A number of factors were responsible, embarrassment, lack of financial resources, beliefs in home remedies and a determination to 'soldier on'. Such attitudes were not just applicable to VD but to other illnesses and helped keep diseases prevalent in populations. In Cork in 1871, 4,000 people were infected with the smallpox from one single case of a seaman. The epidemic occurred due to the filthiness, squalor and overcrowding of deprived areas and the unwillingness of sufferers to seek medical help or a vaccination (Cummins, 1957). Quackery was very common throughout the country and alternative medicines for a range of ailments - including impotence - were sought after by the populace (O'Mahony, 1997). In Cork city, one could choose from a range of advertised anti-venereal pills, such as *Leake's Philula Salutaris* or

1985). These political discourses used Catholicism as their mechanism to regulate and negotiate Irish sexuality. Such definitions broke down in the face of the economic and social changes Ireland experienced in late 20th century.

Venereal Disease in 18th Century Ireland.

In 1735, surgeon George Doyle, supported by a committee of trustees, established a hospital for VD in Rainsfort Street, Dublin (Fleetwood, 1983). This makes it one of the two oldest hospitals of its kind in the British Isles, the other being the London Lock hospital in 1746 (Malcolm, 1999). Over the following 47 years, the hospital was transferred to an old maternity hospital in George's Lane in 1757, Clarendon Street in 1768 and the Buckingham Smallpox Hospital at Donnybrook Road in 1778 (Fleetwood, 1983). In 1792, the Lord Lieutenant (the King's representative in Ireland) moved the lease to other premises in Townsend Street, where the hospital could be operated under new and better management. The hospital was renamed "Westmoreland" in honour of the said Lord-Lieutenant (Fleetwood, 1951). The new board consisted of the Presidents and Vice-Presidents of the Colleges of Physicians and Surgeons, the Physician and Surgeon-General, the State Physician and Surgeon, the Surgeon to the King's Military Infirmary, the Professor of Surgery in the College of Surgeons and two senior surgeons to the hospital (Fleetwood, 1983). The hospital initially only accommodated 300 beds and medical attendance was irregular until salaried medical posts were created (Meldon, 1914). From then onwards, the hospital flourished. Although it is difficult to determine how much input the board had in the day to day running of the hospital, it is worth pointing out that the interest of such impressive medical officials in the VD hospital suggests that venereal disease required their medical intervention.

From the 18th century onwards, Dublin had established itself as a major medical centre, on a par with Edinburgh and London (Daly, 1999). An indication of a city's medical eminence is the number of hospitals it boasts. By the 1840s, Dublin had 35 hospitals, dispensaries and asylums (Malcolm, 1989). Dublin was also the location for the Royal College of Surgeons an institution renowned for its medical successes. In 1784, they obtained their first charter to establish a liberal and extensive system of surgical education in Ireland (Widdress, 1984). In 1840, the college was the first to hold the appointment of the Chair of Preventive Medicine in the British Isles. "The educational outlook of these Irish surgeons proved to be 'liberal and extensive' to a degree hardly equalled by any body of surgeons at the time. They had built up their own school in which students were taught medicine, surgery and midwifery at least fifty years before the triple qualification became a legal requirement. Such an approach to the later concept of a general practitioner, trained in both physics and surgery appears to have existed only in Glasgow, under the auspices of the Faculty of Physicians and Surgeons" (Widdress, 1984:vii). Due to the prominence of the medical discipline, it is unlikely that they would associate their names with VD and its implications of quackery, if they were propelled to control the extent of the diseases.

While much of the discourse of the 18th century viewed VD as diseases of the body, the growing dominance of middle class morality would have also existed in Ireland. However, VD appears to have been included in the general medical services. In the 19th century, Steeven's Hospital was not only a centre for developments in mercurial

Cline and Barncastle's Anti-Venereal Pills, which claimed to be secret, safe and could cure an infection within 24 hours (O'Mahony, 1997). On a more local level, a variety of treatments were easily available from widows of surgeons, midwives, medics and self-proclaimed physicians (O'Mahony, 1997). The use of self-medicated treatments may have relieved symptoms, but their usage would have kept the disease prevalent in the population.

Venereal Diseases in 19th Century Ireland.

In the 19th century, official rates of venereal diseases only recorded the cases seen in hospitals and workhouse infirmaries (Malcolm, 1999). In 1851, 824 cases of syphilis were recorded and this fell to 453 in 1871 (Malcolm, 1999). At first, these rates seem comparable to those of the 1950s, when syphilis was declining in Ireland. The famine had just occurred and the population was 6.6 million in 1851, almost one and half times that of Ireland's population today (Lee, 1989). However, it is probable that the incidences and prevalence of venereal disease were much greater than what contemporary authorities would admit (O'Brien, 1982). During the CDAs, out of a total of 504,000 medical examinations of women, 47,000 women were diagnosed with venereal diseases (O'Mahony, 1997). In the 1840s and 1850s, beds were reduced, funding cut and many wards closed, including the Lock hospital in Limerick (Malcolm, 1999; Fleetwood, 1983). These moves were quite likely to have been outcomes of the economic disasters of the 'Great Famine'. As a result, workhouses were overcrowded with patients. In the Cork Workhouse (situated at St. Finbarr's Hospital, later the site of the first VD clinic in Cork), the early months of 1850 saw a huge increase in syphilis cases, immediately filling the lock wards of the workhouse. By 1853, the wards had at least 2 patients in every bed (O'Mahony, 1997). Furthermore, hospital patient records were often inadequate and diagnoses unclear (O'Brien, 1982). As in Britain, venereal disease was viewed as a punishment for sinful behaviour and due to the stigma of the disease, many sufferers, especially males, were afraid to seek treatment and many hospitals would not treat them (Malcolm, 1989). There persisted, especially in rural Ireland, a reluctance amongst country-folk to consult a doctor about VD and for the doctor to report such cases (Malcolm, 1999). All of these factors would have contributed to the prevalence of diseases.

Concerns about the army prompted the Contagious Diseases Act and amongst the troops stationed in Ireland, it was military policy to make it difficult for men to marry (Malcolm, 1999). Irish women in the 19th century were also influenced by the Victorian ideals of wife and whore and so premarital sex was socially frowned upon. Not surprisingly, they availed of prostitution and similar to Britain, increased their use of prostitutes who were declared free of disease during the years of the CDAs (O'Mahony, 1997). In 1845, 85 brothels were estimated to exist in Cork city with 356 public prostitutes (McLoughlin, 1994). Moreover, Irish soldiers were active participants in the wars for the Empire and such travel abroad would have brought them in contact with venereal diseases. During World War I, there was a high incidence of venereal disease amongst the Irish soldiers in the British forces. The British state sanctioned funding (75% of the total expense) for the setting up of VD services in Ireland (Local Government Board for Ireland, 1918). Local authorities along the East coast were most active in complying, as most Irish soldiers had come from these counties but no special campaign was applied to the country (Barrington,

1987). This was partly due to the change in political atmosphere regarding British rule fuelled by the execution of the participants in the 'Easter Rising' of 1916. Unlike their British comrades, the Irish soldiers were not greeted as heroes, but instead experienced indifference and hostility. Barrington (1987) maintains that this may have been a factor in restricting local health initiatives on their behalf. Indeed, in Cork, the County Council refused to implement the Royal Commission on Venereal Diseases recommendations, stating that if the prevalence had increased due to war, then it was the British government's duty to deal with the matter, not the local Irish authorities (Marnane, 1986).

As Malcolm (1999) pointed out, important advances did take place in the diagnosis and treatment of VD cases. One example is William Wallace who pioneered advances in the treatment of syphilis in the first half of the century by developing a successful alternative treatment to mercury and establishing the secondary stage of syphilis as being contagious (Malcolm & Jones, 1999). Mr. Hamilton, at the Richmond Hospital, Dublin, contributed enormously to the surgical study of the symptoms and pathology of the syphilitic testicle (West, 1859). Furthermore, the Dublin based Richard Carmichael – considered the 'brightest star' of them all (Fleetwood, 1983) – was well renowned for his contributions to medical science as a whole and made some groundbreaking efforts in relation to venereal diseases. Barton (1868) wrote that the "vigorous and original observations of Ricord in Paris and Carmichael in this city, produced such an interest in the subject that ever since, both in these countries and on the Continent, it has been pursued with great ability and success" (Barton, 1868:2). These advances would not have taken place if the number of cases were not perceived as warranting medical attention. Like elsewhere, VD was seen as the 'great evil' and the belief persisted that "the fact of its present wide-spread extent demands from each member of the medical profession an attentive study of it" (Barton, 1868:2).

What Can Irish Venerologists Tell us About Past Prevalence of VD in Ireland?

Locating a sample of the voices of medical professionals working in the field of venereal diseases in the 19th and early 20th centuries involved an analysis of some of the major journal publications of that time. These were namely the Irish Journal of Medical Science, the Dublin Quarterly Journal of Medical Science and the Dublin Journal of Medical and Chemical Science. Between 1833 and 1957, a total of 93 articles on venereal diseases were located – 21 on venereal disease, 8 on gonorrhoea and 65 on syphilis. This is not a large amount given the period of time covered, yet it was evident from the contributions that Irish venereologists viewed their work as pioneering, alluding to a form of acceptance amongst their medical peers. Some of the contributions were from English doctors on cases or treatments viewed in London and so these articles were disregarded. In relation to the remaining Irish produced works, a few articles were written by Irish doctors abroad with the British navy or army.

Most articles concentrated on specific treatments and the various manifestations of the diseases. For example, Cherry (1942) wrote on observed blood and urine levels of sulphayridine in the treatment of gonorrhoea. Moreover, Irish venereologists were working on gonorrhoea and chancroid ulcers from the 1840s onwards. Before gonorrhoea was apparently established as a separate disease in the 1870s, Irish

doctors such as Maurice Collis in 1863 and William Colles in 1850 were distinguishing between the two (Collis, 1863; Colles, 1850). There was also a strong working relationship between venereologists in Dublin, London (such as Mr. Acton) and those in Paris. Sir Francis Smith (1840) reported for his colleagues in Dublin, the latest treatments from Paris including a form of mercury biscuits (Biscuits D'Ollivier) and Ricord's proposed vaccination for syphilis - which was later shown to be ineffective. However, there were a small number of articles that did mention the extent and social aspects of venereal diseases in Ireland and these articles will subsequently be discussed, divided into roughly three periods – (1) 19th century up to the repeal of the Contagious Diseases Acts; (2) Late 19th century and early 20th; (3) VD in the Free State and the Republic.

(1) 19th Century up to the Repeal of the Contagious Diseases Acts.

In relation to the first category, it is interesting that none of the studied articles of this period referred to prostitution. Instead the bulk of articles focused on the results of different diagnosis techniques and treatment practices. Medical advances were of tremendous importance to the Irish medics and there was a characteristic irritability inherent in the writings on not receiving the recognition from abroad that they felt they deserved. Samuel Gordon, in his introduction to Richard Carmichael's "Clinical Lectures on Venereal Diseases" (1842), expressed the annoyance of "the unfairness of English and Scottish writers, in not acknowledging the labours of our countrymen, or in ascribing their discoveries to friends at the other side of the channel" (Carmichael, 1842:487). He points out that it was Mr. Carmichael and not Mr. Rose who introduced the first non-mercurial treatment of syphilis, yet Mr. Rose was accredited for the introduction of the norm of non-mercurial treatment in European countries (Carmichael, 1842). Furthermore, he adds that much of the following issues of the Dublin Quarterly Journal of Medical Science will attempt to rectify ignorance regarding the stellar work done by Irish medics. John Egan, one of the surgeons at the Westmoreland Lock Hospital, also remarks upon the great advances done by his fellow countrymen in relation to venereal disease, adding that the "exertions in this department of surgery are not alone appreciated in Great Britain but in every part of the civilized world which has been visited by British troops" (Egan, 1845:178). In Ward no 2, Steeven's Hospital, the surgeon Abraham Colles developed mercurial fumigation, "his celebrated law of immunity, and the true nature and accompanying signs of the lymphatic swelling known in every country as Colles' constitutional bobo" (Swan, 1899:405).

In the introduction to Richard Carmichael's lecture notes, Simon Gordon displays a knowledge that historically has been considered to have been developed later in the 19th century. For example, Carmichael's work convinced him that more than just one venereal disease existed, that there were a variety of venereal poisons that had different symptoms and required different treatments. It was not until the 20th century, that the diseases other than syphilis and gonorrhoea were identified and added to venereal diseases. Like other Irish venereologists of his time, Carmichael believed that venereal diseases were actually present since biblical times within Europe but that an epidemic of syphilis did occur at the end of the 15th century (Carmichael, 1842). Interestingly, Carmichael engaged with a language of the colonised, remarking that if syphilis was brought home from America by the Spaniards, then it was "a just retribution...for the evils they inflicted upon the natives

of the New World” (Carmichael, 1842:493). This comment stands out from the rest of the article and others from this period, as the discourse engaged with predominantly is one of medical objectivity and not medico-moral.

Throughout the articles, nothing is mentioned on the judgement of sufferers nor on the extent of venereal disease due to prostitution. The inclusion of articles in a journal does rely on the agenda upheld by the journal’s editorial panel. It is very likely that a conscious decision was made to avoid issues pertaining to socio-moral discussions on venereal disease. Medical journals are not really the forum to engage in public debate but given that elsewhere, medical professionals were engaged in making social observations, it was believed that some form of morality would enter the writings. The collective body of the Irish venereologists appear to be a dissenting voice, more interested in sharing knowledge on different forms of treatments and contributing to the better health of the British troops. Prostitutes, businessmen, soldiers and their families are all portrayed as patients within this period, without social commentary.

Many of the articles are actually case histories drawn directly from personal medical notes. Patients are quite frequently named with personal details in the publications. This of course leads to the question of whether patient confidentiality existed then and if venereal disease was really as stigmatised as thought, if the patients were aware that their names were being used. On the other hand, it could reveal a disregard for human feelings in the pursuit of medical knowledge by the authors. Hamerton (1841) provides an interesting submission on the transmission of syphilis through non-venereal methods. Drawing from his medical notes, he describes an incident that occurred amongst his patients in Castletown with the treatments he prescribed. A married woman, named Anne Gerrard, contracted syphilis from her husband in the fourth month of her pregnancy with her first child. The child was born in a sickly state and one of Anne’s breasts became sore. Her sister, Mary Duffy, tried to help Anne out by giving Anne her healthy baby to draw the milk while Mary tried to nurse the sickly baby. Both Mary and her child developed syphilis. Additionally, Anne’s servant, Mary Fay, contracted the disease from sucking her mistress’s breast to try to draw milk. When Mary gave birth to her own child - also ill with syphilis - her midwife was affected due to a scratch on her hand at the time of the attendance. She in turn passed it onto her husband. While this depicts an interesting spread of venereal disease through nursing, Hamerton (1841) ends with a comment that in such situations, it is not necessary to treat the husband – therefore, overlooking the possibility of the husband spreading the disease back to the wife, after her initial treatment. It appears that in their pursuit to share medical knowledge and personal experiences, many doctors did not view the diseases as a problem for the wider population.

(2) Late 19th Century/Early 20th Century.

Only eight articles were published between 1880 and 1900. These continued the common trend of clinical records, though now including reports from Irish doctors abroad, such as Wallace (1901), who described cases he treated in the Home Hospital in Calcutta - where many Irish soldiers were stationed. Writers also resumed discussing the variety of venereal sores, new techniques in treatments and the need to be informed of the diseases in order to treat patients properly – for example (Battersby, 1890). Knott (1904) addressed the ongoing question of the origin of

venereal disease, lamenting that the rise in science meant the decay of culture and loss of regard for early contributions on syphilis, such as Fracastorio. While he points out that the epidemic in the 15th century had more to do with the recognition of a common poison for the range of symptoms, he adds that a more destructive type of venereal disease tends to develop from inoculation with the virus derived from an individual of a remoter race” (Knott, 1904:294), thus continuing the ongoing fear of race and venereal disease.

Social observations did appear amongst these articles and as the 20th century progressed, they became more customary. McCaw (1889) mentioned the role of alcohol in aggravating gonorrhoea, which would be later echoed by other medics such as Power (1916). Swan (1899) spoke of a patient in a ward in Steeven’s Hospital whose body was covered with sores, stating: “His appearance was remarkable, and he served as a moral and warning to careless youth” (Swan, 1899:406). Swan (1899) also gave some indication of why the public discussion on the CDAs were not engaged with in the medical journals. “Almost all persons who are competent to form opinions unbiased by side issues have offered those opinions to successive Governments in this country” (Swan, 1899:17). Congenital syphilis was a dominant subject matter with Spencer Sheill (1910) apologising for discussing an issue that was not unusual but very common in Ireland. Apart from Battersby (1890), briefly mentioning that he treated a large number of venereal cases while stationed in the Curragh during the 1880s, this is the first glimpse in all the articles of how the prevalence of syphilis was viewed in Ireland. Later in 1917, McCullagh, a bacteriologist at Dublin’s Portobello Military Hospital, argued that “the question of venereal disease is one of vital importance at the present time, when these diseases are so rife amongst all classes of people” (McCullagh, 1917:212). He added the outbreak of World War I had meant the spread of disease from city to hamlet and while he is referring to the British Isles as a whole, it is apparent that Ireland is very much included.

Power (1916) also speaks of Ireland and Britain cohesively and adds that civil statistics throughout the British Isles are unreliable, rendering it impossible to measure the changes in the prevalence and incidences of venereal diseases. Furthermore, Power (1916) points out that the spread of venereal disease had been gaining momentum in the previous five years. Engaging with the trends in medico-moral discourse in Europe at that time, Power (1916) attempts to socially account for the diseases. Firstly, he blames the spread on irregular sexual intercourse. “As long as man give free vent to passions which he possesses, and which is right for him to possess, he will run the risk of infecting himself with one or other virus” (Power, 1916:215). He hastens to add that men should avoid alcohol, operate moral restraint and do more physical exercise instead. Secondly, he maintains that it is a fallacy that only professional prostitutes have “led many man to his fate” as young women and girls help the transmission through their ignorance (Power, 1916:216). Finally, he blames the lower classes for their participation and adds that sexual education should be implemented. “It is foolish to object to such lectures on the grounds that they lower the general moral tone. The only possible effect they could have would be to instil into the minds of the next generation a healthier and saner attitude towards matters of the most vital importance to our national hygienic warfare” (Power, 1916:221). This he views as the best way to deal with VD, as all “other forms of

administrative interference have failed us in the past, as they are failing on the Continent at present” (Power, 1916:221).

The article of most interest in this period is Meldon (1914) with his report as senior surgeon in the Westmoreland Lock Hospital in Dublin on the venereal cases seen between the years 1860 and 1914. Westmoreland catered for female patients, who were mostly prostitutes working in Dublin. Meldon (1914) maintained that the majority of prostitutes would be hospitalised in Westmoreland Lock Hospital at some point in their lives. This indicates that despite the introduction of salvarsan treatments in Dublin hospitals in 1911, the chances of a working Irish prostitute in Dublin acquiring the infection was perceived as being quite high. There was a recognisable ‘pool of infection’ in the Dublin population in the early 20th century.

Using graphs, Meldon (1914) illustrates the overall cases and new cases by decade and separate trends for gonorrhoea and syphilis. During 1860 and 1870 – the time of the implementation of the CDAs – the rates started with 820 overall admissions, peaked at 920 in the middle of the 1860s before dropping dramatically to 600 and resurging to 860 by 1870. The following decade was as erratic but the peaks and dives were of a smaller range, between 680 and 870. The period 1880 to 1885 also dipped and rose, moving from 770 to 695, 760 to 695 and back to 755. From there onwards, the rates begin to decline, which can be said to correspond to the repeal of the Acts and the clerical movement to clear out the brothels of the cities. By 1914, total admissions were 350 (Meldon, 1914). Through the entire period new cases varied between 220 cases and 80 cases, which is a small proportion of the overall rates. The largest proportion of the rates was non-syphilitic cases, mainly gonorrhoea.

Meldon (1914) attributes the declining rates from the 1880s to the changes in the severity of the disease, the closing down of brothels and the change in the type of woman infected. While these account for the decline in admissions, they would be responsible for the escalation of diseases’ prevalence in the wider population. With regard to syphilis, Meldon (1914) believed that disease had become milder in its symptoms. As a result, a woman did not usually present themselves at the hospital until she was suffering “very considerable discomfort or she finds herself unfit to continue her avocation. As long as she suffers comparatively little inconvenience either she remains untreated or, at least, visits one of the various dispensaries, probably at very irregular intervals” (Meldon, 1914:111). While Meldon (1914) states that this results in fewer seeking admission to hospital, he is not at all concerned that these patients were capable of further transmitting the disease in the population. Up to 1899, the majority of brothels were on the North Side of Dublin city and each house had someone responsible to send infected girls to the hospital. “A good number of our admissions in past years were these patients who would not have come of their own accord” (Meldon, 1914:113). These brothels were closed by 1914 and prostitution moved to the streets of the city and its suburbs, with women less likely to come forward. Meldon (1914) also mentions the rise of the ‘non-professional’. As these women also pursued other occupations, they were opposed to visiting the Lock hospital and sought treatment elsewhere (Meldon, 1914).

Although the largest in terms of numbers of beds, Westmoreland Lock Hospital was still only one hospital reporting its admissions. The hospital attracted “female persons of a not very orderly type” and this restricted the type of patient who would come

forward for treatment. Meldon (1914) stated that treatments in the earlier part of the century were less effective and resulted in higher numbers of readmissions. This of course leads to a higher probability of the infection being spread in the population. Furthermore, the rates did not include scabies or lice, which were even more prevalent. It was policy from the 1880s onwards to confine the hospital's admissions and rates to patients suffering from venereal disease (Meldon, 1914). Exclusion of other genital infections not only limits our knowledge of the extent of all the diseases at that time, but venereal diseases can often be misdiagnosed as other sexual problems and may not therefore be included. Taking this into account, it is likely that the prevalence and incidences of venereal diseases were as high as those reported from the 1940s onwards in Ireland.

(3) VD in the Irish Free State and Republic.

In most of the articles from this period, Irish medical professionals depicted VD as a problem pertaining to other countries – for example, O'Connor (1935) who focused on treatments of syphilis in London. In relation to an article by Lanigan-O'Keeffe (1957) on the recent changes in venereal diseases – again pertaining to Britain – an appendix of commentary from Irish medical doctors asked for information regarding the prevalence of venereal diseases in Ireland:

Is there much venereal disease in this country? Or is much of it treated by unqualified people? I fully realise that it is difficult to get any statistics on this matter. We have set up special clinics, but do not publicise them. My impression has been, having talked to doctors all over the country that it is not very prevalent in the country. Most of the private practitioners to whom I spoke said that they did not see cases of venereal disease and most of them if they did see them, advised them to go to the clinics.

(Dr. T. Murphy, as cited in Lanigan-O'Keeffe, 1957:233).

While doctors may be of the impression that it was not very prevalent, there are two articles that suggested the diseases were more common than presumed. The first article is a report on the work done by the first venereal disease clinic, which opened in Steeven's Hospital in January 1919. Each week, the clinic was open for two morning sessions for women and two morning sessions and two evening sessions for men (Kirkpatrick, 1923). During the four years ending December 31 1922, a total of 4222 patients were seen, 743 of which were women (Kirkpatrick, 1923). Many of the women were married. Out of the 110 women seen in 1919, 64 of those were married (Kirkpatrick, 1923). Given the restricted hours and the fact that the patients' names and address were recorded, the numbers are quite high.

Cherry (1943) addressed the lack of public activity in regard to venereal diseases in Ireland. Other countries, such as the USA and Britain, had publicly recognised venereal diseases as a problem that needed to be controlled. However, in Ireland, the VD clinic system remained unchanged since its implementation in 1919, with local authorities having no interest in improving it. Cherry (1943) argued that there was more venereal diseases in Ireland in the 1940s than in previously recorded periods and that control measures had to be undertaken. Compiling figures from Steeven's Hospital's VD clinic, Cherry (1943) pointed out that throughout the 1920s an average of 1000 new cases were seen each year. By the year 1942, the number had risen to 1300 (Cherry, 1943). Such an incline occurred during a period where Dublin lost population through people seeking employment in Britain and through the number of

men in the Defence forces, who received their treatments at military centres (Cherry, 1943). Furthermore, there was a high defaulter rate amongst Irish VD patients – defaulters are patients who do not finish their course of treatment. Cherry (1943) cites that 50% of men diagnosed with syphilis at Steeven's would default within the first year of their treatment. This of course not only keeps the infection in the population but in relation to gonorrhoea, helps produce antibiotic resistant strains. Cherry (1943) is adamant that the general public be enlightened on the existence of venereal disease in Ireland. He calls for sex education and availability of information on the clinic's locations and hours. For Cherry (1943), the diseases can only be controlled if the public and the medical professionals co-operate by being informed. However, he is aware that "once again, we are up against the Puritanism and hypocrisy which would appear to result in making both the medical profession and the public think that VD does not exist in Ireland, or is, at any rate, a rare disease, while in fact nothing could be farther from the truth" (Cherry, 1943:170). Irish sexual morality was a strong determining force and sexual problems would remain hidden until the late 20th century.

Irish Sexual Behaviours:

Before examining how Irish sexuality became construed as one of sexual morality, it is worth mentioning again that there is a notable absence of studies on sexual lifestyles and behaviours. Additionally, there is a lack of research on the loosening of sexual taboos and changes in sexual meanings for the young within the war periods and during the 1960s' economic boom. Such periods have been documented for other western countries and it is interesting why such attention has not been averted to Irish society. It is worth pointing out that at the start of the 21st century, a small number of publications emerged addressing sexual practices in Ireland. For example, Finnegan (2001) has documented the role of Convent Magdalen asylums in the late 19th and early 20th centuries firstly in the detention of prostitutes undergoing reform and later for unmarried mothers, abused women and 'wayward' girls. Yet any historical and sociological work that has been done on sexual issues in Ireland has been preoccupied with the role of Catholicism in sexuality. These reviewers are more interested in how Ireland maintained its sexual morality, that like the historical documents they engage with, they are guilty of viewing it as the norm. "Irish Catholics have long been proud of what they see as Ireland's moral uniqueness, its defence of old style Christian values in a world that is forgetting them" (Armagh, 1994:179). With this veneer of moral conservatism comes the practice of keeping sexual behaviours private. Such privacy of matters has actually been a part of the Irish persona for centuries. A variety of sexual behaviours have always existed in Ireland. Moreover, these behaviours differ between rural and urban areas, between classes and geographically. This section will briefly highlight a few studies done on sexual behaviours prior to the Famine of the mid 19th century.

Previous to the mid 19th century, Ireland's sexual culture was similar to that of other contemporary European countries. In the 17th century, Ireland had a greater laxity of morals in comparison to later centuries (MacLysaght, 1979). It was a time of continuous warfare, during which, cohabitation, adultery and incestuous relationships were widespread. Polygamy was common and divorce widely practised with marriages often only lasting one year. Jesuits were described as undertaking great endeavours to prevent Ireland from becoming pagan and a law was passed by the

ruling community of 'settlers' in 1634 to enforce monogamy on the Irish 'natives'. Compared to the courtly 'civilisation' of the English, the Irish engaged in social relations similar to those of the English Middle Ages, for example, many people shared a bed and nakedness in public was a natural state. Despite that, the Irish were described as 'decent folk' by outsiders "though they certainly had no very high sense of morality, sexual or otherwise" (MacLysaght, 1979).

Emphasis on chastity did not appear until after the Penal Code was introduced (MacLysaght, 1979). This Code, also known as the 'Penal Laws', had been imposed on the Irish Catholic population by the British government after the Battle of the Boyne. The laws removed various rights from the population including the right to practice religion, the right to education and the right to vote. This persecution resulted in the creation of 'us' and 'them' - coloniser and the colonised. The Irish reacted by wholly identifying themselves with Catholicism. As Turner (1991) points out religion can function as a vehicle for national sentiment against outside aggression. Due to its illegality, the private nature of Irish Catholicism was formed and people shielded their personal pleasures. According to Inglis (1997), sexuality did not enter public discourse, with the exception of esoteric theological debates in the 18th century. A national survey on manners and customs in Ireland was conducted at the end of the 18th century and it had little to say about the sexual morality of the people (Inglis, 1997). Sexuality was expressed through the means of poetry and literature but it was not a matter of public concern. The private nature of Catholicism is quite a crucial aspect of the Irish personality. Messenger (1976) conducted an anthropological study of sexual repression on a small island community. Although the results of the study have been dismissed as being naïve by many Irish commentators – and I'd like to add that it perhaps overlooked the Irish sense of humour of 'ball hopping' or 'taking the mick' - Messenger did point out that the island residents feared to have their most intimate revelations becoming common knowledge in the community, thus indicating a distinction between private sexual behaviours and public sexuality.

Despite being constrained within a short journal article, McLoughlin (1994) did attempt to describe sexual lifestyles of women in Ireland during the 19th century. A variety of sexual relationships existed. As well as marriage, women procured celibacy, religious life, prostitution, cohabitation, common law marriages, lesbian lifestyles, other non-stereotypes or were kept women (termed 'gentlemen's miss'). McLoughlin (1994) is also sceptical about the apparent low illegitimacy rates and absence of sexual activity outside marriage. She argues that minutes' books of the various Poor Law Unions contain numerous letters of single unmarried women who had emigrated to North America and Australia and were seeking their children they had left behind in the workhouses. In addition to McLoughlin's observation, Ireland also maintained several asylums, workhouses and county homes, where pregnant women entered in private and gave their children up for adoption. Other women left for England and had their children there. During the 1920s, roughly 500 pregnant women were seen each year by one of the many British societies, The Liverpool Society of the Prevention of International Traffic in Women and Children (McAvoy, 1999). Therefore, the Irish were augmenting the rates abroad instead of in their homeland. McLoughlin (1994) speaks of a practice of wealthier men purchasing husbands for their daughters who were impregnated and abandoned. She adds that such a practice was not common as both father and son-in-law were reluctant to

conceal the daughter's shame. However, Connelly (1979) argues that according to Catholic parish registers, illegitimacy and pre-nuptial pregnancies were quite common and enforced 'quickie' marriages were regularly undertaken. Given the private nature of Irish Catholics about sexual behaviours, many families would probably have protected their secrets. For example, there is actually a common phrase 'the afterthought' in Cork in Ireland, which is used when a woman in her forties has a baby some years after her youngest child. According to Corkonian folklore, this phrase originated from the practice of grandmothers in the past claiming the child as their own, in order to protect the daughters from shame. Similar to their counterparts in Britain, women of the lower classes such as cottiers and labourers were considered to indulge in promiscuous lifestyles but in Ireland, their behaviours were deemed outside the bounds of decency and were not considered worthy of public scrutiny (McLoughlin, 1994). Their exclusion obviously would have an impact on what was actually recorded in relation to sexual practices.

One final observation of McLoughlin (1994) that should be noted is that economic not religious factors played a pivotal role in Irish women's sexual expression. "An awareness of the vulnerability of pregnancy outside marriage was acute for many young women and the fear of their families wrath coupled with the astute realisation of their lack of employment prospects in Ireland made many of them extremely conservative in their courtships. There were no prudish maidens or sheltered daughters. Instead they were reared with an awareness of the seriousness of sexual laity outside marriage of an aspiring class " (McLoughlin, 1994:273). Just like the rest of the British Isles, Ireland was a Victorian society.

The Creation of Irish Sexual Morality.

The 'Great Famine' (1845-1847) is the great watershed in the history of Irish sexuality. In its aftermath, a combination of economic, religious and political forces formed the construction of Irish sexual-morality. The Catholic Church has often been criticised for being responsible for the demographic pattern of Post-Famine Ireland. As Lee (1989) points out, the Church was merely reflecting the dominant economic values of Post-Famine rural society. Under British rule, Ireland's status as colony stunted its economic growth. In the Post-Famine years, the rising Irish bourgeoisie became aware that the modernisation of Ireland required a reduction in population. Farmers, fearing the economic dangers of large families previous to the Famine, engaged the Church's anti-sex ethos and attempted to control the Irish population by encouraging late marriage, celibacy and chastity (Larkin, 1997; Ardagh, 1994; Brown, 1985). A tradition was started of the oldest male offspring inheriting the land of the family farm, to ensure that the practice of 'subdivision' between family members died out and as a result, the farm remained large enough to prosper and grow (White, 1999). The first born daughter received a dowry upon marriage, whilst all other offspring had to sustain a living from elsewhere either from learning a trade, migrating to cities, emigrating or joining the religious orders.

Late marriages and repression of sex outside marriage were made the norm in order to reduce the number of years of fertility for married couples and the overall birth rate (Inglis, 1997). The average age of marriage remained in the mid to upper twenties until the 1960s, when it declined slightly (White, 1999). Celibacy was also widely promoted and the large numbers of bachelors and spinsters helped to decline the

population in Post-Famine Ireland (White, 1999). This demographic pattern, which at the time was the only method of population control then available, remained intact throughout the early years of the Free State and the Republic (Sweetman, 1979). Publicly, Irish society was associated with being sexually repressed. Privately, illegitimacy and venereal diseases persisted. Despite the postponed marriages, the Irish fertility rate was still higher than other European countries. While this echoes the Roman Catholic ethos of reproducing, birth spacing and stopping were successfully practised amongst the middle classes and those living in urban areas (Inglis, 1997).

The Post-Famine period also marked the rise of the Catholic priest. Numbers at church increased and the priests found themselves with growing congregations, and in many parishes, leaders to uneducated and impoverished communities (Sweetman, 1979). According to Stark (1999), religious behaviour is as rational as other forms of human action. People go about being religious in much the same way that they go about everything else. The Post-Famine period was one of great economic and political changes. Farmers were growing in power and would later fight the 'Land War' for rights to own their properties. Furthermore, social status became an obsession and the aspiring Catholic bourgeoisie and farmers were interested in emulating their social betters, who preached and practised the social primacy of the professions, the Church, law and medicine (Lee, 1989). In Victorianism, religious and civil codes were tied up with Victorian propriety (Sweetman, 1979). The Irish Catholic bourgeoisie were more interested in gaining respectability than in developing trade (Inglis, 1998; Lee, 1989). An alliance with the Catholic Church was sought and forged. Irish sexual morality became an extreme version of Victorian morality (Hug, 1999).

At the same time, the Catholic clergy were interested in eliminating what they perceived as lax civil mores of pre Famine Ireland. For example, sexual practices and alcohol were common at parties (McLoughlin, 1994). Indeed, the slang word 'fla', signifying 'to have sexual intercourse', is derived from the Irish word 'fleadh', meaning party. Drawing on the private nature and non-intellectualism of Irish Catholicism (both influenced by the practice of the religion being banned in the 18th century), morality centred on the private, specifically the sexual side of life. The Church gained access to the family life through the Irish mother and once incorporated into the private sphere, it influenced the relations between spouses, the level of fertility, the circumstances and manner in which children were reared and the type of personalities that emerged (Inglis, 1998). The education system was asserted through religious orders and from infancy on, a consensual Catholic morality was instilled in the majority of the Irish people (Sweetman, 1979).

An Anti-Contagious Diseases Act movement did occur in Ireland, but unlike other religious groups, the Catholic Church was notably absent from it (Malcolm, 1999). Instead, the Catholic clergy were very involved in the combat of prostitution, alongside the Contagious Diseases Acts' enforcers. In Cork, a Fr. Michael Shinkwin got involved after complaints of residents in Cuthbert's Lane area about the activities of prostitutes (O'Mahony, 1997). He approached the women, lectured them on the immorality of their lives, recited the Rosary with them and within days he had cleared the area of 120 prostitutes from 20 brothels. The girls were not permitted to return to the parish and had to go to the Magdalene Asylums, the workhouse or to family and

friends in the city or elsewhere. Fr. Shinkwin was then joined by two other priests and plain clothes Contagious Diseases Act Constables and within a month, 40 brothels had been vacated. Prostitution in the city centre decreased, incidentally the number of illegitimate births also declined and both were attributed to Fr. Shinkwin's activities. However, prostitution just moved to the suburbs and the number of ex-prostitutes increased numbers dramatically in the already over-crowded asylums during 1876, thus causing further social problems (O'Mahony, 1997).

For the Catholic clergy, prostitution was a moral problem and by the mid 20th century, they viewed the combat of venereal disease as their mission. Up until the *Infectious Diseases Regulations* in 1948, the Catholic Church was opposed to state intervention, as they viewed issues relating to VD as moral and not social concerns. For example, in 1942, the Archbishop of Dublin, Dr. John Charles McQuaid, persuaded some Catholic Dublin voluntary hospitals to open clinics for sufferers of venereal disease. This was part of his plan to encourage voluntary and communal organisations to help the poor and the sick, and to reduce the need for state intervention (Barrington, 1987). Malcolm (1999) maintains that the removal of the state regulation of prostitution through the repeal of Acts endorsed the right of the Catholic Church to control female sexual behaviours. However, the Catholic Church had already been embroiled in Irish sexuality.

From the 19th century onwards, Catholicism dominated the public forum on sexuality. Even the language of medicine was not different from that of the Church and similarly, lawyers, judges, politicians and journalists did not write in a resistant voice, but supported the prevailing religious discourse (Inglis, 1997). The other churches – for example, the Anglican Church – also perpetuated sexual morality. It was not until 1930, that the Anglican Church (i.e. the Church of Ireland) separated from the Catholic view on the issue of contraceptives, allowing its usage within marriage but only in certain circumstances (McAvoy, 1999). The sexual was censored in public life and silenced in the family. Those who deviated were branded sinners. Unlike Victorian England, where social ills of prostitution and VD were discussed in public, the late 19th century hid its sexual deviances through institutionalising the 'sinners', emigration or ignoring family problems.

Contrary to the interpretative monopoly assumed by the Vatican, Catholicism can be produced by multiple micro-producers (Dillon, 1999). After the Famine, the Irish Catholic bourgeois engaged in Catholicism in order to secure its social status and economic growth. Moreover, it became an embodiment of a political assertion. The societal dislocation caused by the Famine in the 1840s had undermined traditional forms of cultural identity. Fervent devotion to the Church provided a viable substitute symbolic system for failing indigenous cultural forms (Hoppen, 1990). Religious affiliation became caught up with the construction of identities. Previously, notions of 'Irishness' and 'nationalism' were Protestant constructs but as the Catholic farmer and other Catholic bourgeoisie rose in power, they engaged in these concepts and tied British xenophobia with Catholic hegemony (Hoppen, 1990). This excluded the Protestant, Jewish and Travelling communities from the construct of 'Irishness' and furthermore, incorporated a conservative, non-sexual sexuality. National identity was discursively produced and operated as what the Irish wanted to be (Finlayson, 1998).

The Irish State, Sexuality and VD:

By the time, the Irish State was created in 1922, the Catholic bourgeoisie had incorporated Catholicism into state control. "The machinery, laws and institutions of the Irish State were based on a Catholic theology fashionable in the 1920s and informed by Victorian bourgeois ethics" (Sweetman, 1979:9). Inglis (1998) argues that because the Catholic Church played a role in the first period of modernisation of Ireland, it continued to influence the economic, social and political life of the country, when more mature capitalist countries were reducing the role of religion in their societies. As a result, Ireland was legalistically moral rather than secularly civilised. The Catholic hierarchy is reported to have pressurised the government into imposing Catholic moral mores into the state (McAvoy, 1999; Hug, 1999). The Church previously had been an ally against an enemy, the British Government. Without the enemy, it turned on the enemy within. The Catholic clergy were upset by the outbursts of violence during the Civil War and were questioning the morality of the Irish (Hug, 1999). In addition, the Irish Catholic Church was also acutely aware of problems facing Catholic in other western countries and its stance was partly fuelled by a desire to avoid secularisation and socialism (Whyte, 1981). However, the involvement of the Church was also in the interest of the Irish people as Irish Catholic bourgeoisie wished to maintain their identity through the social and economic changes as a Free State and later as a Republic. Other states were seen to have revealed their degeneracy through the public tolerance of sexual practices. The newly formed Irish state needed to be established and unified and this meant regulating its population through the confinement of the body to the home, the defiance of the debilitating influence of foreigners and the perpetuation of an individual's self-control to ward off sin (Finlayson, 1998). The ideology was both nationalist and Catholic. It glorified rural life and romanticised the family (Hug, 1999). However, the incorporation of sexuality with politics and economics meant that a crisis or change in the latter two would unsettle the perceptions of sexuality. From the establishment of the State and periods of war, to the economic booms of the 1960s, 1980s and again in the 1990s these phases would become marked by public discussions on contraceptives, abortion, divorce and sexually transmitted infections.

During the 1920s, there was public concern about the apparent changes in sexual behaviour. Venereal disease did not enter the public arena as an outcome measure of increasing 'high risk' behaviours. Instead, the public discussions focused on divorce, contraceptives and illegitimacy. The absence of VD could quite possibly be due to a continuation of the perception that venereal diseases were urban diseases and Ireland was predominantly a rural society. Despite the efforts of the Local Government Board for Ireland to stress that war increases the incidence of venereal diseases and that the diseases could be conveyed in a number of ways that were not immoral, many local authorities refused to believe action was necessary. In Cork, the County Council was fronted by forceful arguments for the provision of VD services, including a local doctor, Dr. McCarthy, who argued that syphilis was a very serious disease and that it was urgent to endorse an effective scheme to control venereal disease (Marnane, 1986). The Cork County Council refused to implement the Act for the Treatment of Venereal Disease. They maintained that as there were no statistics, there was no evidence that rural Ireland had cases of VD. It also argued that treating VD would be unsettling to Cork society:

The methods of dealing with this matter outlined to us could not possibly be successful. A hospital for this disease would be availed of only by the very abandoned. The establishment of special beds in existing hospitals would cause the general public to shun the hospitals; and should a special doctor be appointed to visit persons at their homes through the County, such doctor would be rigidly avoided by the people.

(Marnane, 1986:146).

Irish society had by the mid 1920s endured three wars – World War I, the War of Independence and the Civil War. Its new government had been formed from an irreconcilable spilt in Sinn Féin and it was the first time since the Act of Union in 1800 that a national parliament resided over the affairs of the country. Additionally, Ireland in the 1920s experienced the popularity of the cinema, the radio, the motorcar and the dancehall. Contraceptives – both commercially produced and homemade alternatives – were widely available (Jones, 1992). With such outside influences and the need to establish the nation, anxieties about the social upheavals emerged and were manifested in public outcry on the perceived changes in sexual mores. Bishops spoke out against the dance halls and picture houses contending that they helped to promote immorality. They argued that Irish women were less advanced in coping with sexuality and so they were easier to lead astray (McAvoy, 1999). A resistance to birth control emerged, fuelled by the fear that this modern development would retard population growth, challenge accepted moral norms and by undermining the family as a unit of social organisation, would ultimately affect the stability of the state (McAvoy, 1999). Marriage was essential to the Irish sexual-morality. The Irish took pride in the permanence and stability of their marital unions (Connery, 1968) – a contrast to the fears about the family in the USA and Britain in the first years of the 20th century. Women were actually only recognised in the Constitution as contributors to the state by their roles as wives and mothers (Valiulis, 1995). There were dissenting voices that argued for the provision of contraceptives. Many of these were medical professionals, who were concerned for the sexual health of women. They maintained that if the contraceptives were banned, VD, infanticide and abortion would increase (McAvoy, 1999). Women's health was seen to be subordinate to the public morality question and consequently, the importation and advertising of contraceptives were prohibited under the 1929 Censorship Act. Five years later, prostitution was outlawed under the Criminal Law Amendment Bill. Divorce had previously been made illegal in 1925 (Hug, 1999).

Sexuality was a focus for the government in constructing a stable Catholic society (McAvoy, 1999). The apparent conformity to Catholic mores simply disguised the multitude of sexual behaviours. The sexual behaviours of the working classes remained outside that of the social norms being imposed by the dominant middle class Catholics (McAvoy, 1999). Sexual values and norms also varied between cities, towns and countryside and between classes with the cities. Public discussion on sexuality was muted (Ardagh, 1994). The media was devoid of arguments concerning divorce, birth control, and support for unwed mothers. Cases of rape, sexual abuse, domestic abuse and illegitimate births were unreported (Ardagh, 1994). Foreign literature containing material that was against the sexual norms sanctioned by the state were banned and Irish writers were constrained to write on a particular ideal of the Irish personality – the 'clean living', decent, 'God fearing' rural inhabitant. The media were also prohibited from informing the public about venereal diseases

(McAvoy, 1999). This of course prevented venereal diseases from being raised in public discourses by voices other than the state or the Catholic Church.

The outbreak of World War II meant restrictions on travel and finance. Illegitimacy rates rose and prostitution became more prevalent, in particular, the presence of the 'non-professional' – i.e. women who needed money short-term. Both increases were due to Ireland being unable to export its social problems (McAvoy, 1999). In 1944, a memorandum to the government expressed alarm at the rise in VD, particularly among married people and called for much more radical measures to deal with the situation (Barrington, 1987). It was in a time of state instability. Irish society had been affected by an economic war with Britain followed by the 'emergency' period during World War II. In 1948, it would gain independence as a Republic. Fears were again expressed in relation to sexual mores. Breaking from the Church's belief that VD and prostitution were moral issues, the state incorporated the provision of VD services and the notification of the diseases under the establishment of the national health services. Venereal diseases became a medical concern and with the finding of penicillin as a cure, Ireland like other countries saw declining rates.

Throughout the 1950s and 1960s, Irish sexual morality constantly dealt with potential threats. In the 1950s, when poverty and disease were rife in Ireland, the Bishops opposed the State's granting of bar licenses to dance halls, as this they believed would motivate immoral behaviours (Williams, 1953). Whilst the Church continued to denounce the dance hall, the popularity of the show-band amongst the youth brought about a huge growth in the 'ball room' industry. A forerunner to the disco and the nightclub, dance halls were places where young people gathered and enjoyed each other's company just as in other western countries (Connery, 1968). During the decade of the 1960s, the public barriers against the outside influences began to break. With the advent of television, modern consumerism, an economic boom and the arrival of former emigrants from more liberal societies, there was also a fall in the age at marriage (Ardagh, 1994). Doctors started prescribing the contraceptive pill as 'a cycle regulator' (Ardagh, 1994). A candour about sex in public emerged. Although a contemporary observer, Connery (1968) saw the sexual attitudes of the Irish youth being comparable to those of a previous generation in the USA and Britain, by the end of the 1960s, the new 'permissiveness' of western societies began to creep into Ireland.

While other issues, such as abortion, divorce, contraceptives and homosexual rights would plague the sexual morality over the next four decades, VD disappeared from the public arena until the HIV/AIDS pandemic. The presence of sexually transmitted infections was silenced like the sexual behaviours and practices on the micro level. Only certain sexual issues entered the public consciousness. Divorce, abortion, homosexuality and contraceptives were viewed as threats to the public moral sexuality. It was perceived that if these issues were accepted and tolerated, then Irish sexual morality would fall into disarray. The state was only interested in regulating these social phenomena (Hug, 1999). In regard to the sexual and relationship problems that already existed within the Irish population – for example, sexual and physical abuse in the home - these topics did not enter the public arena. Illegitimate births did become a public concern from time to time but mostly in relation to public debates on sex education. Perhaps unmarried parents were seen more as a threat to the Irish family than sexually transmitted infections. In order to maintain the

constructed sexual norm, perceived sexual deviances had to be ignored. Even details of intimate relationships were not discussed – hence the lack of surveys on sexual behaviours and attitudes. With the changes in the political, economic and social climate of Ireland from the end of the 1960s onwards, these issues could no longer be ‘swept under the carpet’.

The silence of the medical profession on sexually transmitted infections since the 1940s is quite apparent. Since VD was considered to have been contained within western societies and the fact that venereology only constituted a tiny proportion of the overall health services, medical attention was probably shifted elsewhere to more pressing diseases, for example, polio and tuberculosis. The impact of HIV/AIDS, followed by the huge changes in sexual politics, saw an emergence of STIs in the Irish media. The concerned reports on the increases in rates were spearheaded by various medical professionals engaged in genitourinary medicine. In continuation of the history of VD in Europe and the USA, these medics were exerting their voices in an effort to gain respectability and funding. However, the current rates of STIs are not as high as other comparable western countries. It is probable that since there has been a change in legalisation regarding divorce, contraceptives and homosexuality - and like Britain, a growing tolerance of different lifestyles and behaviours - abortion, sex education, teenage pregnancies and sexually transmitted infections are the last frontiers for the sexual morality.

Conclusion:

The socio-historical account of venereal diseases, sexual behaviours and sexuality in Ireland reveals a morally conservative sexuality yet sexually deviant practices, such as illegitimacy, were practised but were oppressed or sedulously ignored. In relation to sexually transmitted infections, public awareness was muted through the 19th and 20th centuries, but advances in medical work were being regularly produced. Inconsistencies in rates and reports on VD coupled with an absence of studies on sexually behaviours, does make it difficult to assess the extent of the problem. It suffices to conclude that STI rates are not a phenomenon of the 1990s. A range of sexual behaviours has always existed, with a proportion of the population engaging in ‘high risk’ behaviours.

Having examined the national reported rates of STIs in Ireland, the presence of ‘high risk’ behaviours in the Irish population and the prevalence of STIs in the past, it is now appropriate to look at Irish sexual culture in the 1990s. Reported rates of STIs are used to estimate the proportion of risk taking in a population, yet as we have established, the proportion of the Irish population who may be exposed to a potential risk of STIs (i.e. through multiple partners per unit time) is small. At the same time that the reported rates of STIs increased, there was a change in Irish sexuality. Legalisations on abortion, divorce, homosexuality and contraceptives were passed. A growing liberal discourse in the media prompted public discussion on STIs and other sexual issues, such as sexual abuse of children, while the moral power of the Catholic Church crumbled in the early 1990s. Ireland would also have been affected by the ‘sexual permissiveness’ trend of sexual attitudes within Europe and the USA. These changes in public attitudes would create a greater tolerance of different sexual behaviours and a public openness of sexual problems including sexually transmitted infections.

Chapter 7: Irish Sexual Attitudes – A Norm of Western Societies in the Late 20th century?

Everyone knows, or thinks he knows, all about the Irish while knowing nothing at all about Ireland as it is today.

(Connery, 1968: 12).

Introduction:

Within the very same period that the national rates of sexually transmitted infections were rising in Ireland, Irish sexuality underwent rapid changes. The Catholic Church's authority diminished almost completely through a number of processes, perhaps the most well known being the catalyst of allegations of sexual abuse and the economic boom of the late 20th century heralded a more secularised Irish society. In the early 1990s, new legislation regarding the issues of sexual morality was passed, resulting in contraceptives being widely available, divorce legalised, homosexuality decriminalised and women seeking abortions had the right to information about the procedures (Hug, 1999; Inglis, 1998a; Inglis 1998b). Since the sexual climate of a country is reflected in its legal situation and in its access to birth control (Sandfort et al, 1998), these changes in sexual morality mark the emergence of a more liberal Irish sexuality in the 1990s. Additionally, these changes in Irish sexuality took place amidst the trend of sexual permissiveness¹ in western societies in late 20th century, which has undoubtedly affected Ireland. There has been an increase in the number of single parents, working mothers, cohabitation and children born by new reproductive technologies. Premarital sex was publicly accepted and discussions about sex were widespread in the popular media. Rates of women seeking abortion in the UK, cases of child and domestic abuse and rising rates of unmarried mothers also came to the Irish public's attention, thus ending the era of repressive sexual morality.

If we are to understand why the rates of STIs have increased in Ireland during the 1990s, we need to know about the sexual culture at that time. As shown in Chapter 4, STIs have been traditionally used as markers of high-risk behaviours and public interest in their prevalence and incidences has spawned in times of crisis over sexuality. Thus, we need to be aware of the changes that have taken place in the 1990s in relation to the fall of Irish sexual morality. It is very possible that the transition that Irish sexuality is undergoing is prompting public concerns about sexual deviance, with national rates of STIs being used as evidence. This deflects attention away from why people risk STIs in their sexual encounters and impedes primary prevention. Instead of using rates of STIs to indicate sexual behaviours, we should be studying sexual behaviours and attitudes to gain insight into how STIs are spread in

¹ This trend was marked by the "decline of the rule of the experts who characterized the previous epochs with more restrictive sexual norms and the replacement of these by informed 'morally mature' citizens who require little formal regulation" (Hawkes, 1996:143). While 'sexual permissiveness' implies that individuals are in a position to make their own moral choices in their sexual behaviours, it should be noted that like other periods in the history of sexuality, sexuality is influenced by a number of social forces. 'Sexual permissiveness' has been influenced by a growth in consumerism, urbanisation and secularisation.

the population. It is thus essential to this investigation to identify Irish sexual culture in the last decade of the 20th century.

Sexual attitudes are important to the study of STIs in Ireland because they help constitute the climate of public opinion against which behaviour is judged (Scott, 1998a). The more permissive the sexual climate, the greater the variety of sexual behaviours tolerated. In relation to the national reported rates of STIs the more liberal the sexual attitudes, the less stigmatised the infections and the more likely people are to come forward for treatment. This results in larger numbers at clinics and ultimately more diagnoses and higher measured rates. Since attendance numbers have been increasing at GUM clinics throughout the 1990s, it is very probable that the changes Ireland experienced in relation to sexual morality are having an effect. Ross (1984) studied STIs in male homosexual populations in four countries, including Ireland, and concluded that attitudes towards sexuality and homosexuality affected patterns of STI reporting between countries. The more liberal the attitudes, the more homosexuals came forward for treatment. In addition, Smith (1994) has argued that whether or not people regulate their sexual behaviours in accordance with their own personal norms or adopt norms that match their behaviours, those with more permissive attitudes towards premarital, extramarital and homosexual relations are more likely to have engaged in the related behaviours. So while disapproval does not necessarily mean refraining from condemned behaviours (for example, extramarital sex), those who are more accepting of the behaviours may be more likely to indulge in them. This however does not mean that people will be more prone to promiscuity, which has been incorrectly confused with permissiveness in previous studies – for example Grey & Swain (1996). Sexual permissiveness can be viewed as a positive effect for a society. It can be argued that as a society becomes more sexually liberal, the public openness about sex improves sex education with people being more encouraged to use contraceptives and being better informed about risk taking. The long term result would be a decrease in incidences of STIs and unwanted pregnancies.

The aim of this chapter is to specify Irish sexuality in the 1990s and to generate hypotheses concerning the relationships between attitudes and their impacting factors. Sexuality is defined here as what is publicly considered to be appropriate and inappropriate sexual behaviours. This examination alludes to the decreasing effect of religion in Ireland and the rising influences associated with economic progress, urbanisation and secularisation. In order to assess how liberal Irish attitudes were in the 1990s, they need to be compared to those of other western societies. This involves an overview of existing literature on the decline of Irish sexual morality in the late 20th century and the changes in family. Previous studies on Irish sexual attitudes and those of other western countries will also be discussed. Drawing on this background, we can use the 1994 ISSP dataset to assess the degree of Irish sexual morality (i.e. on the issues of abortion, divorce and homosexuality) with countries that have more established legislation on these sexual matters - namely, Poland, Spain, USA and Australia. All of these countries have experienced an era of growing sexual permissiveness, which can also be measured by attitudes to premarital sex, extramarital sex, sex between teenagers under the age of 16 and cohabitation.

After the initial explanation of data and methods used, this chapter will address the growth of sexual permissiveness in the western countries and the decline of sexual morality in Ireland. Irish sexual attitudes will then be compared with the other

countries and this will be followed by an inspection of the explanations for the patterns of sexual attitudes across countries. Finally, the variations in sexual permissiveness across the countries will be analysed by use of multiple regression models. Since sexual norms vary across cultures as well as over time, cross-national research can highlight the similarities and peculiarities of Irish sexual attitudes in comparison with some of the other western societies at that particular period of time.

Data and Methods:

Due to the lack of previous sex surveys and longitudinal data on Irish sexual attitudes and behaviours, Irish sexual attitudes during the 1990s must be assessed through a comparative analysis with other countries. The time frame of 1994 of the International Social Survey Programme (ISSP) dataset is beneficial as it can provide a snapshot of Irish sexual attitudes within the mid 1990s, that is, in the immediate aftermath of the introduction of more liberal legislation on sexual issues and the demise of the power of the Catholic Church. Furthermore, probability-sampling techniques were employed to recruit the samples in each country, thus rendering the dataset appropriate for quantitative sociological analysis.

Cross-national research is a useful tool for gaining insight into how national or social structures affect individuals' attitudes, how social processes can be related to variations in national characteristics and for understanding a particular country (Arts & Halman, 1999). In this study we assume that each country constitutes a set of variables that dictate what attitudes, values and beliefs individuals share within each nation. These influences are mediated through other confounding factors within the countries, which means that patterns of attitudes vary between countries and between groups within countries. In this particular instance, we want to infer from the comparison just what values Ireland shares with other countries in terms of sexual permissiveness and where it retains its Catholic sexual morality. We also want to look at differences between social groups within Ireland and in comparison to social groupings in the other countries. The data can be adapted to generate a measure of sexual morality in Ireland. Using factor analysis, a scale on the inherent level of sexual permissiveness can be constructed. The higher the score on this scale, the higher the level of sexual permissiveness. Analysis of the relationships between sexual permissiveness, religion and other confounding factors such as age and education will be determined through multiple regressions. National differences can also be accounted for through the same process.

There are two methodological problems with the collection of the data, which do need to be taken into consideration when analysing the results. Firstly, the use of five-point scales running from 'strongly agree' to 'strongly disagree' has been shown to incite response bias. Wellings et al (1994) argue that the use of this scale can result in the general tendency towards assent rather than dissent with an expressed viewpoint. Secondly, the data on sexual attitudes were collected in face-to-face interviews in the countries. This can induce the response bias of social desirability, where the respondents give answers that they feel they are expected to state. However, the responses are in line with other surveys and it is believed that fair representations of the countries can still be produced.

Countries.

Countries used for the comparison are Poland, Spain, Australia and USA. These countries were partly chosen for pragmatic reasons concerning the data availability. Only a small number of the twenty-four participating countries in the International Social Survey Programme included an appendix on sexual behaviours, hence limiting the amount of countries available for comparison. Ireland does however have connections with these four countries, which makes them viable for comparative purposes. Firstly, Spain and Poland are also devoutly Catholic countries. In this dataset, 94% of the Spanish respondents, 89% of Polish and 94% Irish proclaim membership of the Catholic Church. This provides a useful basis on which to test the role of the Catholic Church in maintaining traditional beliefs. Poland and Ireland have strikingly different political histories but their histories have helped to create a political position of religion in the face of an external power in the two states. Both Poland and Ireland have close links between nationality and Catholicism. In Poland, the Catholic Church had been involved in the resistance against National Socialism and in the past, Catholicism was used to distinguish Poland from Protestant Prussia and Orthodox Russia (Pollack, 2001). With the collapse of communism, confidence in Catholicism fell from 87.8% of the people trusting the Church in 1989 to 40.5% in 1994 (Pollack, 2001). Within the same period, trust in Catholicism also plummeted in Ireland although to the higher level of 46.2% (Pollack, 2001). Looking at the two countries in the aftermath of the fall of the Catholic Church in Ireland and the demise of communism in Poland at the beginning of the 1990s makes for an interesting comparison. In Spain, the Catholic Church was also intertwined with national and political affairs and since the demise of the autocratic regime in 1975 the Catholic Church has lost much of its influence over the people (Coleman, 1999).

Australia and USA are connected to Ireland through a long history of emigration from Ireland to the 'New World' including widespread travel of the populace in the late 20th century and USA and Australian media, such as television shows, are distributed widely and are very popular amongst the Irish population. In terms of contrast, USA and Australia have multiple religious denominations with only 22.2% Australians and 25.7% USA respondents being Catholic. Comparisons with Ireland can help highlight any similarities Ireland has with the wider movement of sexual permissiveness and if membership of a religiously monolithic country does result in more conservative attitudes.

Factor Analysis.

Since sexual permissiveness can be deemed a theoretical concept, 'principal component' analysis (a form of exploratory factor analysis) was used to create a measurement of this latent variable using a collection of indicators. These indicators incorporated attitudes to cohabitation without marriage and before marriage, divorce, abortion, extramarital sex, homosexual sex, premarital sex and sex between teenagers. Divorce, abortion, sexual freedom and status of marriage can be combined to measure sexual morality (Whelan & Fahey, 1994). The variables had to be reversed – in the cases of the 5 point scaled variables on cohabitation, divorce and abortion – or modified – the other 4 point scaled variables included a fifth category of 'depends' for Spain, which was recoded into a middle category, corresponding to the neither agree

or disagree. Although, a Likert scale² could have been used, factor analysis was the preferred method because it takes into account that some items of the scale will have weaker linkages to the underlying factor than others. A criterion for the extraction of a reliable and valid factor is that the variables have to reflect the underlying factor (Pallant, 2001). They must 'load' on the factor through Pearson correlations of the variables with the factor. The set of variables were thus tested in a correlation matrix for appropriateness for factor analysis, using the KMO statistic. All variables were shown to yield high KMO values (i.e. over 0.7), thus making factor analysis suitable (Pallant, 2001).

According to Wellings et al (1994), respondents are inclined to treat most issues of sexuality in a conceptually similar manner. For example, those who disprove of homosexuality generally tend to be disparaging towards divorce, premarital sex etc. and this is equally true of more permissive attitudes. Certainly, a little variation is expected to occur, as some individuals may tolerate certain sexual behaviours and not others. Within this sample, levels of approval did vary from attitude to attitude, indicating that some issues like homosexuality are not as easily accepted as divorce or premarital sex. Indeed, when executing the principal components analysis, the eight variables loaded on two factors and when rotated, extra-marital sex and teenage sex did not load on the first while divorce and abortion did not load on the second. Cohabitation, divorce, abortion and premarital sex loaded more heavily (0.57 to 0.75) on the first, whilst the loading of homosexuality, extramarital sex and teenage sex fell more heavily on the second component (0.65, 0.77 and 0.79). This suggests a possible difference between what can be called 'permissive sexual morality' involving family and reproduction and 'sexual liberalism' regarding non-reproductive sex. The difference between these two factors is arguably arbitrary. Both can be viewed as dimensions of sexual permissiveness. Since our interest is in sexual permissiveness and the first factor can be determined to represent this latent trait, it is appropriate to combine the attitudinal questions. Statistically, all variables loaded strongly on the first component before rotation and again after rotation with the exception of extramarital sex and teenage sex. The first component also had a higher eigenvalue of 3.198 compared to the second of 1.115 and the first explained 40% of the variance as opposed to just 14%. The principal component analysis was therefore rerun extracting only one component to represent sexual permissiveness on which all variables were strongly loaded - ranging from 0.35 to 0.8. (See Table 1 in Appendix II). This single component was taken as the central underlying dimension of sexual morality.

Due to the variables being measured on either a five point or a four point scale and the presence of missing values on some of the variables, the best procedure for calculating the scores on the factor was the creation of factor scores via the regression method³. This method compensates for the difference between the measures of the

² The proposed selection of items used to create the scale of sexual permissiveness were also tested to see if the items conceivably belonged together on a Likert scale. Cronbach alpha coefficient was used to test the internal consistency of the scale. Ideally, the Cronbach alpha coefficient should be above 0.7 (Pallant, 2001) and in this study, the final alpha value was 0.7813. This provided a secondary insurance that the extraction of factors was based on correlations between variables.

³ This is a method provided by the SPSS 11 computer package for simulating standardised factor score coefficients. The scores have a mean of 0 and are calculated by multiplying a respondent's standardised score for each variable with the factor score for the same variable. These figures are then added up to form that respondent's score on the new factor scale variable.

variables and allows for a range of values that could adequately assess levels of sexual permissiveness. In relation to the respondents who failed to answer an attitudinal question, missing values were replaced with the mean responses. This was deemed an appropriate procedure as omitting these respondents would result in a loss of 2387 out of the 8255 cases. This loss would have distorted the overall measure of sexual permissiveness.

Regressions.

Multiple regressions were used to assess the variations between and within countries. This method was chosen for evaluating the relations between sexual permissiveness scores and the predicting variables because the coefficients are expressed as deviations from the mean of the reference category (excluded class) in each set of variables. Interesting comparisons within groups can thus be yielded from the output. Predictor variables used include age, attendance at religious services and dummy variables to represent categorical variables of sex, area of residence, marital status and educational level reached. The base or reference categories for these variables are male, rural, married/living as married and primary level reached or completed. Due to the large number of categories, the variable for religious services was recoded as a continuous variable with those who never attended coded as zero. For presentation purposes, the regression coefficients of age were multiplied by 10 to produce a value per decade rather than per year.

Ireland and the Growth of Sexual Permissiveness:

Establishing Irish sexuality in the 1990s requires knowledge of the overall rise of sexual permissiveness in western societies. Growth in sexual permissiveness has been fuelled by two main factors. Firstly, changes in the family system, such as cohabitation, birth control and divorce have affected constructions of sexuality across nations (Weeks, 2000; Weeks, 1989). This was compounded by the feminist movement in the 1970s which resulted in changes in attitudes to sexual equality and expression and increased numbers of women working (Scott, 1998a). Ultimately, the traditional family unit was affected. Secondly, sexuality in western societies has been influenced by the rise in secularisation and personal religiosity in the late 20th century (De Graaf & Need, 2000; Halman, Petterson & Verwelj, 1999). Such secularisation has been linked to the increased urbanisation, affluence and education of western societies, which have allowed younger generations to reject attitudes of previous generations (Weeks, 2000; Scott, 1998a). Both processes are relevant to Ireland.

Family and Irish Demographic Behaviours.

The changes in the family unit across western nations involve a variety of influences including the romanticising of marriage (O'Connor, 1995), an increased proportion of working mothers (Harding, 1989) and changed gender roles in the family unit and marriage. While sexual culture does involve the shared norms of beliefs about marital unions and family, it is sufficient to restrict discussions to changes in rates of marriage, fertility and illegitimate births and the rise of cohabitation and premarital sex.

In the late 20th century, Western Europe and the USA experienced what is termed the second demographic transition, which is marked by the growth in abortion, contraception, cohabitation and illegitimacy (Coleman, 1999). “Since 1960 we have seen a weakening of the normative imperative to marry, remain married, to have children, to restrict intimate relations to marriage and to maintain separate roles for males and females” (Thornton, 1988:873). Throughout the western world, rates of divorce and births outside marriage rose, marital rates decreased, while rates of age at first marriage and cohabitation have increased. In the USA, the number of USA households with cohabiting heterosexual couples grew from 523,000 in 1970 to 3.5 million in 1993 (Kalish, 1994). Furthermore, fertility rates in all western countries have dropped to below replacement level (Chesnais, 1996; Courtney, 1986). In Mediterranean countries, which are usually labelled as traditional family orientated Catholic countries, fertility rates have been approximately 1.2 children per woman since the early 1990s (Chesnais, 1996).

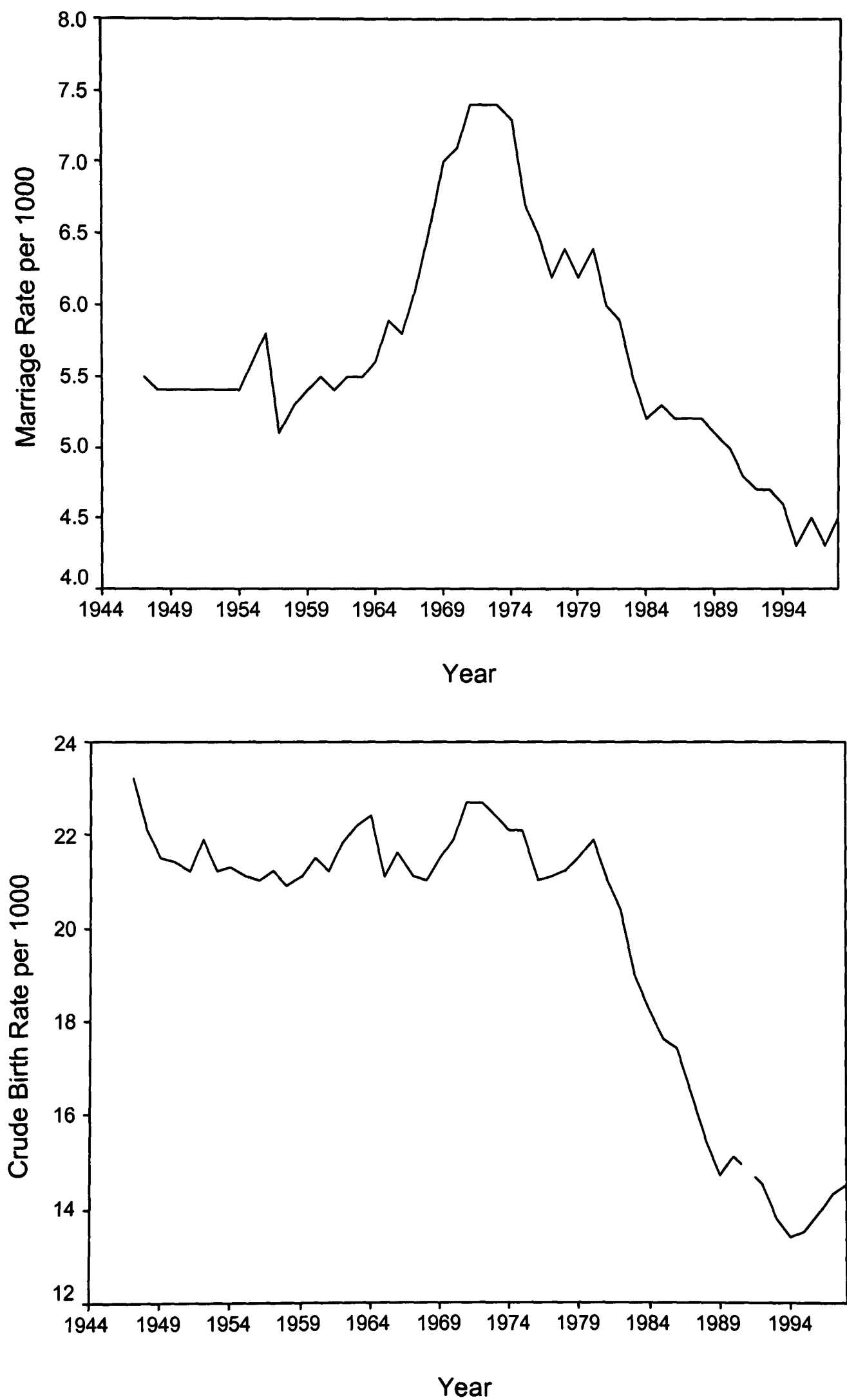
Ireland had for much of the 20th century been struggling to complete the initial demographic phase with persistently high fertility rates and the continual reliance on emigration and late marriages to control population. As O’Connor (1995) pointed out one of the main differences between Ireland and the rest of Europe was that other countries controlled fertility with marriage while Ireland controlled access. In the 1950s, Ireland had the lowest rate of marriage in Europe (Curtin, 1986). However, by the late 1970s, marriage had become more popular and the average age of bride and groom also decreased from 31 for men and 27 for women in 1960 to 27 for men and 24 for women in 1980⁴. Completed family sizes decreased over the 20th century. By 1971, the family sizes were commonly between 1 and 6 children in contrast to families being commonly between 4 and 9 children in 1911 (Courtney, 1986). From the 1970s onwards, marriage and family life underwent further changes. There was a rise in marital breakdowns, another rise in age of marriage and there was an increase in the number of births outside marriage. In 1978, only 4.2% of all births were illegitimate, but by 1998, 28.3% of all births were outside marriage⁵. Such an increase occurred when the marital rate and the fertility rate fell substantially (See Figure 1). Despite the overall fall in fertility rates, Irish crude birth rates were still high in comparison to other countries. For example, in 1995, the Irish crude birth rate per 1000 was 13.5, while the UK had a rate of 12.5, Spain a rate of 9.2 while the EU average was 10.8 (Department of Health and Children, 1999). However, family sizes were more in keeping with those of other western nations. Ireland had an average family size between 1980 and 1990 of 3.7 children, while Spain had 3.5 children, Poland had 3.1 children; USA had 2.6 and Australia had an average family size of 3 children (Unesco, 2000).

By the 1990s, Irish demographic behaviour was becoming more typical of European patterns (White, 1999; O’Connor, 1995). It had started its second demographic transition (Coleman, 1999). With the exception of abortion, Ireland had comparable levels of cohabitation, illegitimate births, divorce rates and contraceptive usage. As

⁴ Numbers taken from Department of Health and Children’s Reports: (1) *Report from the Department of Health* (1949 – 1969), (2) *Statistical Information Relevant to the Health Services 1982. Prepared by the Planning Unit, Department of Health* (1970 – 1985) and (3) *Health Statistics* (1986 to 1999).

⁵ Numbers taken from Department of Health and Children’s Reports: (1) *Report from the Department of Health* (1949 – 1969), (2) *Statistical Information Relevant to the Health Services 1982. Prepared by the Planning Unit, Department of Health* (1970 – 1985) and (3) *Health Statistics* (1986 to 1999).

Figure 1
Graphs showing crude birth rates per 1000 and marital rates per 1000 for Ireland.
Data compiled from the Department of Health and Children's annual statistical reports.



elsewhere in Europe, the proportion of couples who do not marry is increasing and with it the rise in illegitimate births (Coleman, 2000). While data on cohabitation is difficult to come by, the 1996 Irish census reported that 3.9% of family units had cohabiting couples (Coleman, 1999). Furthermore, by the 21st century emigration had ceased to be a means of population control. Instead, emigrants were often highly educated and regarded emigration as an opportunity to develop personal and occupational experience before returning home at a later stage (Doak, 1998).

The Decline of Sexual Morality in Ireland.

Within the same period that Irish demographic behaviour was changing, Ireland underwent a huge social and economic overhaul. Standards of education and levels of affluence rose. There were increased numbers of women in paid employment and Ireland was industrialised, urbanised and secularised (O'Connor, 1995; Courtney, 1986). This change reputedly commenced in the late 1950s when the Taoiseach (Irish prime minister) Sean Lemass initiated a plan to modernise the Irish economy by opening it up to foreign investment and later gained EU membership in 1973. Since the early 1970s, Irish society has experienced a period of fast social change "to such an extent that the contemporary Republic is fundamentally different to that of the 1950s" (Doak, 1998:28). The rapid development of the Irish economy has even coined the popular phrase "The Celtic Tiger" in the 1990s. There were two main outcomes of this economic change. Firstly, Ireland shifted from being an agricultural society in the 1960s to being predominately urban in the 1990s (Doak, 1998). This was fuelled by the occupational changes from agriculture into the production and service industries (Courtney, 1986). Secondly, there were substantial changes to the composition and expansion of the Irish middle classes. This resulted in the emergence of a new national intelligentsia, who were employed by the state as academics, policy advisors or media experts (Doak, 1998). Because many of the key institutions run by members of this intelligentsia are situated in a one particular postcode of Dublin, the social group has been dubbed the 'Dublin 4 crowd' (Fennell, 1993).

Since their rise to power, the 'Dublin 4 crowd' have provided a liberal voice within Irish politics and are most notable for their cultural revisionism of Ireland, where 'Traditional Ireland' or 'Irishness' is reconstructed as being rural, backward and derogatory while 'Modern Ireland' is Europeanised, cosmopolitan, secular and sexually liberal (Doak, 1998; Fennell, 1993). While this process will not be discussed in detail, it is suffice to say that the Irish identity underwent a change in the 1990s. Casting off the old social and political identity of the Irish Free State and its preoccupation with being a former colonial state, the Irish state has embraced its stance as a member of the European Union. This process had implications for sexuality.

A large proportion of Irish people had for a long time supported Catholic ideals of Irish sexual morality. In the face of the social and economic changes and the embracement of the 'Europeanisation' of Ireland, ignoring the disjuncture between practice and attitude could no longer be substantiated. The professed value systems on marriage and sexuality had lost the stability and homogeneity of the past (Whelan & Fahey, 1994). Through the public debates over legalisation regarding contraceptives, divorce, right to separate, abortion and homosexuality in the 1990s,

the opposition between old conservative ideals and popular practice was finally brought to the surface. While many were reluctant to abandon their ideals (Ardagh, 1994) – for example, abortion is still illegal despite two referenda and the large numbers of Irish women who seek abortion abroad – change towards a more liberal sexuality was deemed acceptable. Whelan & Fahey (1994) in their analysis of the 1990 European Values Survey noted that Irish value systems were in a state of uncertainty, with a striking variety of traditional and modern value positions. Irish values were distinctly conservative on some issues like abortion but regarding family, marriage and sex roles, Irish values were not consistently more traditional than those of the economically more advanced countries (Whelan & Fahey, 1994). The outcome has been a transformation in sexual attitudes (White, 1999; Hug, 1999, Inglis, 1998b) and the development of a climate of sexual permissiveness, which as time progresses, is arguably falling in line with other European countries.

How does Irish Sexuality Compare to Other Western Nations?

Western societies have been undergoing a growth in sexual permissiveness since the 1960s (Weeks, 2000; Scott, 1998a). This has involved the liberalisation of attitudes towards birth control, premarital sex, abortion, divorce and cohabitation. There has been some acceptance of homosexuality but continuing disapproval of extramarital sex (Scott, 1998a; Smith, 1994; Scott, 1990). Inglis (1998b) has contended that the 1990s was a period of sexually unsettled times for Irish society, with clashes between old traditional beliefs of sex and sin and new liberal values stressing sexual pleasure, diversity and rights. This situation is not unlike the experiences of other countries such as Britain and the USA (Weeks, 2000; Smith, 1999). Many USA respondents in the 1972 to 1991 General Social Surveys lamented the growth in permissiveness (Smith, 1999), while in the mid 1980s Britain saw a growth in younger generations who believed that premarital sex was wrong (Wellings & Wadsworth, 1990). The AIDS crisis further strained public tolerance throughout western countries, particularly in relation to homosexuality (Scott, 1998a; Harding, 1998; Smith, 1994; Goldstein, 1991). As Weeks (2000) has observed, the climate of sexual permissiveness is marked by a high degree of moral confusion, where attitudes and beliefs have continuously lagged behind or denied behavioural changes.

Ireland does have much in common with other European and western societies. Its difference lies with its prolonged inconsistencies between behaviour and attitudes. According to Sweetman (1979), a double standard regarding sexual attitudes and behaviour was in operation throughout the 1970s. Statistics and information on Irish sexuality and behaviours were largely absent, yet Irish people were indulging in a range of sexual activities. “What may be unique in the so-called emancipated world is that the sexual problems now being experienced by many Irish people are often not even admitted to, let alone discussed or provided for” (Sweetman, 1979:7). Throughout the 1970s, large numbers of married and unmarried couples were using contraceptives despite their illegality (Ardagh, 1994; O'Donnell, 1970). The first family planning clinic opened in Ireland in 1969, operating on a technical loophole in the law (Sweetman, 1979). Instead of selling contraceptives to patients, patients were asked for a donation and in return, received contraceptives and family planning advice. By 1979, five family planning clinics were operating in Dublin and an estimated 100,000 married and unmarried couples were using contraceptives (Sweetman, 1979). Through the 1980s and 1990s, 6,000 to 7,000 women were

estimated to have been travelling secretly to Britain each year for abortions (Ardagh, 1994). According to British clinic records, 3,721 women gave Irish addresses in 1989 and this number increased to 6,391 in 2000 (Southern Health Board, 2002). The majority of these women were between 20 and 24 and had urban, middle class backgrounds (Southern Health Board, 2002; Ardagh, 1994). Broken marriages were also commonplace with 37,200 couples reported as being separated in 1986 (Kilfeather, 1999). After the legalisation of divorce in 1995, this number rose to 87,800 people recorded as being separated in the 1996 census (Hug, 1999; Kilfeather, 1999). Another notable example of the disjuncture between beliefs and practices lies with the Irish government. A number of Irish politicians who campaigned against the right to divorce throughout the 1970s and 1980s, obtained divorces themselves and remarried abroad (Ardagh, 1994).

Despite the prevalence of sexual 'deviance' in the Irish population, the Irish have always maintained an image of conservative sexual morality. Even amongst comparative studies of social patterns in Europe, Ireland has been considered unique on an array of social indicators (Halman, Petterson & Verwelj, 1999; White, 1999). It has been classified as being socially conservative and demographically, had high fertility levels (White, 1999). Its level of religiosity has also been considered to be higher than other western countries with the exception of USA, Northern Ireland and depending on the source, Italy or Poland (De Graf & Need, 2000; Halman, Petterson & Verwelj, 1999). It has a strong enactment of traditional Catholic family values (Halman, Petterson & Verwelj, 1999). Catholic ideology did have dominance within Irish nationalism where Roman Catholicism acquired particular authority as a channel for national sentiments (Coleman, 1999). The formation of the state in the 1920s placed the family unit at the core of the Irish social system (Fahey & McLaughlin, 1999). As a result, Ireland continued to outlaw contraceptives, abortion, homosexuality and divorce up until the 1990s, long after other West European countries had permitted them (Ardagh, 1994).

While explanations for Ireland's difference from other European countries focus on the influence of the Catholic Church on the Irish people, the actual influence of the Catholic Church on issues of sexuality is debatable. Certainly, the Church was actively involved in political issues when the Irish state was founded and since then, it has been informally linked to the state through the education system and health services (Inglis, 1998a). Ardagh (1994) has argued that the Church actually kept a low profile on issues pertaining to sexuality, preferring to let lay Catholic groups – who are usually more militantly conservative – be politically active on issues of sexuality and family. Hug (1999) reported that while over 80% of the Irish Catholics attended mass every week in the late 1980s, over half of them did not let their religious beliefs influence their views on sexuality. By 1996, only 21% of regular church attendees based their decisions on morality on church teachings (Hug, 1999). Nic Ghiolla Phadraig (1986) also supports this argument, adding that the institution of the Church was actually quite weak in the 1980s and predicted that any loss of creditability by the bishops on a single issue would jeopardise the commitment of the Irish people to the Church's teachings. This fall occurred in the early 1990s, when the Irish media exposed allegations of sexual abuse of children by members of the Irish clergy (Inglis, 1998a).

By the mid 1990s, any moral power that the Church had enjoyed was weakened (Hug, 1999; Inglis, 1998a; Ardagh, 1994). Members of the Church still get involved in the debates surrounding the implementation of the Relationships and Sexuality Education (RSE) programme in 1997. However, the Church was not unified on the issue. Some lay Catholic groups stressed that sex education was the sole responsibility of parents whilst many members of the clergy maintained that sex education should be done by both teachers and parents (Inglis, 1998b). There was even a division of opinion on whether instruction should be on social and sexual relationships or within a scientific perspective. This fragmentation is indicative of the new sexual moral order of Ireland in the 1990s. Individuals may still be drawing on Catholic teachings but they were making their own conclusions and deciding their own actions. In the words of Coleman (1999), Catholicism has become ‘customised’.

Scott (1998a) has previously utilised the ISSP (1994) dataset in order to compare sexual permissiveness in Britain, USA, Germany Sweden, Poland and Ireland. She concluded that religion plays an important role in explaining cross-national variations in attitudes and remarked that Ireland’s attitudes were amongst the most traditional in Europe because of the dominant influence of the Catholic Church on family values. While I do not dispute the findings of Scott (1998a), I do not agree with her explanation that Ireland is traditional with respect to all aspects of sexual morality because “the Catholic Church’s religious monopoly has gone unchallenged” (Scott, 1998a:839). The time that this survey was conducted was amidst changes in Irish sexual politics and hence revisiting the dataset with this perspective should yield information on a number of other factors that account for Ireland’s similarities and differences with USA, Australia, Poland and Spain.

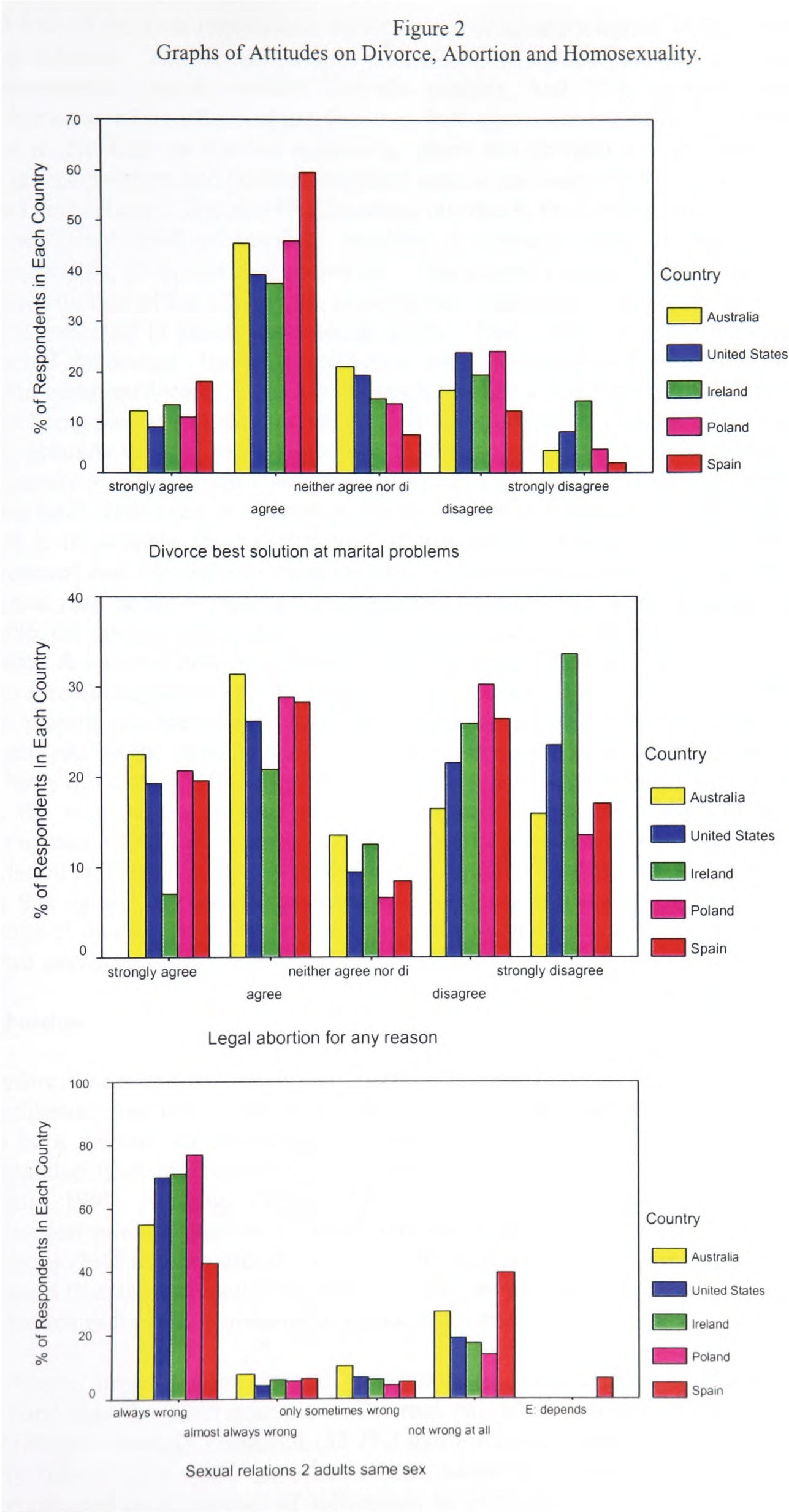
A Cross National Look at Sexual Attitudes.

Before examining some of the factors that can help explain the differences and similarities between the countries, we will first look at the general picture of attitudes across the nations. A total of 1779 Australian, 1447 American, 1597 Polish, 2494 Spanish and 938 Irish respondents completed the surveys. Figures 1 to 3 illustrate their responses to the questions on divorce, abortion, homosexuality, extramarital sex, cohabitation, premarital sex and sex between teenagers under the age of sixteen. Questions on abortion, divorce and cohabitation were answered by a five point ordinal scale ranging from strongly agree to strongly disagree while views on extramarital sex, premarital sex, homosexual sex and teenage sex were recorded on a four point scale of always wrong, almost always wrong, sometimes wrong or not wrong at all.

Divorce.

In relation to whether or not divorce is the best solution to marital problems (first graph in Figure 2), the largest proportion of respondents in each country agreed that divorce was the best solution. Except for the USA, the median response was category 2, that of agreement with the statement. USA respondents gave a median response of neither agree nor disagree. Median responses are considered a better measurement than mean for the attitudinal questions measured on the five point ordinal scale, as the mean tended to fall in the middle category – that of neither agree nor disagree - for many countries. The median also best reflects the largest proportion of responses. Ireland was similar to the other countries in its responses on divorce. Over half

Figure 2
Graphs of Attitudes on Divorce, Abortion and Homosexuality.



(51.1%) of the Irish respondents either agreed or strongly agreed that divorce was the best solution. This is comparable with 57.7% of Australians and 57.2% of Polish respondents. Spain, another Catholic country, had 78% approval amongst its respondents while USA had just less than half agreement (48.5%). The slightly lower rate in the USA is not too surprising, given the strength of the 'moral majority', religious devotion and perhaps backlash against the ease and frequency of divorce in the United States. Dennis (1962) pointed out that in the 1960s, Americans had a very romanticised ideal of marriage resulting in extreme rarity of marital happiness. Despite this, divorcees still remarried. This suggests a centrality of marriage to the sexual culture of the USA. It is possible that thirty years later USA respondents still need marriage to satisfy their social needs. Thus, they are likely to disapprove of marital break-ups. Ireland's responses were recorded a year before the second referendum on divorce in ten years, which resulted in the Family Law (Divorce) 1996 Act being passed in February 1997. This law allowed for couples to seek divorce on the grounds of four years separation (Coleman, 1999). The referendum was only narrowly won by the yes votes. This can partially explain why the agreement was just over half. However, in relation to voting, voters are affected by trust in government and it is possible that many voted against divorce because they did not like the proposed deal for divorce implementation. Furthermore, how campaigns on issues of sexual matters are worded and presented in Ireland play a large determining role. In 1986, the divorce referendum resulted in the rejection of legislation on divorce, which Darcy & Laver (1990) contributes to the withdrawal of political elites on the issue and the forceful arguments by the opponents of divorce. These arguments raised doubts by playing on the voters' fears of change, in particular women, who were also portrayed by the opponents of divorce to be the victims of the proposed legislation (Darcy & Laver, 1990). Hug (1999) attributes the win of the yes votes in 1995 partly to the way the government and the pro-choice campaigners appealed to the Irish compassion for those trapped in unhappy marriages. In doing so, they unleashed the tolerant and pluralist side of Irish society. While this has no bearing on the responses in this dataset, it does indicate that when looking at sexuality or sexual morality, a range of factors are at play and reliance on religion as the main explanatory factor for Irish sexual attitudes in previous studies is perhaps too simplistic.

Abortion.

Before discussing the results on abortion, it must be pointed out that abortion is a problematic issue. In previous works done on sexuality, abortion has been considered to be a measure of the degree to which people are prepared to tolerate sex being separated from procreation (Wellings et al, 1994) or as a matter of women's rights (Hug, 1999; Harding, 1988). These views are unfortunately rather simplistic. Abortion raises a number of moral and social questions, including the rights of the unborn child and the use of abortion in the place of contraceptives. While it can be argued that abortion could be left out of the sexual permissiveness scale, it has been included as it is still a measure of sexual attitudes.

Attitudes towards abortion and homosexuality reveal a very different pattern for Ireland than the other countries. The majority of Irish respondents either disagreed (25.9%) or strongly disagreed (33.7%) that a woman could have a legal abortion for any reason. As with the other sexual issues in Ireland, views on abortion are complicated by a number of influences, in particular Irish politics. Smyth (1998)

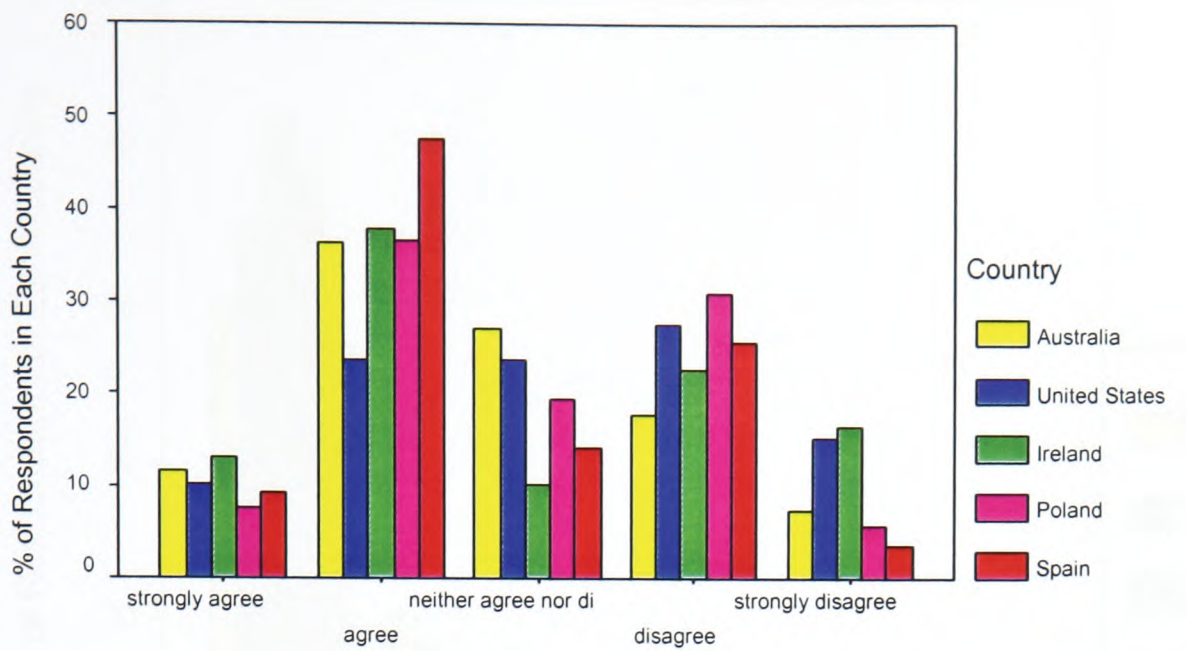
maintains that the abortion debate continues to be fuelled by national identity rather than individuals' rights. The abortion debate erupted in 1992 after the X case⁶ and since then abortion continues to be a hotly debated issue in the public forum, where Catholic doctrine cannot be reconciled with the growing number of women who have abortions each year. As recently as 2002, people voted on whether abortion in cases where there is a threat to the mother's life including suicide should continue to be allowed by the state. The referendum just narrowly passed the proposal and similar to the climate of the early 1990s, the Irish remain divided on the issue of abortion. Arguably, the reason for the failure to reach consensus is possibly due to equally militant pro-choice and anti-abortion campaigners, whose actions have kept a middle ground from being reached. With effort going into sustaining an oppositional debate on whether abortion should be permitted for moral reasons, constructive consensus cannot be achieved. Whelan & Fahey (1994) have observed that the Irish have become more tolerant over time and are willing to accept abortion if the mother's health is at risk or the baby is likely to be born physically handicapped. This shift in approval has been seen in all age groups – in 1981, only 45% agreed with abortion where the mother's health was at risk, compared to 65% in 1990 (Whelan & Fahey, 1994). Since 1990, Poland also only permits abortion in medical emergencies (Coleman, 1999). Unlike the Irish, the majority of the Polish respondents did not disagree on the issue with 49.6% Polish respondents either strongly agreeing or agreeing compared to 43.8% disagreement. However, in the other countries, where abortion is legal, opinion can still be divided. USA and Spain were almost equally divided on the subject – 45.5% USA respondents strongly agreed or agreed while 45% strongly disagreed or disagreed with women having a legal abortion for any reason and 47.9% Spanish agreed with 43.6% disagreeing. Australians did side towards favouring abortion with 54.1% agreement.

Homosexuality.

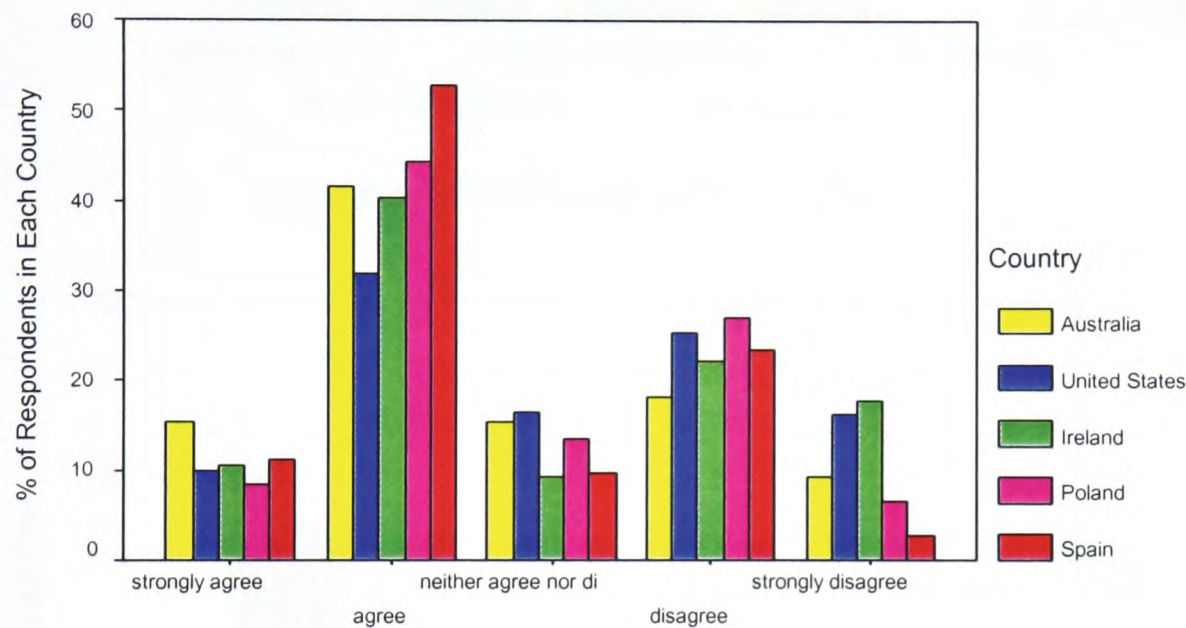
In relation to homosexuality, all countries showed a lack of tolerance with the majority citing homosexual relations as always being wrong, although this ranged from 42.7% of the Spanish to 76.8% of the Polish. Ireland was the second least tolerant at 70.9%. The lack of acceptance for homosexual sex could be indicative of the responses being collected in the aftermath of the AIDS crisis of the mid-1980s. As pointed out earlier, attitudes towards homosexuality had been strained by AIDS and its associations with gay lifestyles. Weeks (2000) has argued that AIDS halted the unfinished revolution of homosexual rights. As the 1990s progressed and the crisis of AIDS became more distant, attitudes were expected to liberalise (Wellings & Wadsworth, 1990). However, this can only be seen through data collected in more recent years. Almost 40% of Spanish respondents did not find homosexual sex wrong at all. This is quite a comparison to other Catholic countries of Poland and Ireland (Catholicism deems homosexuality immoral). Spain does have thriving gay communities in Madrid, Barcelona and other major cities. Furthermore, holiday resorts such as Ibiza and Sitges are popular destinations for gay tourists and gay lifestyles (Ellingham & Fisher, 2001). These visible gay activities are symptomatic of

⁶ This case in 1992 involved a ruling against the right of a 14-year rape victim to travel to Britain to have an abortion, during which it emerged that the 14 year old was suicidal. The case threw open a huge public debate on abortion, resulting in the referendum granting the rights of women to travel abroad for abortion and the right to information. Furthermore, abortion was deemed acceptable by the state in cases where the mother's life was threatened including suicide.

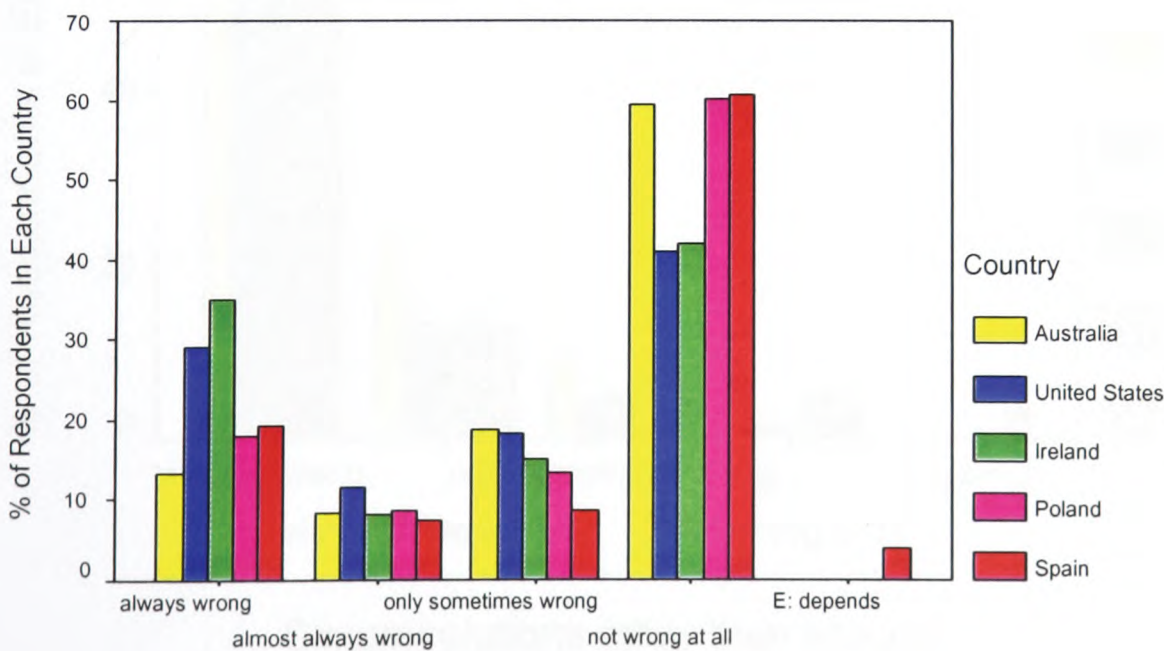
Figure 3
Graphs on Cohabitation and Premarital Sex.



Couple live together before get married

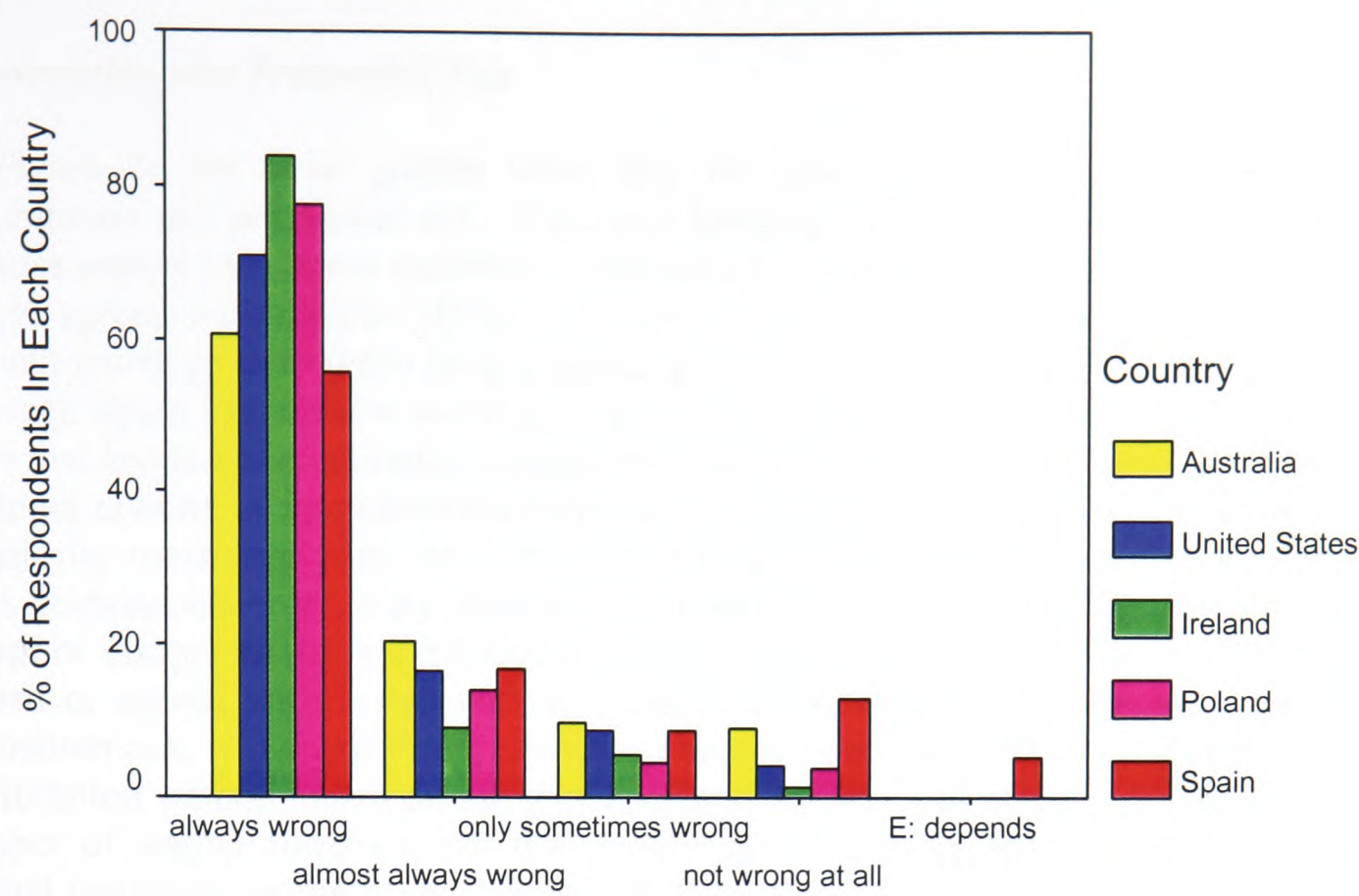


Couple live together without get married

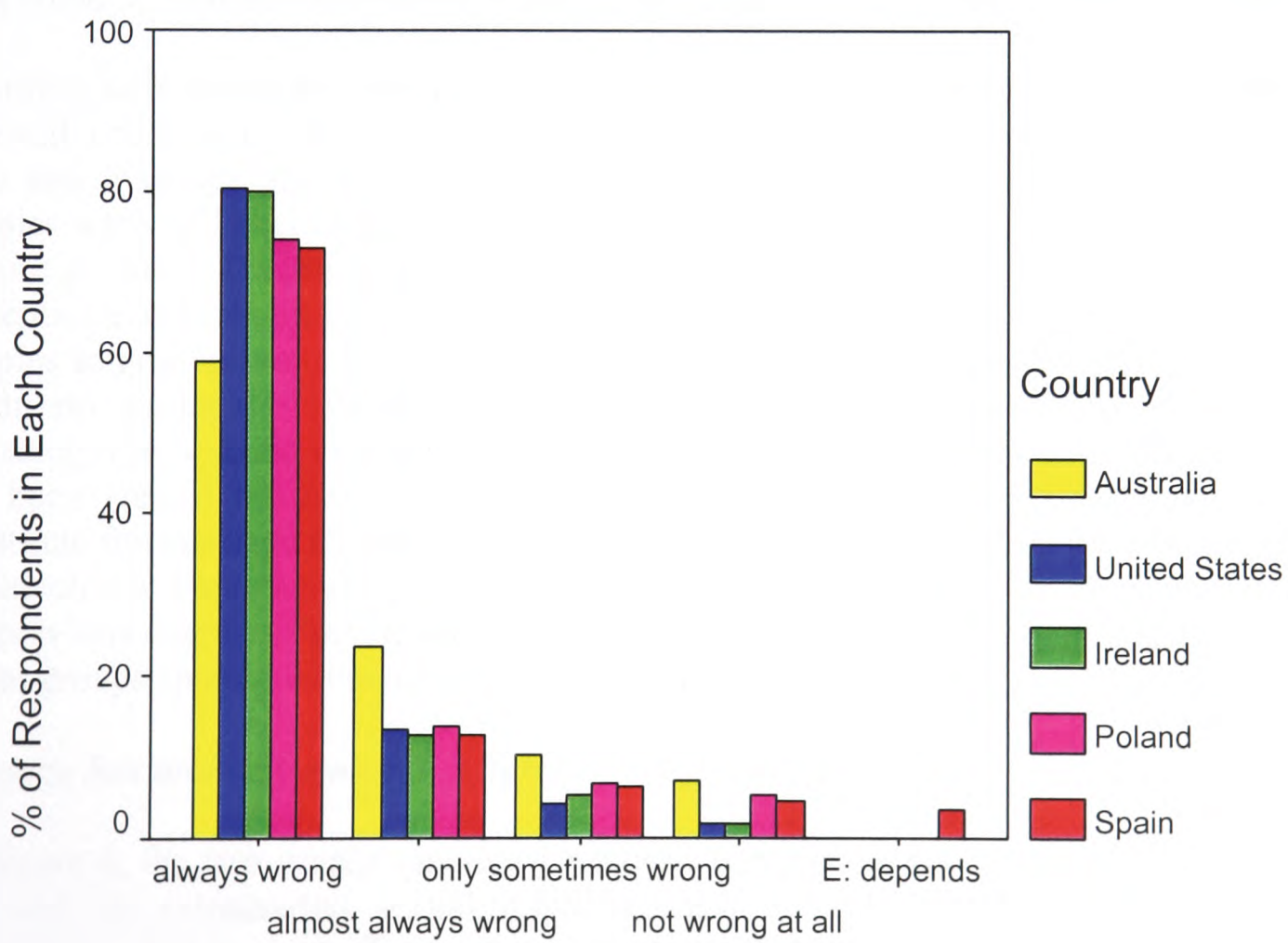


Sexual relations before marriage?

Figure 4
Graphs of Countries for Extramarital Sex and Sex Between Teenagers.



Sexual relations teens under 16 years



Sexual relations other than spouse

a more tolerant climate, despite the difficulty in determining whether the behaviours preceded the attitudes or vice versa.

Cohabitation and Premarital Sex.

In Figure 3, the three graphs show that all countries were mostly tolerant of cohabitation and premarital sex. This is in keeping with the overall trend of sexual permissiveness in western societies. Spain did show the highest level of tolerance – 47.5% agreed with couples living together before marriage, 52.8% for cohabitation without marriage and 60.6% for premarital sex not being wrong. This is interesting as although Spain has positive social perceptions towards cohabitation, the country does have low levels of cohabitation compared to other European countries (Tobio, 2001). Younger cohorts of Spaniards are increasingly delaying residential independence, with a majority remaining with their families of origin until their thirties (Tobio, 2001). USA respondents were more dispersed in opinions. People were equally likely to accept or disapprove of cohabitation without marriage but only 33.7% either strongly agreed or agreed with couples living together before marriage compared to 42.6% opposition rate. It is hard to explain this variation. Perhaps there is a cultural fear of cohabitation before marriage being detrimental to marriage itself. In the USA, a number of studies have showed that cohabitation increased the risk of subsequent marital instability in the USA (Demaris & Rao, 1992; Teachman & Polonko, 1990). Respondents could be drawing on personal encounters with divorcees who had cohabited before marriage. Over half of the Irish were accepting of cohabitation. This could be indicative of the older age of marriage in Ireland than in other countries.

Marrying later in life may have been a means to control population in the past but it was still a cultural practice in the 1990s. People may be embracing romantic ideals of love and marriage and may meet their partners early in their sexual careers, but couples were still encouraged to wait before they wed - particularly since it is also a feature of late 20th century western societies to reproduce and marry at older ages. Acceptance of cohabitation and premarital sex could be a result of the norm of couples setting up home before wedding at a later stage. Coleman (2000) found that in Britain during the 1980s and 1990s, cohabitation delayed marriage rather than replacing it as a stated expectation of most young people. Furthermore, cohabitation has been viewed by many people as an alternative to single life rather than as a substitute for marriage (Rindfuss & Vanden Heuvel, 1990). Having a partner may be preferential to being single, yet still retaining independence. Additionally as stated in the previous chapters, Ireland has also had a tradition of cohabitation amongst certain social groups and the Irish could have just grown to accept different family practices.

Teenage Sex and Extramarital Affairs.

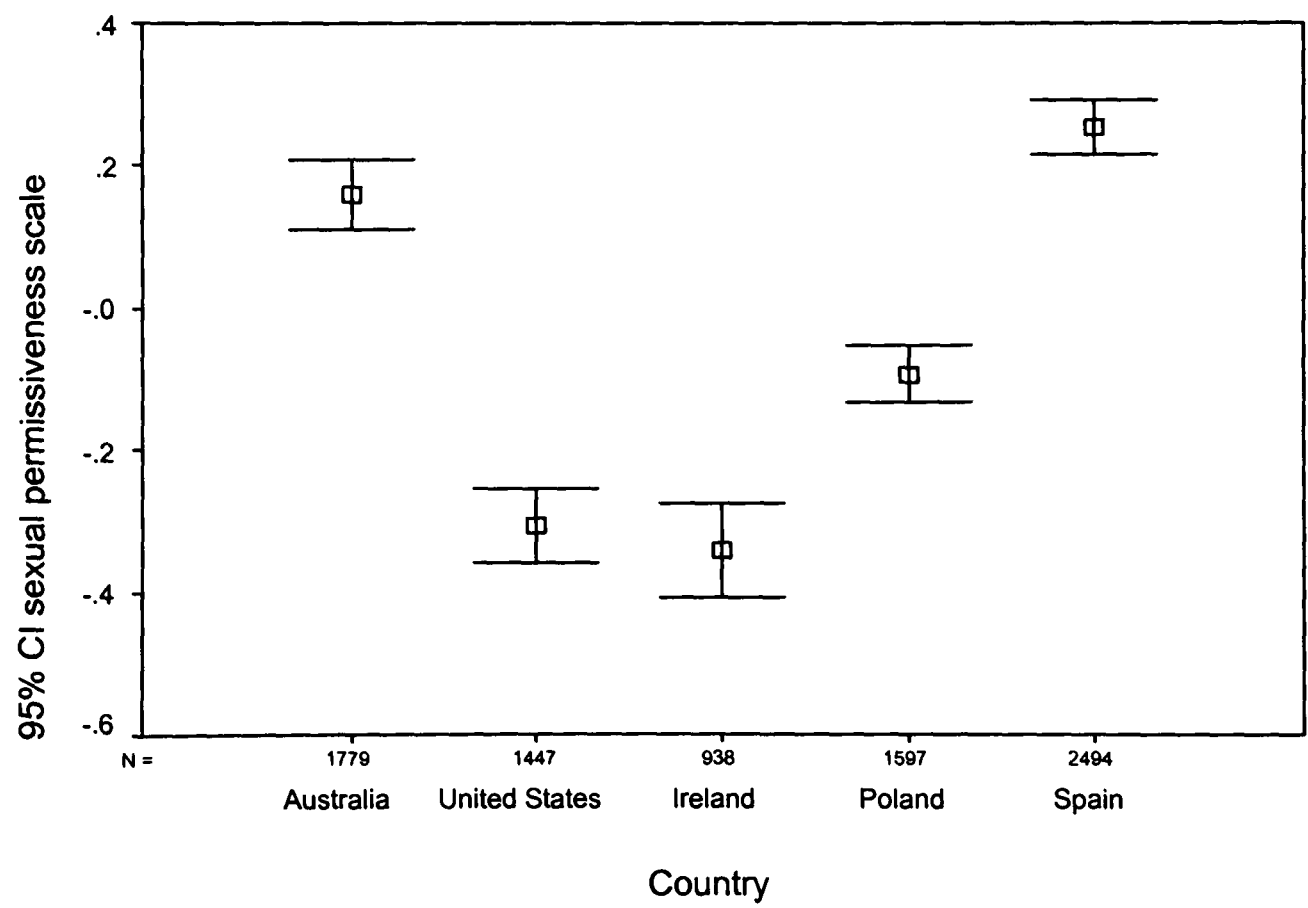
In Figure 4, the two graphs on sexual relations between teenagers under 16 years of age and on extramarital sexual relations show a firm disapproval amongst all countries. Issues pertaining to teenage sexual matters cause public concern, particularly since the age at first sexual intercourse is reputedly decreasing and there is a rise of unwanted pregnancies in some western countries. In regards to extramarital sex, previous research, such as Scott (1998a), has suggested that the trend of sexual permissiveness would bring about an acceptance of extramarital sex. I believe the opposite to be true. Extramarital affairs were almost a staple of 19th

century life – marriage was of reproduction and sexual pleasure was sought outside the marital boundaries. Men were the beneficiaries of this lifestyle and with the rise in women’s rights in the 20th century compounded with their growing social power and financial independence, women became less tolerant of unfaithfulness. Women are also capable of having extramarital affairs but the constant citation of infidelity as grounds for divorce in western countries reflects the disinclinations of both sexes to remain within a marital union once trust is broken. AIDS has further strained acceptance of concurrent relationships and this would have had an effect on attitudes since the mid 1980s.

Discussion.

Using the results of the factor analysis, we can account for the general trend of sexual attitudes across the countries. As illustrated in Figure 5, Ireland has the lowest mean on the sexual permissiveness scale, thus revealing that Ireland is the most sexually conservative of the five countries, although the 95% confidence interval for the Irish mean sexual permissiveness score does overlap with that of USA. Spain and Australia are the only two who display positive means, confirming the findings earlier in this chapter that these two countries were the most sexually permissive.

Figure 5
Graph showing mean 'sexual permissiveness' scores and 95% Confidence Intervals for each country.



Explanations for Patterns of Sexual Attitudes Across Countries:

Former research on sexual permissiveness and sexuality has provided evidence that the social and demographic factors of age, gender, religion, education and area of residence affect sexual attitudes. Younger age groups show the greatest leniency towards premarital sex, homosexual sex and extramarital sex (Wellings & Wadsworth, 1990; Harding, 1988). In relation to abortion, Harding (1988) found that

age had a determining effect, even when religion was taken into account and this finding was substantiated by Scott (1998b) who also showed that younger cohorts were more accepting of abortion. Differences between age groups can be attributed to the younger age groups being brought up in a different moral climate (Smith, 1994). Recent cohorts have been born into societies that have been moving away from sexual repression and this has resulted in the younger age groups being more permissive and tolerant of sexual behaviours. Furthermore, respondents are at different stages of their sexual careers and this influences their sexual conduct and beliefs. Younger age groups are more likely to indulge in premarital sex and so are less likely to be disapproving. Respondents with children, especially teenagers, were less likely to approve of premarital sex, whilst those who were divorced or separated were more permissive than those currently married (Smith, 1994).

Gender has varied associations with the attitudinal variables. Wellings et al (1994) found that women were slightly less tolerant than males on issues of abortion, premarital sex and extramarital affairs. In other studies, women were found to be more approving of homosexual relations but less accepting of premarital sex and extramarital sex (Smith, 1994; Wellings & Wadsworth, 1990). Grey & Swain (1996) also maintained that males held more permissive attitudes than females. Studies like Scott (1998b) and Wellings et al (1994) maintain that age not gender affect attitudes. There are marked generational differences between women on attitudes relating to abortion (Scott, 1998b), while the disparity between the sexes on premarital sex disappears as age decreases (Wellings et al, 1994). In relation to religion, Scott (1998a) argues that religion plays a determining role in explanations for differences within and between countries. The more monolithic the country is religiously, the less permissive the attitudes (De Graf & Need, 2000). One measure of religiosity, church attendance has been associated with negative attitudes to premarital sexual behaviour (Grey & Swain, 1996). Grey & Swain (1996) have argued that this is because religion is more concerned with the form sexual behaviours should not take rather than fostering positive attitudes towards sex. Greater affluence and increased access to education since the 1960s have also led to the development of more libertarian values (Smith, 1994; Harding, 1988). Education promotes progressive liberal thinking. Area of residence was found to have an effect on sexual attitudes with those living in urban areas being more permissive than those living in rural areas, which are more traditionally orientated (Smith, 1994). Social class has on a number of occasions been shown to have an effect. However, there are two opposing hypotheses to its explanation. One argument is that upper and middle classes will be more permissive as they are more likely to be educated and cosmopolitan (Smith, 1994). The counter hypothesis is that the lower classes will be more permissive because they are less constrained by social conventions. Neither hypothesis will be tested here because firstly, the measure of social class is that of subjective membership (i.e. the respondents classified themselves), which affects its reliability. Secondly, trying to prove either hypothesis evokes some of the prejudice towards the lower socio-economic groups, which is inherent in the social history of STIs, class and sexuality.

Tables 2 to 9 in the appendix to this chapter (Appendix II) surmise the levels of tolerance for each country on the issues of cohabitation, divorce, abortion, premarital sex, homosexual sex, sex between teenagers and extramarital affairs. The level of permissiveness is measured by the sum of those who strongly agreed or agreed to the

questions on the first 3 categories and by those who viewed the latter four sexual behaviours as not being wrong. For comparison purposes, the results are presented as percentages of the different subgroups. The predictors used were gender, age group, marital status, education level reached, religious attendance or practice and area of residence for each country. For descriptive purposes, the effect of each variable is examined separately. Implications of interactions and controlling for certain variables are reserved for the regression analysis. Unfortunately, the Spanish component of the ISSP survey did not include the variables of area, education or religious attendance. Information was also lacking on the 18 to 20 year old age group in Australia and on area of residence in Poland.

Gender.

Similar to previous studies, the effect of gender on sexual attitudes did vary by country and in accordance with the sexual attitude. In relation to attitudes towards cohabitation, male responses ranged from 45.6% of males in USA to 63% of Spanish males agreeing that couples could live together before marriage. The range was lower for females, most notably in the USA (37%). A similar finding can be seen in Table 3, where only 26.4% of females agreed that couples were entitled to live together before marriage. The lower percentage of women compared to USA males could mean that the institution of marriage has more meaning for females. The Irish showed little difference between the sexes for both questions on cohabitation and with the exception of Spain were more tolerant of couples living together before marriage than the other countries. Australians were more accepting of cohabitation without marriage than before marriage, with little difference between the sexes. Spain again displayed the highest level of tolerance in Table 4, where 72.3% of males and 72.4% of females deemed divorce as the best solution for marital problems. Although we have little information on the religious practice of the Spanish respondents, it is still remarkable that such a large percentage would favour divorce in a predominantly Catholic country. Irish males and females varied slightly with 52.7% of males compared 46.5% of females agreeing that divorce was the best solution for marital problems. The difference between sexes was also seen in Australia and the USA, although of a smaller nature (2.9% and 1.6% difference respectively).

The question of abortion does differentiate the Irish respondents from the rest with only 26.8% of males and 25.7% of females favouring legal abortion for any reason (Table 5). Elsewhere, there was a slight difference between the sexes for each country, with larger proportions of the other Catholic countries advocating abortion (46.2% Polish males, 43.5% Polish females and 45.7% Spanish men and 42.5% Spanish women). Similar to the findings of Smith (1994) and Wellings & Wadsworth (1990), women were less accepting of premarital sex and extramarital sex than men throughout the countries. Over 60% of males in Australia, Poland and Spain agreed with premarital sex compared to 56.2%, 54.6% and 56.8% of the respective female respondents (Table 6). In Ireland, 45.7% of men were in agreement with premarital sex while only 38.3% women approved of sex before marriage. The lowest percentage was amongst USA women, which combined with the responses on cohabitation could suggest a persisting societal value on traditional matrimony for women. In relation to homosexual sex, women were not universally more tolerant as previously found in other studies. In Table 7, Poland had the lowest tolerance level amongst the sexes with 12.8% of males and a slightly higher percentage of women

(14.3%) accepting homosexual sexual behaviours. Australia and USA also had variance between the responses of the two sexes, although the difference was only about 4%. Ireland had the same levels of tolerance between men and women, with only 17% deeming that homosexual sex was appropriate. Spain had the largest percentage with 39% of both men and women approving of homosexual sex. Approval of teenage sex did have marked differences, with males on the whole being more accepting of sex under the age of sixteen. The largest difference occurs in Spain, where 18% of males compared to 8.4% of females agreed on sex between teenagers. Despite 18% being a low percentage, its relative difference to the other countries could be indicative of the national projection of the imagery of the masculine Latin lover. Overall, the findings were in keeping with those of the aforementioned studies on differences between gender and countries on sexual issues.

Age.

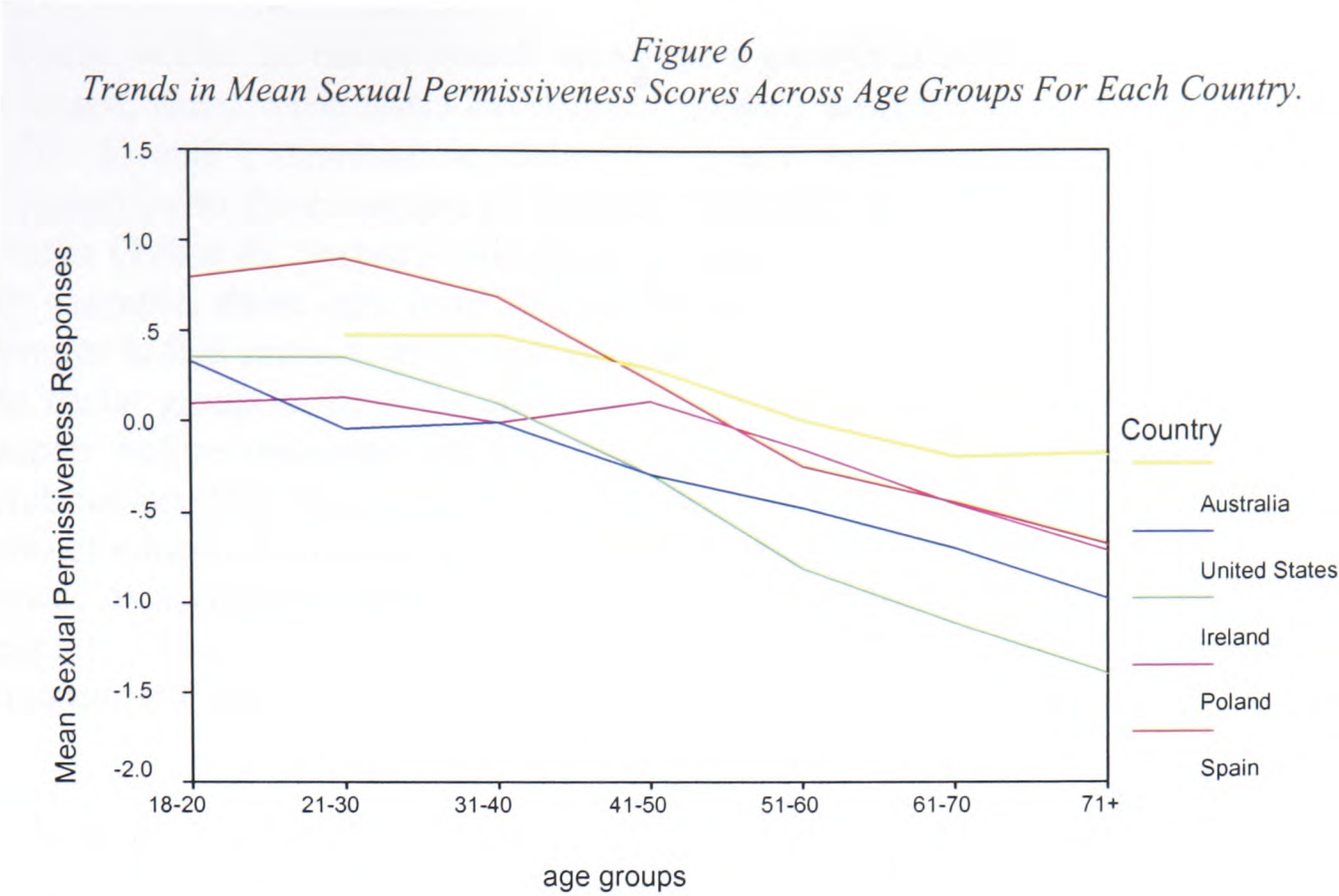
The impact of age on sexual attitudes was again similar to previous research on sexual attitudes with the younger age groups showing the greatest tolerance of sexual behaviours. In terms of cohabitation, the majority of those aged 40 years and younger in each country were favourably disposed towards couples living together. This pattern remained true of Ireland in relation to divorce, whilst the other countries showed a greater proportion of tolerance amongst the older age groups. Spain was an exception with all age groups being similarly disposed towards divorce. Perhaps this difference between Ireland and the other countries is symptomatic of Ireland's later development in the second demographic transition. Ireland's response to abortion was markedly negative. Although the younger age groups did have larger proportions of agreement – 37.1% of 18 to 20 year olds, 47.8% of the 21 to 30 year olds and 39% of the 31 to 40 year olds (Table 5) – none of the groups were in the majority favourable towards abortion. Australia, USA and Spain all displayed a steady decline of agreement as age increased, with the expected greatest levels of tolerances amongst those most likely to avail of abortion. Poland, however, increased in level of tolerance with age, peaking with 59% in the 41 to 50 age group before decreasing to 31.2% in the 71 plus age group. This pattern is unusual with those under the age of 30 showing more conservative attitudes, especially since there is little difference in church attendance with just under 40% of those 30 and under attending church weekly compared to 40.4% and 41% of 31 to 40 and 41 to 50 age groups. Poland did, as previously mentioned, introduce a law on abortion in 1990 restricting the procedure to medical emergencies. It is possible that like Ireland, changes in religious practices may be creating a situation whereby people are choosing what aspects of Catholicism they follow and what to disregard. Trust in the Church may be declining but certain Catholic beliefs could be growing in force. With the fall of the Communist regime and its laws on abortion, younger generations may be asserting themselves sub-consciously or consciously through Catholicism and their relatively conservative opinions on abortion when compared to middle age groups may be one symptom of this change.

Like previous studies, the greatest levels of tolerance towards premarital sex existed in the younger cohorts (Table 6). Spain once again had higher proportions of agreement (84.4% of the 18 to 20 age group) while USA had the lowest tolerance levels of 52.8% of 18 to 20 year olds and 49.3% of those 21 to 30 years of age. Perhaps this lower tolerance level is indicative of the sexual climate in the USA in the

aftermath of the AIDS pandemic. AIDS did strain acceptance of premarital sex and as mentioned in Chapter 2, age at first sexual intercourse increased in the 1990s. Ireland does display a high proportion of its younger age groups approving of premarital sex, which contrast dramatically with the small percentages of the later age groups – for example, 76.4% of those aged 21 to 30 to just 18% of the previous cohort of 51 to 60 years. This marks the effect of the societal changes Ireland has undergone in the previous 20 years.

Similar to the findings of Wellings & Wadsworth (1990) and Harding (1988), the younger generations were generally more accepting of homosexual sex (Table 7) although the proportions were much smaller in comparison to opinions on premarital sex. Spain was the exception in approval with 66.3% of those aged 21 to 30 approving of homosexual sex compared to just 32% of the Irish, 38% of the Australian, 26.6% of the Americans and 20% of the Polish respondents of the same age group. In terms of extramarital sex, both Poland and Australia bucked the trend of age related tolerance. The two countries displayed a higher tolerance level amongst the 41 to 50 age group, which is arguably the age group most likely to participate in extramarital affairs as they are more likely to have been married for some time or may be experiencing a mid-life crisis of sorts. Unfortunately, information on participation in extramarital sex was not collected in Australia, however, in relation to Poland, the mean age of those who had an affair whilst married was 47.61 with a standard deviation of 11.95 years, which is similar to the mean ages of the other three countries. Where Poland differs is that 15% of married Polish respondents admitted having an affair compared to 7.7% Irish and 6.3% Spanish. Respondents from the USA had a higher rate than Poland with 16% yet they displayed a very low tolerance rate, thus revealing the typical gap between attitude and practice in relation to extramarital sex in western countries. It appears that Polish respondents may have a greater linkage between behaviours and attitudes than is found in the other western countries. In relation to sex between teenagers under the age of 16, younger generations were more tolerant, despite the small nature of the percentages (Table 8). Spain again provided the highest percentage with over 25% acceptance amongst the two youngest age groups. An anomaly does occur within Australian responses with all age groups more or less hovering around the 8%. It can be concluded that throughout countries and age groups (inclusive of older teenagers) tolerance of teenage sex amongst those under the age of sixteen is not generally acceptable. This is interesting given the apparent decrease in age at first sexual intercourse in western societies.

The effect of age on the overall levels of sexual permissiveness across the countries is illustrated in Figure 6. As we can see from the graph, the generational effect is more pronounced in the monolithic Catholic countries of Ireland and Spain, with those aged 40 and under being far more permissive. In contrast, the Australian trend is more fluid, with a gradual decline in sexual permissiveness scores as age decreases. Both Poland and USA display peaks in their lines across generations – i.e. Americans between the ages of 21 and 30 are less sexual permissive than those between 31 and 40, while Polish respondents in their thirties held lower sexual permissiveness scores than those immediately younger or older than them. This constitutes possible intervening factors in those generations and it is possible that these include the previously mentioned growth in religiosity in Poland in the aftermath of the fall of communism and the growth in sexual conservatism post AIDS in the USA.



Marital Status.

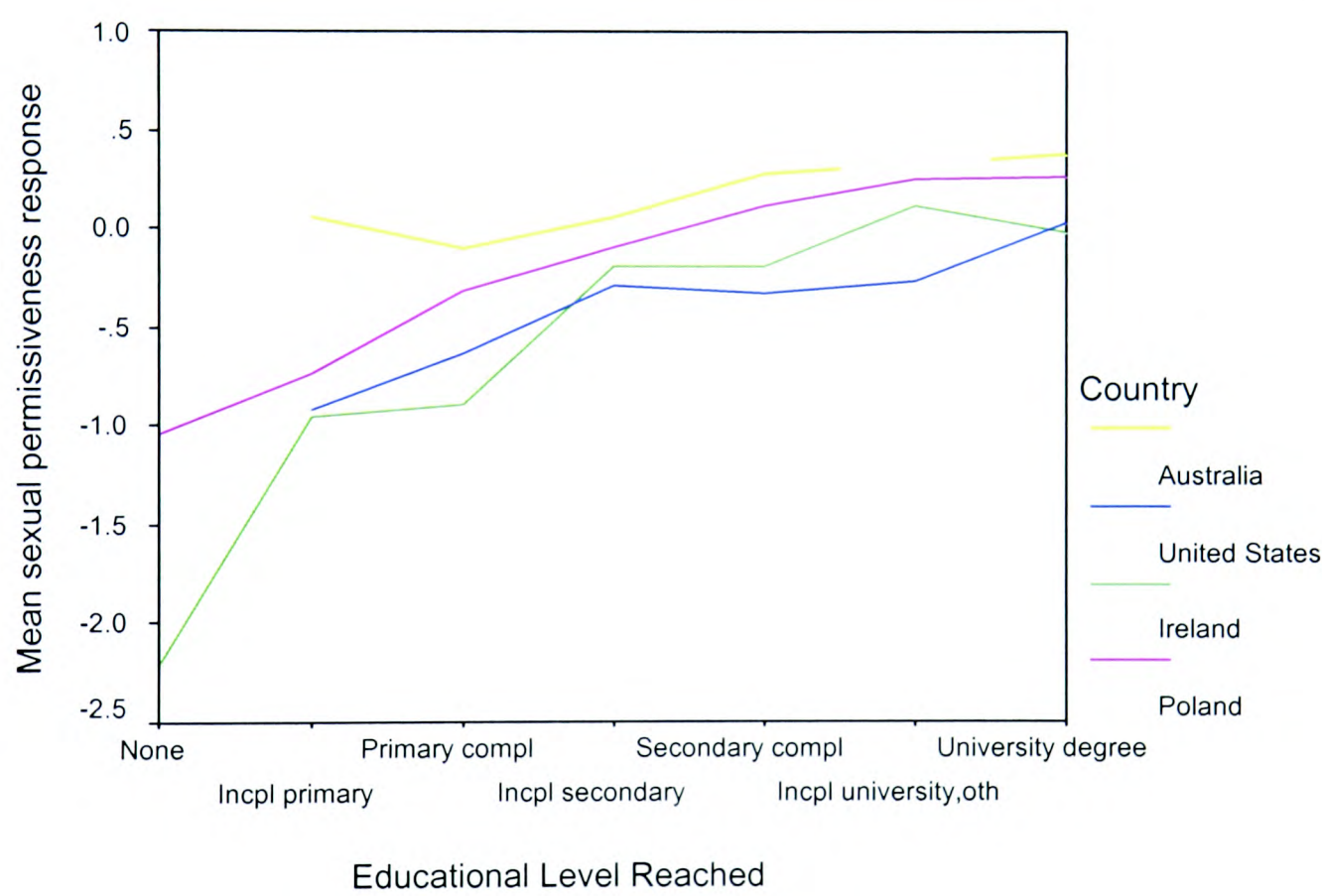
Levels of tolerance vary across the categories of marital status, with those who are married being less accepting of cohabitation than those who have never married or are separated or divorced (Tables 2 and 3). The lower agreement percentages amongst the married group and the widowed group could be influenced by age as the older age groups did report higher proportions of these statuses. A similar trend is also seen across the countries in relation to premarital sex (Table 6) with those separated, divorced and never married being more accepting of sexual intercourse before marriage. However, the percentages did vary between countries with the USA reporting the lowest levels of acceptance – for example, 54.3% of the never married group as opposed to 68.0% of Australians, 61.4% of Polish respondents and 82.9% of the Spanish. Ireland had similar responses to the USA respondents, which again illustrates a similarity between USA attitudes and those held by the Irish. On matters of homosexual sex, extramarital sex, teenage sex, abortion and divorce, married groups were universally the most conservative group within countries. Furthermore, the evidence from each country and across countries also supports the findings of Smith (1994) on those divorced or separated being more permissive than their married counterparts.

Educational Level Reached.

The effects of education on sexual permissiveness can be summarised in Figure 7. In Poland, Australia and the USA, as educational level increased, mean sexual permissiveness scores also increased. This supports previous findings of sexual permissiveness being influenced by education (Smith 1994). Ireland also displays a general trend of increasing sexual permissiveness as educational level increased. However, the trend is not as smooth as in the other countries but this can be explained by the sub-categories of each level of education – for example, incomplete secondary level and completed secondary level. If the categories were restructured into primary, secondary and tertiary level education, the rising trend of sexual permissiveness would be similar to those of the other countries. In relation to the individual sexual

attitudes, whilst the tables overall displayed a growth in tolerance as educational level increased, there were some exceptions, notably attitudes in relation to teenage sex (Table 8) and a decrease in tolerance of extramarital affairs as educational level increased (with the exception of Poland). USA also showed a decrease in tolerance of divorce (Table 4), perhaps indicating personal grievances with a marital breakdown (for example, those who have attained higher levels of education had higher weekly incomes in this sample, so it is possible that the financial repercussions of divorce hits this social group harder). In addition, the level of tolerance of cohabitation between couples before marriage did not vary much between the categories. If viewed in combination with views on divorce, we can surmise that all Americans despite the level of education enthuse about matrimony. (Cohabitation without marriage may be viewed as a viable alternative to marriage as it can also romanticise the union of two people). This is in keeping with the previous findings of marital unions being more romanticised by American society than by the other countries.

Figure 7
Trends in Mean Sexual Permissiveness Scores By Educational Level Reached for Each Country.



Area of Residence.

Generally speaking, those living in urban areas hold more liberal sexual attitudes than those in rural areas. In keeping with this finding, those residing in urban areas in this dataset were more liberal than those living in rural areas, although the difference in levels of approval was quite small. Throughout the tables, the percentages of approval did vary in size from country to country and attitude to attitude. Surprisingly, the USA respondents showed a much lower percentage of agreement on issues of cohabitation and premarital sex than their Irish and Australian counterparts (Tables 2, 3 and 6). For example, only 39% of USA urban dwellers thought that couples could live together without getting married compared to 55.8% of Irish and 57.5% of Australian urban residents. Australia showed the highest levels of tolerance

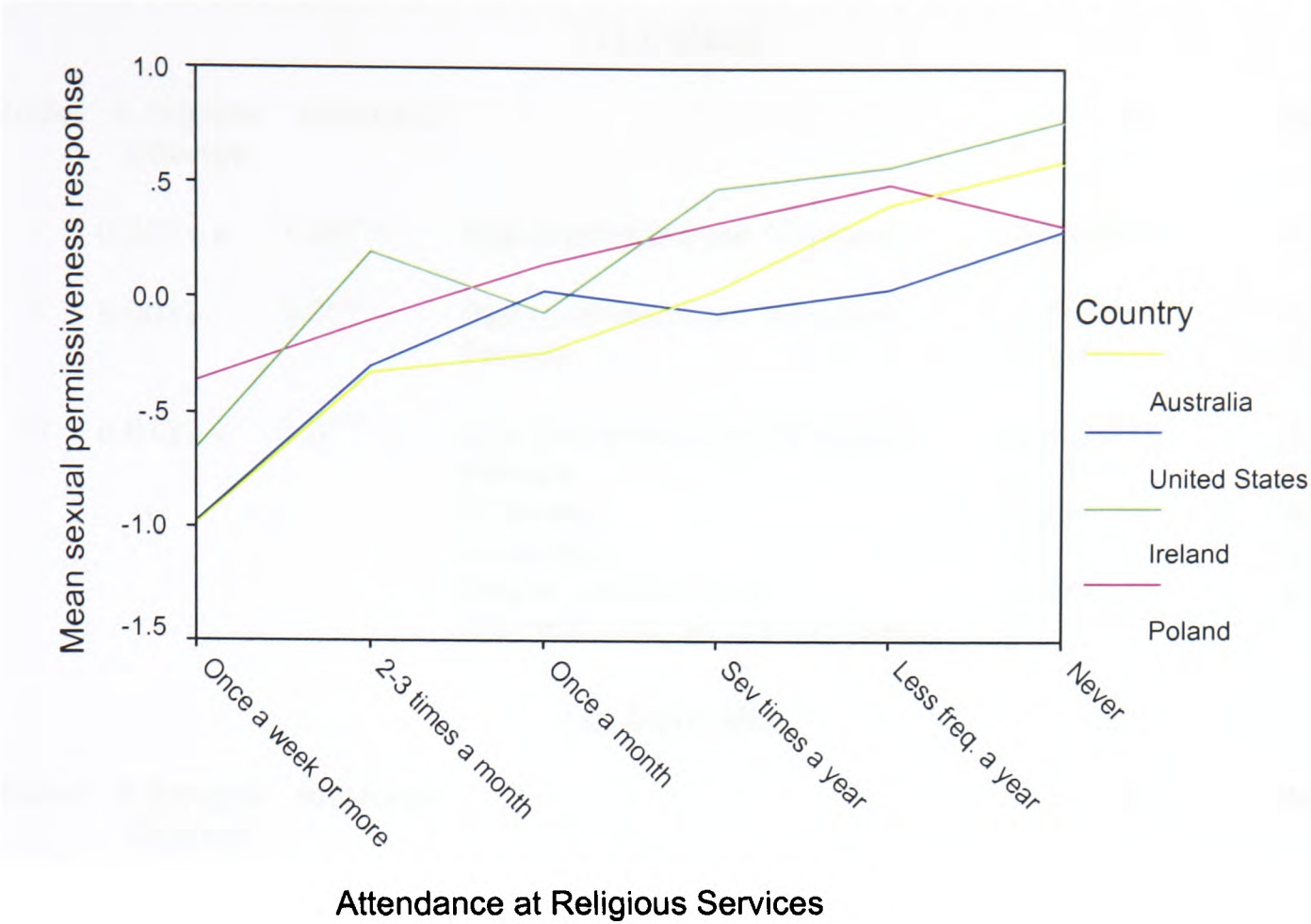
but did display variances that seem on the surface to contradict the influence of the urban/rural divide. In relation to divorce (Table 4), 3.3% more rural dwellers approved and a similar disparity was also seen in relation to teenage and extramarital sex. Since the difference is quite small percentage-wise in this sample, it is quite possible that generally there is little difference between urban and rural dwellers in the Australian population. This of course is something that a multiple regression is more likely to tease out rather than simple descriptive statistics. However, given that overall the Australians are generally very permissive towards sexual issues, it is possible that there is little difference between the two forms of residential areas.

Religion.

When looking at the effect of religion, each country display a general pattern of the level of sexual permissiveness increasing as church attendance decreased (See Figure 8). In terms of mean sexual permissiveness scores, Ireland does show a peak amongst those who attend church 2 or 3 times a month. This could represent a group of people who attend church infrequently for reasons other than religious devotion, i.e. out of family duty or habit. Interestingly, in Poland the mean sexual permissiveness score decreases for those who never attend church. Perhaps those do not attend church are affected by apathy and hence do not hold as strong views on the sexual attitudes as those who attend infrequently. For the individual issues on cohabitation, divorce, abortion, premarital sex and homosexual sex, levels of tolerance increased with decline of attendance at religious services but variation did occur in relation to teenage sex and extramarital sex. Nevertheless, it can be presupposed that the hypothesis of the greater attendance at religious services, the more conservative the sexual attitudes. With the growth in sexual permissiveness and the subsequent decline in religious beliefs, it can be assumed that there is the intervening factor of age group membership. This cannot be explained here and hence requires the use of multiple regressions to determine the main and interaction effects on levels of tolerance or sexual permissiveness.

In terms of between differences between countries, Irish regular attendees at church (i.e. once a week or more) were not the most conservative on issues pertaining to cohabitation, divorce, premarital sex and, to a smaller extent, homosexual sex. Indeed it was Australia and the USA who provided the lowest levels of acceptance throughout the tables. These were also the two countries that had the lowest numbers of regular attendees with 14% of Australians and 33.1% of USA respondents attended church each week as opposed to 71.9% of Irish and 45.8% of Polish respondents. Given that Australia had as a nation expressed a general high level of tolerance, it is interesting to see that religious attendance is having an effect, thus revealing that the minority of those who do attend church (when compared to Ireland) are more diligent in merging their attitudes with religious teachings. This also adds weight to the previous argument that the Irish in the 1990s were practising a selective or 'customised' form of Catholicism and is indicative of the climate of changing sexual morality in Ireland during the 1990s. It should also be pointed out that attendance at Church had been dropping since the 1980s, falling from 81.6% in 1988 to 66% in 1996 (Hug, 1999) and the 70% of respondents who regularly attended church in this sample falls in line with this declining trend. This lessening impact of religion highlights the inadequate use of religion as the main explanation for the difference in

Figure 8
Trends in Mean Sexual Permissiveness Scores By Attendance at Religious Services for Each Country.



Irish sexual attitudes compared to other countries in the 1990s – for example in Scott (1998a). Certainly Ireland is predominately Catholic but church affiliation does not necessitate practising religious beliefs. It is more appropriate to account for Irish sexual attitudes in the late 20th century culturally rather than relying on the supposed unchallenged impact of Catholicism.

Variations in Sexual Permissiveness – How Ireland Compares to its Counterparts:

Since we are interested in what factors account for variations within countries (i.e. what is helping to constitute a national sexuality), multiple regressions were run testing the effects of demographics on the sexual permissiveness cores for each country. Due to the missing variables of education, area of residence and attendance at religious services for Spain, all five countries will be compared with the common variables of age, gender and marital status. An examination of the additional effects of religious attendance, education and area of residence on sexual permissiveness scores is carried out for Ireland in comparison with USA and Australia.

Table 1 surmises the findings of the three regression models. All five countries have different intercepts for the three models, thus reflecting different sexual cultures. The same intercepts and slopes would have revealed the same patterns of sexual permissiveness across the western nations. It is not surprising however that the factors had different impacts in each country. Throughout the five countries, age accounted for most of the variation in scores on the sexually permissive scale. The addition of this independent variable led to the biggest changes in R Square for the models. Furthermore, each decade of age resulted in a decrease in sexual

Table 1
Results of Multiple Regressions for Scores on Sexual Permissiveness Scale by Country.

(1) Ireland

Model	R Square Change	Intercept		B	Beta
I	0.327♦♦	1.28***	Age (expressed per 10 years)	-0.3557***	-0.572
II	0.003♦	1.3***	Age (expressed per 10 years)	-0.3561***	-0.572
			Female	-0.12*	-0.056
III	0.013♦♦	1.3***	Age (expressed per 10 years)	-0.3629***	-0.583
			Female	-0.13*	-0.065
			Widowed	0.26*	0.075
			Separated	1.2**	0.086
			Single, never married	0.094	0.041
			Married/Living as Married (Base)	0	

(2) Australia

Model	R Square Change	Intercept		B	Beta
I	0.062♦♦	0.99***	Age (expressed per 10 years)	-0.1676***	-0.249
II	0.003♦	1.05***	Age (expressed per 10 years)	-0.1694***	-0.252
			Female	-0.11*	-0.153
III	0.008♦♦	1.09***	Age (expressed per 10 years)	-0.1784***	-0.265
			Female	-0.12*	-0.059
			Widowed	0.07	0.012
			Separated	0.39**	0.072
			Divorced	0.42*	0.054
			Single, never married	-0.04	-0.013
			Married/Living as Married (Base)	0	

(3) USA

Model	R Square Change	Intercept		B	Beta
I	0.113♦♦	0.6***	Age (expressed per 10 years)	-0.1988***	-0.336
II	0.008♦♦	0.7***	Age (expressed per 10 years)	-0.1956***	-0.331
			Female	-0.19***	-0.092
III	0.029♦♦	0.42***	Age (expressed per 10 years)	-0.1666***	-0.282
			Female	-0.2***	-0.096
			Widowed	0.08	0.024
			Separated	0.42***	0.150
			Divorced	0.22	0.036
			Single, never married	0.35***	0.143
			Married/Living as Married (Base)	0	

Table 1 (Cont'd)
Results of Multiple Regressions for Scores on Sexual Permissiveness Scale by Country.

(4) Poland

Model	R Square Change	Intercept		B	Beta
I	0.082♦♦	0.55***	Age (expressed per 10 years)	-0.1423***	-0.286
II	0.007♦♦	0.61***	Age (expressed per 10 years)	-0.1387***	-0.279
			Female	-0.14**	-0.081
III	0.011♦♦	0.66***	Age (expressed per 10 years)	-0.1535***	-0.308
			Female	-0.16***	-0.097
			Widowed	0.11	0.042
			Separated	0.38***	0.097
			Divorced	0.21	0.026
			Single, never married	-0.03	-0.012
			Married/Living as Married (Base)	0	

(5) Spain

Model	R Square Change	Intercept		B	Beta
I	0.329♦♦	1.64***	Age (expressed per 10 years)	-0.3129***	-0.573
II	0.005♦♦	1.71***	Age (expressed per 10 years)	-0.3105***	-0.569
			Female	-0.14***	-0.072
III	0.015♦♦	1.57***	Age (expressed per 10 years)	-0.2918***	-0.535
			Female	-0.14***	-0.073
			Widowed	0.03	0.000
			Separated	0.70***	0.084
			Divorced	0.58***	0.085
			Single, never married	0.13**	0.060
			Married/Living as Married (Base)	0	

♦♦ R, R square and R square change are significant at 0.005 probability level.
♦ R, R square and R square change are significant at 0.05 probability level.
*** Significant at 0.0005 probability level.
** Significant at 0.005 probability level.
* Significant at 0.05 probability level.

permissiveness, thus reaffirming that sexual permissiveness is negatively correlated with age across western societies.

Age.

Within the countries, the impact age had on sexual permissiveness scores fluctuated. The effect was greatest in relation to Ireland. In the models run on Irish scores on the sexual permissiveness scale, age had a beta weight⁷ -0.583 when controlling for gender and marital status. Although age was also an important independent variable for Spain, its beta weight decreased from -0.573 in the first model to -0.535 when controlling for gender and marital status (a similar decline was also seen in Australia and USA). Australia, USA and Poland had relatively smaller beta weights for age. In Spain, the most sexually liberal of the five countries, age had predictive importance and as age increased, sexual permissiveness significantly decreased and even when controlling for sex and marital status in Model III, an increase in age by one decade resulted in a decrease of 0.2918 units on the sexual permissiveness scale. The same model for Ireland showed a decrease in 0.3629 units for an increase of one decade of age. Both the beta weights and the regression coefficients show that much more of the variation in sexual permissiveness scores in Ireland are explained by the effects of age than in the other countries. This age difference denotes a higher level of sexual permissiveness amongst the age groups most likely to be sexually active. In relation to STIs, this means that those who are more likely to be exposed to STIs (i.e. those under the age of 30) hold greater levels of sexual permissiveness than previous generations (and hence may be more amicable towards visiting GUM clinics). Therefore the rising reported rates of STIs in Ireland may be indicative of a growing public openness about sexual issues. It is also probable that Irish society will become more sexually permissive over time with older age groups being replaced by the more sexually liberated generations.

Gender.

Gender had significant effects for all countries, although levels of significance did vary. Females were more likely to have lower sexual permissiveness scores than males. For Poland and the USA, gender had a significant predictor effect at the 0.0005 probability level for Models II and III and higher values of unstandardised and standardised regression coefficients when compared to the other three countries. Furthermore, both countries also had a moderating effect of age on gender (significant at the 0.05 level), with age effects being stronger amongst women than men, even when controlling for marital status (See Table 2). The standardised coefficients also revealed a stronger impact in Poland than the USA (-0.201 for Poland and -0.161 for USA). The trends in sexual permissiveness across western nations were partly fuelled by greater liberation in female sexuality. It is not surprising then that there would be a greater generational effect amongst women than men. What is interesting here is that this observation was not seen throughout the five countries. For Poland and USA, much of the increase in sexual permissiveness amongst younger generations has to do with changes in attitudes of women. In the other three countries, differences in sexual permissiveness scores between generations were similar for both sexes, with

⁷ Beta weights are the regression coefficients for standardized data and represent the average amount the dependent variable increases with the independent increases one standard deviation and when other independent variables are held constant.

women throughout holding more conservative views of sexuality. Growth in sexual permissiveness was fuelled just as much by changes in male attitudes over the generations. Thus revealing that men were just as likely as women to uphold traditional values of sexual morality in Ireland, Australia and Spain. It can be concluded that while Irish women have lower sexual permissiveness scores than men, Irish sexuality is likely to become more permissive as these younger generations age and are replaced by younger cohorts. Differences between sexes may also be likely to decline.

Marital Status.

Marital status had varying but anticipated effects for each country. For Ireland, only those who were separated or widowed remained significant when controlling for the other variables in the final model. The effect of separation was also seen in the final models for the other four countries, affirming that those who have been involved in the dissolving of a marital union are more likely to be sexually permissive than those who remain married. One would expect divorced individuals to be similar as detected earlier in the chapter but only the final models of Australia and Spain revealed a 0.42 increase in Australian sexual permissiveness scores and 0.58 increase in Spanish scores relative to those who are married or living as such. This could be due to small numbers in valid cases, which makes the detection of an effect difficult. In relation to Ireland, Australia and Poland, the single, never married group did not have a significant effect when controlling for gender and age. Age is likely to have an intervening influence – i.e. a larger proportion of younger generations being single and never married than older. Single marital status was significant for both Spain and the USA, even when controlling for age and gender. In Table 2, the USA regression models continued to show significant effects of single marital status, indicating that despite age, gender, area of residence, educational level reached and religious devotion, those who are single in the USA hold more sexually permissive views than those who are or have been married (sexual permissiveness scores increased by 0.26 relative to those who are married and the beta weight was 0.105, compared to those of 0.048 for divorced, 0.107 for those separated and 0.02 for those who are widowed). This suggests a group of singletons, leading certain lifestyles that involve more open, sexually liberal attitudes. Given that this group includes homosexuals and since the USA and Spain had higher levels of homosexual behaviours than the other four countries, it is thus not surprising that this group would hold more sexually permissive attitudes.

What are the Effects of Area of Residence, Educational Level Reached and Attendance at Religious Services on Irish Sexual Permissiveness?

Given that other studies have focused on the effects of religiosity on Irish sexuality, it is necessary to examine the effects of religious attendance on Irish sexual permissiveness scores. Regression models for the USA and Australia were also run for comparison. According to Table 3, when controlling for age, gender, area of residence, marital status and educational level reached, as attendance at religious services increased, scores on sexually permissiveness scale decreased for all three countries. The more frequent attendance at religious services, the more sexually conservative the individual. While all three countries saw a decrease in sexual permissiveness scores for each increasing unit of religious attendance (-0.21 for

Ireland, -0.29 and -0.22 for Australia and the USA in Model VI), the standardised regression coefficients indicated that the impact of religious attendance was greater for the Australian and the USA models than for Ireland (-0.493 and -0.423 compared to -0.32). This corroborates what was previously seen earlier in the chapter. Those who practise religion regularly in the non-monolithic countries were more likely to hold conservative sexual attitudes than those in the ex-monolithic Catholic country of Ireland.

Table 2
Multiple Regression Model for Scores on Sexual Permissiveness Scale
Including Interaction Of Age by Gender for USA and Poland.

(1) USA					
Model	R Square	Intercept		B	Beta
IV	0.53	0.263**	Age (expressed per 10 years)	-0.132***	-0.224
			Female	0.08	0.037
			Widowed	0.13	0.038
			Separated	0.42***	0.149
			Divorced	0.21	0.036
			Single, never married	0.36***	0.149
			Married/Living as Married (Base)	0	
			Gender *Age	-0.0061*	-0.161
(2) Poland					
Model	R Square	Intercept		B	Beta
IV	0.102	0.507**	Age (expressed per 10 years)	-0.0119***	-0.239
			Female	0.12	0.07
			Widowed	0.15*	0.06
			Separated	0.38***	0.099
			Divorced	0.22	0.027
			Single, never married	-0.02	-0.005
			Married/Living as Married (Base)	0	
			Gender *Age	-0.00627*	-0.201

◆◆ R, R square and R square change are significant at 0.005 probability level.
◆ R, R square and R square change are significant at 0.05 probability level.
*** Significant at 0.0005 probability level.
** Significant at 0.005 probability level.
* Significant at 0.05 probability level.

As seen in Table 1, USA had differences in scores for males and females, with females obtaining significantly fewer scores on the sexually permissive scale than males in the first four models for USA. This difference disappeared once controlling for the effect of attendance at religious services. As pointed out earlier in relation to attitudes to cohabitation, it is apparent that American females hold more traditional values regarding marital and sexual unions and indeed, since the effect disappears once controlling for religious attendance, the more conservative scoring of women on the sexual permissive scale is explained by the female respondents in the USA being more religiously devout. In relation to Ireland, age and attendance at religious services had the largest effects on sexual permissiveness scores (significant at the 0.0005 significance level) when controlling for gender, area of residence, marital status and educational level. Age had the bigger impact, with a beta weight of -0.468 compared to -0.32 for religious attendance. Age not religion accounts for the greater proportion of variation in scores on the sexual permissiveness scale.

In relation to the other independent variables of area of residence and educational level, area of residence as an independent variable had significant predictive power until controlling for religious devotion, thus suggesting a linkage between those who do not attend services regularly and those living in urban areas. In the fourth model, residence in urban areas did increase sexual permissive scores by 0.2 units relative to those living in rural areas, when controlling for the effects of sex, age and marital status. Urban areas attract the young in terms of employment prospects and the lifestyle perpetuated in urban centres also lends itself to more liberal values than in rural communities. Thus the effect of area of residence would interact and correlate with other explanatory variables. Since living in urban areas did not have similar significant effects for USA and Australia, the effect of area of residence in the Irish regression is perhaps due to the recent development of urbanisation in Ireland over the past 20 to 30 years. This shift from being predominantly rural to an urbanised society has perhaps resulted in a divide between rural and traditional and urban and liberal, a spilt that will probably dissolve as the society continues to adjust to its economic and social development.

The addition of educational level in the final models for Australia and USA showed a significant liberalising effect of those who attended university being more sexually permissive than those who did not further their education beyond primary level, when controlling for all other independent variables. This effect was larger for the USA, with an increase of 0.28 units on the sexual permissiveness scale compared to those who only reached primary level and a standardised regression coefficient of 0.127 for the model compared to an increase of 0.26 units on the sexual permissiveness scale and a beta weight of 0.096 for the Australia. The higher the level reached in education, the more sexually permissive the attitudes held. Educational level reached in the Ireland did not reach significance, perhaps demonstrating that there is an explanatory effect of age, i.e. younger generations are better educated, or that religious devotion and the harbouring of religious beliefs offsets the effects of education – especially given the dominance of the religious attendance in explaining the variation in scores in the final model. While it can be concluded that Irish sexuality was more conservative than the other four countries in 1994, there is clear evidence of a generational effect on sexual attitudes. As age decreased, sexual permissiveness increased. If this trend continues, Irish society will become more typical of the levels of sexual permissiveness in other western countries.

Table 3
Results of Multiple Regressions for Scores on Sexual Permissiveness Scale for Ireland, Australia and USA.

Model		Ireland B	Ireland Beta	Australia B	Australia Beta	USA B	USA Beta
I	Age (in years)	-0.36***	-0.571	-0.17***	-0.254	-0.2***	-0.335
II	Age (in years)	-0.36***	-0.571	-0.18***	-0.257	-0.2***	-0.333
	Female	-0.11	-0.053	-0.11*	-0.055	-0.19***	-0.093
III	Age (in years)	-0.35***	-0.562	-0.18***	-0.256	-0.2***	-0.327
	female	-0.12*	-0.058	-0.11*	-0.054	-0.19***	-0.092
	urban	0.21***	0.104	0.06	0.024	0.15	0.043
IV	Age (in years)	-0.35***	-0.565	-0.19***	-0.273	-0.16***	-0.278
	female	-0.13*	-0.062	-0.127*	-0.062	-0.2***	-0.097
	urban	0.2***	0.1	0.07	0.025	0.13	0.039
	Widowed	0.2*	0.061	0.11	0.018	-0.06	0.019
	Separated	1.0*	0.066	0.35*	0.065	0.46***	0.15
	Divorced	N/a	N/a	0.34	0.044	0.2	0.032
	single, never married	0.12	0.052	-0.06	-0.019	0.34***	0.136
V	Age (in years)	-0.3***	-0.486	-0.13***	-0.192	-0.14***	-0.241
	female	-0.05	-0.027	-0.00	0.000	-0.08	-0.041
	Urban	-0.08	0.04	0.03	0.012	0.11	0.032
	Widowed	0.13	0.038	-0.05	-0.009	0.03	0.01
	Separated	0.67	0.043	0.25*	0.046	0.29***	0.104
	Divorced	N/a	N/a	0.29	0.037	0.23	0.038
	single, never married	-0.00	-0.001	0.02	0.006	0.24***	0.097
	religious attendance	-0.21***	-0.321	-0.29***	-0.49	-0.21***	-0.412
VI	Age (in years)	-0.29***	-0.468	-0.12***	-0.176	-0.14***	-0.233
	female	-0.06	-0.031	-0.00	-0.001	-0.07	-0.039
	Urban	-0.66	0.032	0.01	0.006	0.07	0.02
	Widowed	0.14	0.039	-0.05	-0.009	0.08	0.02
	Separated	0.65	0.042	0.25*	0.047	0.3***	0.107
	Divorced	N/a	N/a	0.29	0.037	0.29	0.048
	single, never married	-0.01	-0.005	0.02	0.008	0.26***	0.105
	religious attendance	-0.21***	-0.32	-0.29***	-0.493	-0.22***	-0.423
	secondary level reached or completed	0.05	0.023	0.07	0.028	-0.06	0.027
	university level reached or completed	0.15	0.58	0.26*	0.096	0.28*	0.127

R Square Changes

1 AUS 0.065***	1 USA 0.11***	1 IRE 0.33***
2 AUS 0.003*	2 USA 0.01***	2 IRE 0.00
3 AUS 0.001	3 USA 0.00	3 IRE 0.01***
4 AUS 0.007*	4 USA 0.03***	4 IRE 0.01*
5 AUS 0.321***	5 USA 0.16***	5 IRE 0.09***
6 AUS 0.005**	6 USA 0.01***	6 IRE 0.00

*** Significant at 0.0005 probability level.
** Significant at 0.005 probability level.
* Significant at 0.05 probability level.

Conclusion:

The aim of this chapter was to specify Irish sexuality during the mid 1990s and to generate and test hypotheses about relationships between sexual attitudes and their impacting factors. It was hoped that this investigation would provide a context of sexuality, against which the rates of sexually transmitted infections have been rising. Unfortunately, a longitudinal analysis cannot be given. Instead a cross-national comparison is used to yield information about Irish sexual attitudes. The first part of this analysis comprised of the comparison of levels of approval across Ireland, Australia, USA, Poland and Spain on eight attitudinal variables from the ISSP dataset. A scale for sexual permissiveness was then created and tested for each country, in order to explain variations within countries. Both these analyses provide a picture of how Ireland compares to other countries and how variations in levels of sexual permissiveness can be accounted for within each country. Similar to the findings of previous studies on sexual attitudes, age, sex, education, area of residence, marital status and religious attendance all had an impact on explaining differences in levels of sexual permissiveness within and across countries. While Ireland did have the lowest mean score on the sexual permissiveness scale, it was apparent that the views of the younger age groups were more liberal than those of the older generations. Previous explanations of Irish Catholicism accounting for sexual conservatism in Irish society appear to have weak foundations, especially since regular attendees at religious services in the religiously diverse countries of USA and Australia were more conservative than Irish counterparts or indeed of the Spanish, who consistently showed the highest levels of sexual permissiveness.

Having established the context of Irish sexuality in the mid 1990s and the presence of a generational difference in sexual attitudes, we can now examine the sexual behaviours that were practised within this sexual climate. Due to the absence of longitudinal data on Ireland, comparisons will again be made with other western countries. Through this comparison, we can see if the sexual behaviours of the Irish are typical of western societies and ascertain where the Irish differ in terms of sexual risk taking.

Chapter 8: Irish Sexual Behaviours – A Comparative Perspective.

One cannot describe people's sexual behaviour as if it did not occur in a specific historical context. Some age-related differences between respondents can be understood only as a consequence of historical changes, rather than reflecting a developmental process.

(Sandfort et al, 1998: 407).

Introduction:

Sexual behaviours are both socially and biologically produced. Individuals are driven by the need to reproduce and the desire for recreational sex. Such behaviours may be influenced by public sexual attitudes in a country but are not necessarily caused by them. In the USA, the Kinsey reports of *Sexual Behaviour in the Human Male* (1948) and *Sexual Behaviour in the Human Female* (1953) discovered that many people were engaging in sexual activities that were not approved of on a public level. Approximately 50% of the female respondents had premarital sex (though mostly with their future husbands), yet publicly, women were meant to be virgins at time of marriage (Weinberg, 1976). As seen earlier in the thesis, STIs, illegitimate births and the use of contraceptives were a feature of Irish society at a time when Irish sexual morality was in force. While it is relatively easy to test public attitudes, assessing sexual behaviours and how they have changed in the late 20th century is difficult. Some trends are clear. Firstly, there has been a rise in the numbers of people – especially women – engaging in premarital sex (Weeks, 2000; Coleman, 1999; Adler, 1998). In the USA, the percentage of women who have premarital sex has risen over the course of the 20th century from 36% of those born circa 1925 to 65% of those born before World War II (Keane, 1980). Secondly, western societies in late 20th century have experienced what's termed a 'sexualisation of culture' (Hawkes, 1996). This movement was initiated by studies in sexology in the mid 20th century – such as Masters & Johnson (1966) - and has been fuelled by popular media and consumerism. The expression 'sex sells' has been used to sum up 'sexualisation' and magazines such as *Cosmopolitan*, *More* and *FHM* routinely offer sexual advice pages, articles on expanding the repertoire of sexual activities and improving sexual relationships. Individuals are encouraged to increase the frequency of sexual intercourse and to pursue their sexual desires in non-reproductive sex. Sexology managed to separate 'sexual response' as a matter of physiology from social relations (Kippax et al, 1993). This has continued the trend of medicalising sexual issues – for example, the identification of the female orgasm by Masters and Johnson in 1966 has directed all sex acts towards orgasm. Orgasm has thus become a measure of good health. Orgasmic sex is healthy sex whilst sex without orgasm is dysfunctional and must be treated and cured by 'sexperts' (O'Connell Davidson & Layder, 1994).

It is possible to test sexual behaviours in terms of premarital sex and the effects of 'sexualisation' through the measure of the frequency of sexual intercourse. Information regarding the range of sexual activities may be lost but the measure can still tell us how regularly different social groups have sexual encounters. These patterns will be explored in Ireland in a cross-national context. While it is difficult to

infer any changes in sexual behaviours from past generations, a national comparative study offers us the opportunity to gain understanding of Irish sexual behaviours against the backdrop of other countries. In the last chapter, we discovered that in spite of Irish sexuality being more conservative than USA, Australia, Poland and Spain in the 1990s, the younger age groups were more sexually permissive than others. In Chapter 5, we discovered that age did not significantly predict the likelihood of multiple partners in the last year or past five years once marital status was controlled. If there was a generational effect in behaviours in terms of sexual risk-taking, we would have expected age group membership to remain significant, i.e. those under the age of 30 being more likely to have had two or more partners in the last year than older age groups irrespective of educational level reached, area of residence, religious devotion and marital status. Thus we cannot conclude that the proportion of the population engaging in 'high risk' behaviours have changed between generations. Instead, it is argued that the reported rates of STIs are indicative of generational changes in sexual attitudes and are not reflections of an increase in 'high risk' sexual behaviours.

By comparing the patterns of Irish sexual behaviours with those of other countries, we can see if patterns of sexual behaviours in Ireland are typical of western societies and we can also determine if the explanations for predicting the likelihood of having multiple partnerships differ from those of other countries. Laumann & Wellings (2001) have pointed out that sex surveys on western societies find more similarities than differences, yet the epidemiology of STIs varies between nations. Britain and the USA were found to have similar sexual patterns yet public sexual health campaigns have been more effective in Britain than the USA. This was explained by the existence of a stronger public opinion about improper sexual behaviour in the USA (Laumann & Wellings, 2001). Additionally, as seen in Chapter 2, surveillance systems differ between countries and this affects the reporting of rates. Through cross-national research, we can highlight the differences between Ireland and other nations and test whether the Irish trends of sexual behaviour are culture specific or are typical of western societies. Furthermore, a cross-national approach can enhance our understanding of the underlying dynamics of 'high risk' behaviours in the five countries.

In this chapter, we will examine the proportion of the population that are engaging in multiple partnerships in Ireland, Australia, USA, Poland and Spain. The trend of premarital sex will also be tested. We will then investigate the effect of sexualisation by looking at the frequency of sexual intercourse by different social groups. Since sexual desires and non-reproductive sex are encouraged in western societies, this measure of sexual intercourse can give us an insight into whether or not sexual intercourse is more common amongst those with multiple partnerships. This would have repercussions for spread of STIs. In the final part of the chapter, we will examine the relationship between sexual permissiveness and the likelihood of having two or more sexual partners within a specific time frame. It is hoped that we can verify the similarity of Irish sexual behaviours with those of other countries and in the process, we can confirm that the explanations for the rise in reported national rates of STIs lie elsewhere.

Table 1
Number of Sexual Partners in Last Year by Gender For Each Country.

		Ireland	Australia	USA	Poland	Spain
Men:						
	N	166	642	480	304	816
	Median	1	1	1	1	1
	Mean	1.24	1.19	1.57	1.81	1.23
	STD	0.72	0.7	4.38	1.51	0.73
	Max	5	7	94+	8	6
	Homosexual (% of Total)	2.5%	4.5%	3.2%	7.5%	3%
	Bisexual (% of Total)	1.2%	1.6%	0.2% (one person)	1%	4.2%
	2+ partners (% of Total)	13.3%	9.7%	18.4%	15.8%	11.5%
Women:						
	N	191	613	592	293	738
	Median	1	1	1	1	1
	Mean	1.17	1.08	1.21	1.09	1.02
	STD	0.67	0.49	0.57	0.53	0.28
	Max	7	7	5	6	5
	Homosexual (% of Total)	2.2%	1.8%	2.1%	2.2%	7.8%
	Bisexual (% of Total)	0	1.3%	0.5%	0.4% (one person)	7.8%
	2+ partners (% of Total)	8.9%	4.2%	14.7%	4.1%	2.3%

Table 2
Number of Sexual Partners in Past 5 Years by Gender For Each Country.

		Ireland	Australia	USA	Poland	Spain
Men:						
	N	170	680	516	303	843
	Median	1	1	1	1	1
	Mean	1.64	1.5	2.63	1.36	1.68
	STD	1.32	1.24	6.04	1.05	1.39
	Max	7	7	94+	8	7
	Homosexual (% of Total)	2.9%	4.3%	3.5%	8.6%	2%
	Bisexual (% of Total)	0	1.9%	1.7%	1%	2.2%
	2+ partners (% of Total)	24.7%	19.1%	43%	29.7%	26.1%
Women:						
	N	196	647	668	325	790
	Median	1	1	1	1.26	1
	Mean	1.36	1.26	1.89	1	1.16
	STD	1	0.82	3.83	0.9	0.62
	Max	6	6	94+	8	7
	Homosexual (% of Total)	3.8%	1.4%	1.7%	1.8%	1.3%
	Bisexual (% of Total)	0.5% (one person)	2.3%	1.2%	0.3% (one person)	0.4% (three people)
	2+ partners (% of Total)	14.8%	12.4%	33.3%	11.4%	8.4%

Table 3
Number of Lifetime Sexual Partners by Gender For Each Country.

	Ireland	Australia	USA	Poland	Spain
Men:					
<u>Heterosexual</u>					
N	185	723	508	302	N/A
Median	3	3	5	3	N/A
Mean	4.89	6.85	13.22	8.08	N/A
STD	5.74	10.74	20.73	16.08	N/A
Max	30	80	100+	70+	N/A
% of 2+ partners	57.8%	61%	78%	63.2%	N/A
<u>Homosexual</u>					
N	9	54	37	31	N/A
Median	1	1.5	4	2	N/A
Mean	3.22	3.04	17.68	5.58	N/A
STD	3.42	3.32	27.71	9.39	N/A
Max	9	20	100+	50	N/A
% of 2+ partners	44.4%	50%	67.6%	58.1%	N/A
Women:					
<u>Heterosexual</u>					
N	208	707	731	400	N/A
Median	1	1	2	1	N/A
Mean	2.38	3.31	5.08	2.17	N/A
STD	3.43	5.6	9.9	2.82	N/A
Max	30	83	100+	25	N/A
% of 2+ partners	31.7%	47.2%	63.9%	35.2%	N/A
<u>Homosexual</u>					
N	12	45	23	9	N/A
Median	3.5	1	2	1	N/A
Mean	4.67	2.2	11.39	5.33	N/A
STD	3.5	2.19	20.98	6.84	N/A
Max	9	12	100+	20	N/A
% of 2+ partners	75%	37.8%	69.6%	44.4%	N/A

National Differences and Similarities in Multiple Partnerships for the Sexes:

Tables 1 to 3 show the number of sexual partners reported in the last year, in the past 5 years and over a lifetime (i.e. partners so far) stratified by country and gender. As seen in Chapter 5 and in other sexual surveys – for example, Hubert et al (1998), Wellings et al (1994) and Michael et al (1994) – the distribution of sexual partners is extremely skewed for the last year and past 5 year time periods. The majority of respondents in each country have had only one partner in the respective time frame (medians and means hovered around one). When comparing Ireland to the other countries, a larger percentage of Irish respondents had two or more partners in the last year or 5 years than some of the other nations. In relation to males, 13.3% Irish men admitted having multiple partnerships in the last year compared to only 9.7% of Australians and 11.5% Spanish. Irish women also had a higher percentage with 8.9% as opposed to 4.2% Australians, 4.1% Polish and 2.3% of Spanish women. This difference amongst women was again repeated for the 5-year period, whilst males were only higher than the Australians. It is possible that the extent of non-responses (as discussed in Chapter 5) is causing an over-estimate of the proportion of those with multiple partnerships. However, the other countries are also affected by non-response rates and though it will not be discussed here, those who did not respond to the sexual behavioural appendix shared common characteristics with the Irish sample. Despite sexual conservatism in Ireland (relative to the other four nations), Irish individuals do display a higher proportion of multiple partnerships. This is in keeping with the argument in Chapter 6, that throughout the history of Irish sexual morality, a proportion of the population did engage in risk taking sexual behaviours. Although, the size of the proportion may have varied over time but without longitudinal data, we can only conclude that the Irish population always contained a group of sexual risk takers.

The USA was the anomaly in relation to sexual partnerships. For the time period of 5 years, American men and women had high means and standard deviations compared to the other countries and the maximum number of partners reported was over 94 for both genders. With the exception of the mean for Polish males, this was repeated for the reported partnership in the proceeding year. Laumann & Wellings (2001) and Michael et al (1994) remarked upon the sexual diversity of the USA population and given the somewhat conservative sexuality (as seen in Chapter 7), the high proportion of those with multiple partnerships is an interesting finding. This further substantiates the division between sexual attitudes and practices.

In relation to homosexual pairings, Tables 1 and 2 show a small proportion of each country's population engaging in bisexual or homosexual behaviours. At first glance, the highest percentage was found amongst Polish males. In Table 1, 7.5% reported homosexual relationships in the last year and 8.6% for the past five years. However, one must be cautious in interpreting the percentages, as 7.5% of 304 Polish respondents may not be entirely different from 3% of 814 Spanish. Using Chi² tests, we can determine whether or not the proportions of homosexual and bisexual behaviours vary between countries. These tests of independence were run separately for males and females and due to the small numbers, the numbers of homosexual and bisexual partners reported for the last year and past five years had to be combined. (Otherwise, a large percentage of cells would have had less than the minimum expected counts). In relation to females, we cannot reject the null hypothesis that the

proportion of women with bisexual or homosexual relationships in the last five years is the same for each country. Furthermore, the numbers were too small for the last year to use the χ^2 test efficiently. The proportion of males who had bisexual or homosexual relationships was not the same for each country for the last year (χ^2 was 11.317, $P < 0.05$) and the past five years (χ^2 was 15.388, $P < 0.005$). Looking at the adjusted standardised residuals, both the USA and Poland have adjusted standardised residuals of exceeding 2 in absolute value for the last year (-2.5 for the USA and 2.4 for Poland). For the past five years, all countries with the exception of the USA had adjusted standardised residuals over 2 in absolute value (4.5 for Australia, -4.4 for Ireland, 12.7 for Poland and -11.5 for Spain). In both time periods, we observe a greater number of homosexual and bisexual partnerships in Poland than expected, while the more liberal country of Spain (in terms of attitudes to homosexuality) displays a much lower number of bisexual or homosexual relationships for the last five years than expected. We can conclude that proportions of homosexual and bisexual behaviours vary between countries for males. A lower proportion of Irish males had homosexual or bisexual relationships in the last five years than expected. Additionally, it highlights that despite Poland being a monolithic Catholic country, where homosexual behaviours are deemed sinful, a higher proportion of males had homosexual or bisexual relationships than we would have expected. While we cannot place too much emphasis on these findings - given the possibility that homosexuals are underrepresented in the survey (see Chapter 1) - the χ^2 test suggests that the proportion of homosexual and bisexual behaviours amongst men varies across the countries and so will have different implications for the transmission of STIs within those countries.

In Table 3, the majority of men in all five countries have accumulated more than one sexual partner so far in their lives. In terms of heterosexual behaviours, USA again displays the highest percentages, means, standard deviations and median numbers of partners for both genders. In relation to homosexual partnerships, American men show a higher mean, median, standard deviation and maximum number of partners than Poland (median of 5, mean of 13.22 partners and a standard deviation of 16.08 partners). Perhaps, the lower USA numbers in the previous tables reflect a more conservative climate post AIDS in the USA. Darrow & Valdiserri (1993) argued that in the USA the behaviour of the sexually active population, in particular, homosexuals, changed in response to AIDS. In Britain and Australia, gay communities adapted their sexual behaviours, lowering numbers of partners and increasing usage of condoms (Kippax et al, 1993; Fitzpatrick, Boulton & Hart, 1989). Women show a more varied pattern. Irish women (like Irish men) have the lowest percentage of two or more partners, although in the two Catholic countries, only 35.2% of Polish women and 31.7% of Irish women had two or more sexual partners over their lifetime. The difference percentage wise between men and women in these two countries could be indicative of traditional expectations of male and female behaviours - i.e. the majority of women remain virgins until marriage while males 'play the field', possibly with a minority of women who are outliers with several partners. In relation to Australia and USA, women did have a higher percentage of two or more partners relative to the other female respondents. Perhaps this is the result of an earlier initiation of premarital sex amongst women than in the Catholic countries. There is still a difference between the genders within those countries however. It is a shame that we have no information for Spain, as it would have been interesting to see how the Spanish compare to the other two Catholic countries and in

relation to the number of homosexual relationship (especially since it is the most favourable of all the countries towards homosexuality).

Simple counts can give us an idea of the variation in sexual partnerships between nations. Furthermore the extreme skewness of the distributions for the time frame of last year and past five years, appear to confirm the existence of 'high risk' groups within the populations of all five countries. As Wellings et al (1994) and Morris (1994) have pointed out these groups are not static. As people age, they move between groups in accordance to marriage, divorce, separation, parenthood and availability of partners. Since age group membership is important to the explanation of multiple partnerships in Ireland, we will now examine how the Irish situation compares to other countries.

Age Group Membership and Number of Lifetime Sexual Partners:

As previously stated, it is difficult to infer changes in sexual behaviours over time. We are certain though that there has been a growth in premarital sex across western societies in the 20th century. By examining the number of lifetime sexual partners for the respondents in each country, we can discover if the Irish trend deviates. Figure 1 displays the mean number of lifetime sexual partners for each age group for the four countries. Since we are looking at total number of lifetime partners, one would expect the numbers to increase with age. Knox et al (1993) maintain that the mean number of partners is increasing over time in Britain. However, as seen in Chapter 5, this is not necessarily the case. The peaks in the graph tend to occur in the younger age groups, thus reflecting generational differences in the acceptance and practice of premarital sex. It is evident from the graph that different patterns of sexual partnerships exist across the age groups in each country. For the USA, the line peaks in the 41 to 50 age group and slopes relatively steeply to the 61 to 70 age group. This means that the number of sexual partners accumulated by USA respondents is affected by generational differences as well as life-cycle changes. The generational differences can be seen in the sharp decline in mean numbers of sexual partners across the older age groups of those who are aged 51 and older. In relation to life-cycle changes, in the first half of the graph (up to the age group 41-50), the line is increasing, thus reflecting the accumulation of sexual partners that we would expect if all age groups had been engaging in premarital sex from their early stages of their sexual careers onwards. Changes in premarital sex can be argued to have occurred earlier in the USA than in the other countries. The sexual activities of the 'sexual revolution' and the feminist movement in the 1970s have been documented to have encouraged premarital sex and multiple partnerships in the USA (Weeks, 2000; Scott, 1998a). This is also in keeping with the rising numbers of premarital sex between those sexually active in the 1940s and those sexually active in the 1960s (Keane, 1980).

Poland displays an interesting dip in the numbers of lifetime partners for those aged 21 to 40. These are the age groups who would have been sexually active in the immediate aftermath of the HIV/AIDS pandemic, so perhaps this has constrained the number of sexual partners. This is compounded by the larger mean of sexual partners for those aged 18 to 20, reflecting what Benagiano et al (2000) have identified as symptomatic of emerging younger cohorts who are less concerned with the transmission of HIV. Furthermore, the Polish respondents (particularly the men)

display a higher rate of extramarital affairs in the 41 to 60 age group. Overall 22.7% Polish men had extramarital affairs, 64.8% of these affairs were admitted by men aged 41 to 60. Indeed in all countries (including Spain), extramarital affairs were mostly reported by those aged 41 to 50 but the rates were higher amongst men for Poland and the USA than for the other three countries. For all countries, more men admitted having affairs than women - 60.3% of USA men and 27.4% of women aged between 41 and 60 admitted having an extramarital affair. This could reflect a difference in gender reporting or perhaps men are more likely to have affairs and to have them with single women. While the absolute numbers were small (65 Polish men had extramarital affairs), their inclusion in the overall rate of lifetime partners does distort the mean and hence is reflected in higher means for the 41 to 50 age groups for both USA and Poland.

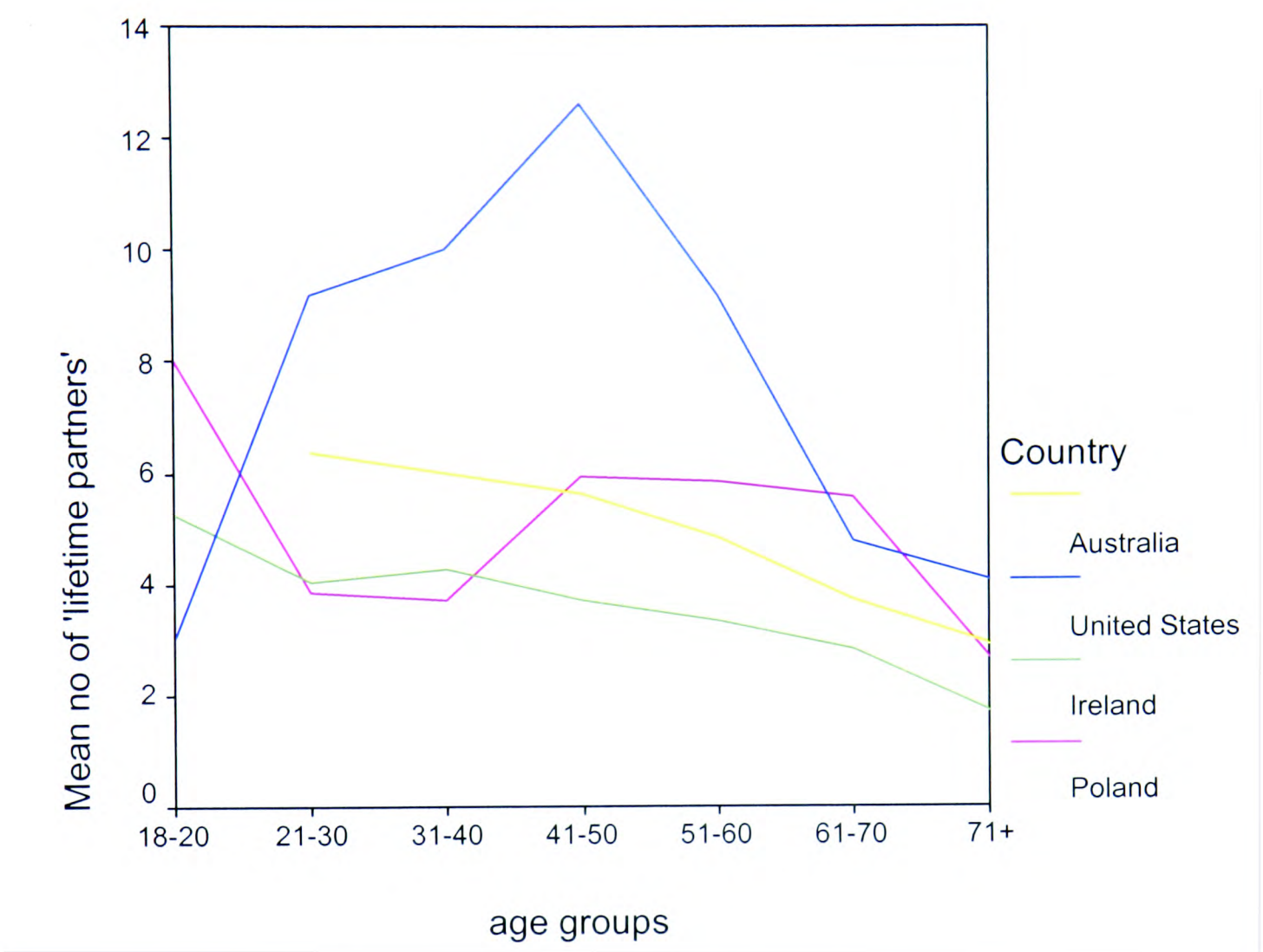
A similar conclusion can be made for use of paid sex. Use of paid sex was higher in the USA and Poland – again amongst the males age 41 to 60, although a total of 1.1% of Polish women and 1.6% of American women had paid sex (it is not known whether these women paid for a gigolo or were prostitutes). Interestingly, Spain had the highest percentage and absolute numbers of males using prostitutes (188 men, 18.2% of the total male population). This percentage was approximately evenly distributed across the age groups. Brothels are numerous and visible along the Spanish motorways so it is not surprising to see this reflected in the Spanish rates. Hart (1998) conducted an anthropological study on prostitution in a city in Spain and remarked that prostitution had a high profile in Spain and paid sex could be obtained easily on the street, in high-class clubs or in private flats. Paid sex was also cheap and attracted men from all socio-economic groups, holiday-makers, travellers and migrants. The largest demand came from men over the age of 40, many of whom were pensioners (Hart, 1998). In relation to Ireland, the Irish trend is more similar to that of Australia, with a gradual sloping downwards as age increases. Thus indicating a generational difference, i.e. as the 20th century progressed, the numbers of people engaging in premarital sex increased over the successive generations, thus resulting in larger mean numbers of partners for the younger age groups. The mean number of sexual partners across the age groups for the Irish respondents is lower in comparison to the other countries. This suggests that the growth in premarital sex is more recent. This is keeping with the decline of Irish sexual morality in the last two decades of the 20th century and the generational differences found in Chapter 7.

Age Group Membership and Multiple Partnerships:

The majority of rates of STIs are reported by those aged between 20 and 30 years in Ireland. In Chapter 5, we found that when ignoring the effect of marital status, this age group has a higher likelihood of having 2 or more sexual partners within a specific time frame than those over the age of 30. We need to see if this situation is typical of other western societies. Tables 4 and 5 display the proportions of each age group with 1 or 2+ partners for the one year period and the five year period. Additionally, the tables include the results of a Chi² test (using observed frequencies) and adjusted residuals. With the exception of the USA, Ireland is similar to other countries with the larger proportion of those under the age of 30 having only one partner in the last 5 years (53.3%). Furthermore, the proportion of those with two or more partners (46.7%) is higher than in those over the age of 30 (10.5%). A similar pattern can be seen for Australia, Poland and Spain and this is replicated for the one

year period. Indeed for all five countries, the percentage of those with 2 or more partners is higher in both age groups for the five year period than in the one year period, thus indicating existence of serial monogamy and the stabilising of partners in those in their late twenties. It is a feature of their sexual career that after the initial

Figure 1
Graph of Mean Number of Sexual Partners Across Age Groups for Each Country.



experimental phase, individuals settle into long term monogamy (Wellings et al, 1994). Given that the average age of marriage is in the mid to late 20s for western countries, it is possible that this is being reflected in the smaller proportion of multiple partnerships for the preceding year. Looking at the χ^2 value¹ for each country, it is apparent that age group and number of sexual partners are not statistically independent, i.e. number of sexual partners differs between the two age groups. While the χ^2 value is influenced by sample size, the large numbers do represent association. Indeed their association is significant at the 0.005 level for each country. This means that the proportion of those under the age of 30 who have two or more sexual partners in the last year or 5 years is significantly different to the proportion of those in the older age group. Adjusted standardised residuals are also high and since they all exceed 3 in absolute value, we have strong evidence that age group membership and number of partners is associated for each country (Agresti & Finlay, 1997). Despite the different patterns of lifetime sexual partners for each country, the

¹ Since we are dealing with a 2x2 table, the chi-square value used is the Yates' Correction for Continuity because this compensates for the overestimate of the chi-square when using a 2 by 2 table (Palliant, 2000).

Table 4
Number of Sexual Partners in the Past Five Years by Age Group For Each Country.

	<u>Ireland</u>	<u>Australia</u>	<u>USA</u>	<u>Poland</u>	<u>Spain</u>
<u>18 to 30 years old</u>					
1 sexual partner	53.3%	52.3%	35.5%	62.6%	61.3%
2 or more sexual partners	46.7%	47.7%	64.5%	37.4%	38.7%
<u>31 years and older</u>					
1 sexual partner	89.5%	88.2%	69.8%	84.7%	90.5%
2 or more sexual partners	10.5%	11.8%	30.2%	15.3%	9.5%
N	366	1130	1181	628	1635
Chi ²	54.465***	125.427***	97.901***	31.331***	189.74***
Adjusted Residuals	7.5	11.3	10	5.7	13.8

Table 5
Number of Sexual Partners in the Last Year by Age Group For Each Country.

	<u>Ireland</u>	<u>Australia</u>	<u>USA</u>	<u>Poland</u>	<u>Spain</u>
<u>18 to 30 years old</u>					
1 sexual partner	75.6%	78.2%	70.1%	79.8%	83.1%
2 or more sexual partners	24.4%	21.8%	29.9%	20.2%	16.9%
<u>31 years and older</u>					
1 sexual partner	93.4%	94.9%	87.6%	92.7%	96.6%
2 or more sexual partners	6.6%	5.1%	12.4%	7.3%	3.4%
N	357	1257	1071	597	1556
Chi ²	19.413***	51.54***	40.411***	17.188***	83.635***
Adjusted Residuals	4.6	7.4	6.5	4.3	9.3

Irish are typical of western countries where the higher frequency of multiple partnerships is in the age group most likely to report STIs.

National Differences in the Frequency of Sex:

In the 20th century, sexual expression became increasingly separated from reproduction through the availability of contraceptives and the prevention of infant and maternal mortalities (Wellings et al, 1994; Rossi, 1994). At the same time, popular beliefs about sexual pleasure were shaped by the findings of sex research, a discipline known as sexology. The central concern of sexology is the orgasm. Until the 19th century, it was a common belief that women could not conceive unless they experienced orgasm during sex (O'Connell Davidson & Layder, 1994). This belief disappeared until the writings of Marie Stopes on women's sexual enjoyment and the psychoanalytical studies of Freud on the vaginal orgasm versus the clitoral orgasm in the early 20th century (Erickson & Steffen, 1996). However, it was the sex surveys of the Kinsey Institute in the late 1940s and the British version 'Little Kinsey' in 1949 and the work of Masters and Johnson in 1966, which focused on the rates and meanings of various sexual practices amongst different social groups and proved the existence of clitoral orgasm. This helped to transform beliefs not only about female sexuality but emphasised the importance of 'wild' sexual intercourse in different sexual positions. Sex is presented as being necessary for human happiness (Stanley, 1996). Sexual dissatisfaction is considered to be destructive to people's relationships and general happiness. It is accepted and demanded in western societies that people enjoy sex (O'Connell Davidson & Layder, 1994). This is heightened by the sexualisation of western cultures – i.e. the invoking of sexual imagery to sell a wide range of products and the presentation of sexual desirability as a leisure commodity to be obtained and utilised (Hawkes, 1996).

The encouragement of frequent and varied sexual practices has some repercussions for risk behaviours. The pursuit of sexual desire may forgo safe sex. Unfortunately, we are unable to infer any information about the types of sexual practices used by different social groups. The ISSP (1994) dataset does not provide any information on sexual activities, for example manual sex, anal sex, oral sex, use of S & M etc. However, we are able to measure the frequency of sexual intercourse in order to determine whether or not those with multiple partnerships place themselves at higher risk of acquiring STIs by having more episodes of sexual intercourse with a greater number of partners in a year than those who have had just one sexual partner.

Frequency of sexual intercourse was similar across countries. People in each country had sex, on average, once a week. This rate is a little lower than the findings of Sandfort et al (1998), where Europeans had an average rate of sexual intercourse of twice a week. To investigate how the regularity of sexual intercourse varies across countries, means of sexual intercourse were compared by gender, age group and sex of sexual partner. Using ANOVA analysis, no significant difference was found between countries across the categories of gender, age group and marital status. Irrespective of gender, sexual intercourse was performed on average once a week. Age groups were similar except for those aged 71 and older, where sexual intercourse occurred on average, once a month for each country. In Ireland, Poland and Spain, those who were single had sex less frequently than those married (on average, 2 or 3 times a month). Whilst in Australia, single people had a higher average (twice a

week). There was no difference for the USA. Frequency of sex did vary in accordance to gender of sexual partner in the previous year. In the USA and Poland, bisexuals had lower means and medians of sexual intercourse, whilst in Spain, bisexuals had a higher rate of sexual intercourse (2 or 3 times a month as opposed to once a month).

Figure 2
Graph Displaying Means and 95% Confidence Intervals for Frequency of Sex in the Last Year For Those Reporting One Sexual Partner and Those reported 2 or more by Country.

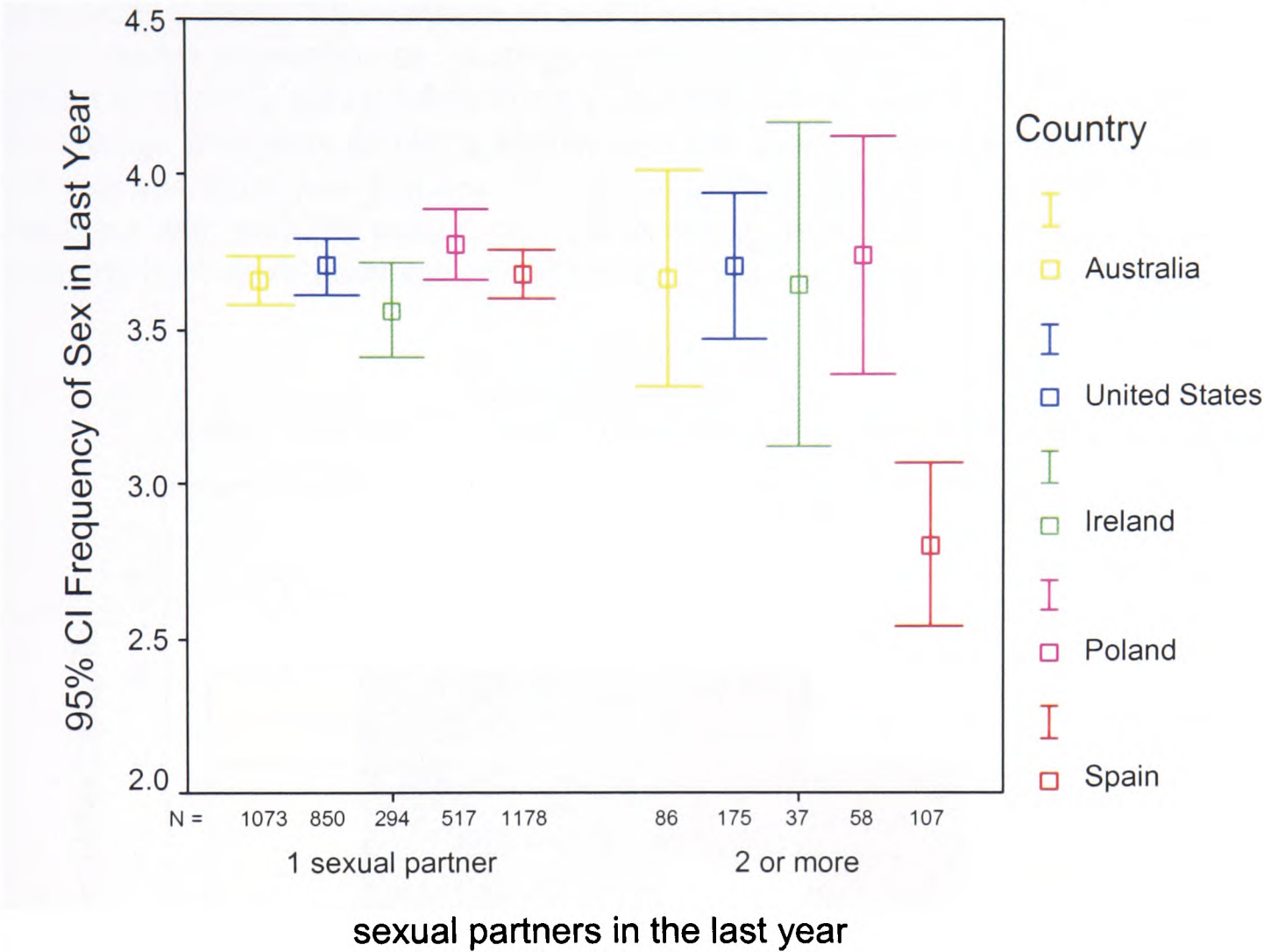
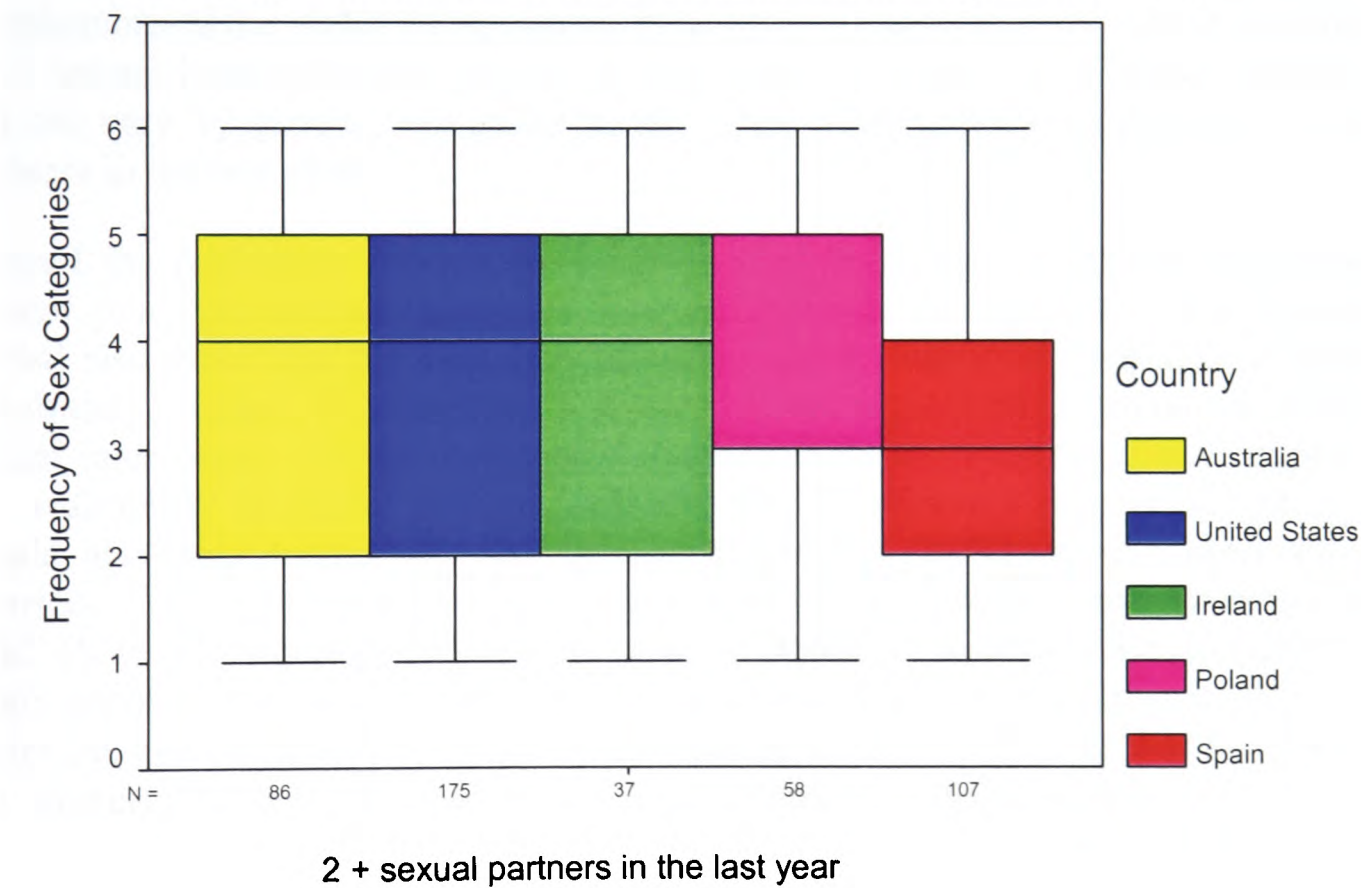


Figure 2 shows the frequency of sexual intercourse in the past year for those with just one sexual partner and those with two or more. The numbers on the y-axis correspond to the different categories of the variable: 1 = once or twice in the past year; 2 = once a month; 3 = twice or three times a month; 4 = once a week; 5 = twice or three times a week and 6 = four times or more a week. For each country, the mean reported category of frequency of sexual intercourse for those with just one sexual partner was 3.5 (median was 4). This corresponds to an average of once a week. Additionally, the 95% confidence intervals were small and the countries overlapped. Those with multiple partnerships were similar, with the exception of Spain and Poland. Spanish respondents with 2 or more sexual partners in the past year had a much lower mean sex frequency of two to three times a month. Perhaps this indicates the presence of casual sexual encounters, which has implications for spread of STIs. It should also be pointed out that for four of the countries, those with 2 or more sexual partners in the last year had overlapping 95% confidence intervals but these intervals were larger than seen for those with just one sexual partner. This reveals a greater variability in frequency of sex. In Ireland, those with multiple partnerships had a population mean frequency of sex falling between twice or three times a month and once a week. Australia and Poland were similar.

Since this is an ordinal measure, the medians and inner-quartile ranges for those with two or more partners can be displayed in a box plot (Figure 3). This gives us an indication of the distribution of responses for each country. Ireland, USA and Australia have negative skewness, which shows a greater tendency to have less regular sex than those with just one partner. 50% of all respondents reported having sex between once a month and twice a week, with the majority of these being under the median. Poland however, is positively skewed with 50% of the respondents with two or more partners having sex between twice or three times a month and twice or three times a week. The variance of sexual intercourse reflects the sporadic nature of casual sexual encounters or meetings of new sexual partners, a feature that is not present in ongoing sexual relationships. Nevertheless, it is clear from the means that the average frequency of sex is similar between those with multiple partnerships in one year and those with just one. In relation to the potential risk of STIs, this means that those with multiple partnerships are increasing their risk of exposure to STIs by engaging in multiple partnerships and having sexual contact at least once a week.

Figure 3
Boxplot of Frequency of Sex
Amongst Those with 2+ Sexual Partners in the Past Year for Each Country.



In order to fully assess the relationship between multiple partners and the frequency of sexual intercourse, multivariate models were used to account for the possible influences on frequency of sexual activity. Gender, age, marital status and number of sexual partners per unit time have been associated with frequency of sexual intercourse (Wellings et al, 1994) and were included in the regression models². Because this is an exploratory analysis of the effects on the frequency of sexual intercourse in each country, stepwise regression was used to find a parsimonious model. Predictions did vary between countries. For Australia, the frequency of

² The variable for frequency of sex was recoded to create a scale so it could be used in the linear regression.

sexual contact was significantly influenced by gender and age group membership. Frequency of sexual intercourse was higher for those aged 18 to 30 than the older age group (unstandardised regression coefficient [B] was 0.577, $P < 0.0005$), whilst females were also more likely to report a higher frequency of sex than males (regression coefficient of 0.292, $P < 0.0005$). In the USA, single marital status and those widowed had significantly lower frequencies of sexual intercourse than those who were married (-0.397 , $P < 0.0005$ and -0.882 , $P < 0.05$). Those aged between 18 and 30 had a higher frequency of sexual contact than those who were older (B was 0.609, $P < 0.0005$). For Poland, again it was those aged between 18 and 30 who had higher frequencies of sexual intercourse (B of 0.607, $P < 0.0005$), while those who were single and unmarried had lower rates of sexual intercourse than those who were married (B of -0.851 , $P < 0.0005$). Number of sexual partners had a significant effect in Spain. Those with two or more sexual partners in the last year had a lower frequency of sexual intercourse than those with only one sexual partner (B of -0.535 , $P < 0.0005$). Similar to Poland and the USA, single people had a lower rate of sexual intercourse compared to those who were married or living as married (B of -0.829 , $P < 0.0005$), while those who were under the age of 30, again had a higher frequency of sexual intercourse (B of 0.419, $P < 0.0005$). In relation to Ireland, none of the independent factors had significant effects, although there were tendencies for membership of the under 30 age group to increase frequency of sex and for women to have sexual intercourse less regularly than males. Frequency of sexual intercourse did not vary by gender, age group membership, marital status or number of sexual partners in the last year.

Overall the regression models have shown that frequency of sexual intercourse is greater amongst marital unions or long-term cohabiting couples. Wellings et al (1994) also found that the frequency of sexual contact was higher amongst married or cohabiting couples. This suggests a combination of reproductive sex and recreational sexual intercourse. Furthermore, the frequency of sexual intercourse does depend on the availability of sexual partners. Marital unions provide a regular partner so this would also help account for the difference between singletons and those who are married. The likelihood of sexual intercourse being more frequent amongst those aged 18 to 30, when controlling for marital status in Australia, USA, Poland and Spain supports the hypothesis of the effects of sexualisation in western world. Those under the age of 30 are, by their youth, deemed at their most sexually desirable and are encouraged to freely indulge in sexual pleasures. (Most magazines containing articles on improving sex lives and sexual positions are geared towards this age group).

It is interesting that none of the independent variables had an effect on the frequency of sexual intercourse in Ireland. This could be due to the small sample size. However, this lack of information does not impede our investigation. In relation to STIs, frequency of sexual intercourse is not as important in the spread of infections as the effect of multiple partnerships. This is because individuals may not be infectious immediately and some people are more vulnerable to acquiring an STI than others (Lerridon, Van Zessen and Hubert, 1998). Furthermore, the spread of STIs depends on the proportion of individuals changing partners over time (or having concurrent partnerships). Frequency of sexual intercourse aids the process, especially if it is unprotected sex, but its effect is negotiated through the number of sexual partners an individual has within a specific period of time.

In Chapter 5, we examined the effects of demographics on the likelihood of multiple partnerships in the past year or five years. We then established the level of sexual permissiveness for different social groups within Ireland and in comparison to the other countries. It is now appropriate to investigate whether or not sexual attitudes are connected to sexual behaviours in Ireland. Could the changes in Irish sexuality have influenced the proportion of individuals taking sexual risks? In other words, could the reported rates of STIs really be the reflection of increasing numbers of 'high risk' behaviours, the product of a more lenient Irish sexual climate?

The Links Between Sexual Attitudes and Behaviours:

While behaviours and sexual attitudes tend to be highly correlated in cross-sectional studies, it is difficult to determine if attitudes influence behaviours or if behaviours affect attitudes (Scott, 1998a; Aral & Peterman, 1996; Wellings et al, 1994). Has the rise in pre-marital sex in western societies derived from more liberal sexuality or did the behaviour pre-empt the attitudes? Do people frown upon teenage sex because they themselves have had a bad experience or did their opinions prevent them from having an early age of first sexual intercourse? What people say and do can be two completely different things. People may condemn extramarital affairs yet may be involved in one. Indeed, adultery is one of the most widely cited grounds for divorce in Britain and the USA yet extra-marital sex is widely condemned (Scott, 1990; Harding, 1988). Changes in behaviours do not necessarily accompany changes in attitudes. People tend to learn behaviours through the experience of the consequence (Zimbardo & Ebbesen, 1970). If people perceive that their sexual behaviours will be met with social approval, they may be more likely to engage in the sexual experience. However, there have always been individuals who engage in sexual practices in spite of public opinion. For example, homosexual relationships have occurred throughout cultures and history, irrespective of whether or not the behaviour was deemed acceptable.

Rates of STIs and determinants of behaviour, such as sexual attitudes, are not adequate proxy measures for measuring behavioural outcomes (Aral & Peterman, 1996). Indeed as stipulated in Chapter 3, reported rates are influenced by the surveillance system and provision of services. Changes in rates of STIs are more likely to reflect changes in public attitudes than actual behaviours. A greater public openness about sexuality may be encouraging a greater number of GUM clinic attendees. Furthermore, a range of sexual behaviours continued through periods of sexual permissiveness and repression, thus revealing a disjuncture between public attitudes and private sexual behaviours. In the absence of longitudinal data on sexual behaviours and attitudes, we cannot establish causal links between attitudes and behaviours. However, we can determine if sexual permissiveness is associated with the likelihood of multiple partnerships. In other words, are people who hold more favourable views towards premarital sex, cohabitation, divorce, homosexuality etc more likely to have multiple partnerships in the last year or five years? We cannot make any assumptions that attitudes lead people to risk multiple partnerships, instead we can only state whether or not those who are sexual permissive are more likely to have multiple partnerships than those who are more morally conservative.

Tables 6 and 7 show the results of a series of logistic models for the prediction of the log likelihood of having two or more sexual partners in the last year and past five

Table 6
 Combined Models for Predicting Likelihood of Having Two or More Partners in the Last Year.

Model		Ireland B	Ireland S.E.	Australia B	Australia S.E.	USA B	USA S.E.	Poland B	Poland S.E.	Spain B	Spain S.E.
I	Sexual permissiveness	1.522***	0.269	0.736***	0.134	0.735***	0.097	0.92***	0.198	1.094***	0.139
	Constant	-2.661	0.268	-2.967***	0.153	-1.672***	0.089	-2.416***	0.163	-3.406***	0.179
II	Sexual permissiveness	1.394***	0.277	0.675***	0.136	0.682***	0.098	0.888***	0.205	0.859***	0.15
	Aged 18 to 30	0.756*	0.383	1.504***	0.251	0.942***	0.182	1.053***	0.289	1.254***	0.22
	Aged 31 + (Base)	0	0	0	0	0	0	0	0	0	0
III	Constant	-2.887***	0.302	-3.238***	0.169	-1.943***	0.11	-2.734***	0.2	-3.794***	0.207
	Sexual permissiveness	1.379***	0.278	0.667***	0.139	0.676***	0.098	0.891***	0.215	0.849***	0.155
	Aged 18 to 30	0.761*	0.383	1.533***	0.256	0.947***	0.183	1.159***	0.3	1.275***	0.224
	Aged 31 + (Base)	0	0	0	0	0	0	0	0	0	0
IV	Male	0.27	0.376	0.909***	0.249	0.226	0.174	1.534***	0.346	1.679***	0.246
	Female (Base)	0	0	0	0	0	0	0	0	0	0
	Constant	-3.018	0.36	-3.786***	0.243	-2.05***	0.139	-3.773***	0.349	-4.965***	0.316
	Sexual permissiveness	1.057***	0.287	0.591***	0.14	0.391**	0.119	0.689**	0.225	0.449**	0.167
	Aged 18 to 30	-0.343	0.503	0.740*	0.377	0.599*	0.247	0.478	0.39	0.053	0.276
	Aged 31+ (Base)	0	0	0	0	0	0	0	0	0	0
	Male	0.219	0.404	0.896***	0.257	0.468*	0.2	1.389***	0.356	1.382***	0.287
	Female (Base)	0	0	0	0	0	0	0	0	0	0
	Single & never married	2.183***	0.537	1.445***	0.371	3.079***	0.348	1.724***	0.397	2.896***	0.373
	Separated/Divorced/Widowed	1.966*	0.821	1.902***	0.367	3.504***	0.333	1.245*	0.507	2.745***	0.498
	Married or Living as Married	0	0	0	0	0	0	0	0	0	0
	(Base)	0	0	0	0	0	0	0	0	0	0
	Constant	-3.4***	0.407	-4.053***	0.265	-4.241***	0.321	-3.906***	0.363	-5.591***	0.383
	Final Model Chi²	73.553***		114.514***		303.759***		82.872***		248.457***	
	N	355		1779		1447		597		1550	

*** = significant at 0.0005 level;

** = significant at 0.005 level;

* = significant at 0.05 level

Table 7
 Combined Models for Predicting Likelihood of Having Two or More Partners in the Last 5 Years.

Model		Ireland B	Ireland S.E.	Australia B	Australia S.E.	USA B	USA S.E.	Poland B	Poland S.E.	Spain B	Spain S.E.
I	Sexual permissiveness	1.658***	0.226	0.828***	0.094	0.833***	0.073	0.856***	0.147	1.238***	0.098
	Constant	-1.901***	0.199	-2.084***	0.103	-0.426***	0.064	-1.52***	0.112	-2.419***	0.116
II	Sexual permissiveness	1.49***	0.238	0.795***	0.098	0.801***	0.075	0.808***	0.152	1.023***	0.104
	Aged 18 to 30	1.345***	0.321	1.858***	0.198	1.35***	0.16	1.067***	0.222	1.252***	0.148
	Aged 31 + (Base)	0	0	0	0	0	0	0	0	0	0
III	Constant	-2.342	0.244	-2.401***	0.117	-0.732	0.076	-1.817***	0.136	-2.769***	0.132
	Sexual permissiveness	1.47***	0.24	0.802***	0.1	0.786***	0.075	0.78***	0.157	1.058***	0.109
	Aged 18 to 30	1.378***	0.324	1.907***	0.202	1.357***	0.161	1.147***	0.231	1.318***	0.155
	Aged 31 + (Base)	0	0	0	0	0	0	0	0	0	0
IV	Male	0.599	0.322	0.614***	0.17	0.345*	0.134	1.207***	0.227	1.485***	.0168
	Female (Base)	0	0	0	0	0	0	0	0	0	0
	Constant	-2.66***	0.311	-2.754***	0.16	-0.889***	0.098	-2.527***	0.21	-3.761	0.193
	Sexual permissiveness	1.232***	0.259	0.722***	0.106	0.656***	0.87	0.628***	0.165	0.775***	0.117
	Aged 18 to 30	0.11	0.444	0.714*	0.281	1.175***	0.205	0.579*	0.289	0.003	0.214
	Aged 31+ (Base)	0	0	0	0	0	0	0	0	0	0
	Male	0.535	0.361	0.585**	0.186	0.652***	0.162	1.197***	0.241	1.402***	0.187
	Female (Base)	0	0	0	0	0	0	0	0	0	0
	Single & never married	2.64***	0.451	2.299***	0.267	2.449***	0.211	1.817***	0.31	2.839***	0.231
	Separated/Divorced/Widowed	1.092	0.665	2.324***	0.277	2.438***	0.186	1.136**	0.36	2.578***	0.306
	Married or Living as Married	0	0	0	0	0	0	0	0	0	0
	(Base)	0	0	0	0	0	0	0	0	0	0
	Constant	-3.084***	0.359	-3.162***	0.184	-2.235***	0.159	-2.805	0.234	-4.423***	0.234

Final Model Chi²

N

590.428***

1628

*** = significant at 0.0005 level;

** = significant at 0.005 level;

* = significant at 0.05 level

years for each of the five countries. Because Spain is missing information on the influence of attendance at religious services, educational level reached and area of residence, only the variables common to all five countries were included. It is thought that the omission of these three variables will not affect the results too much as these factors would probably be explained away by the effect of the sexual permissiveness scores (Indeed, when tested for the USA, Australia and Ireland, the inclusion of the three variables in the regression models did not yield any significant effects). The regression models thus include the sexual permissiveness scale (from Chapter 7), age group membership, sex and marital status. As in Chapter 5, log odds and their standard errors are reported rather than odds ratios.

Sexual Permissiveness.

For all five countries, the degree of sexual permissiveness had a significant effect on the log likelihood of multiple partnerships within both time periods, when controlling for age group membership, sex and marital status. For Ireland, a unit rise in sexual permissiveness scores increased the log odds of multiple partnerships by 1.057 times in the last year. In the Australian model, the log odds of having multiple partnerships were increased by 0.591 times. An increased log odds was also seen for the other countries (0.391 in the USA model, 0.689 for Poland and 0.449 for Spain). It is apparent that sexual permissiveness has a large effect on the log odds of multiple partnerships in either time frame for Ireland. The more sexually permissive the individual is, the higher the log odds of having multiple partnerships. Furthermore, the effect of sexual permissiveness on sexual behaviours is greater for Ireland than for the other countries. If one looks across the table 6 and 7 for each regression model, the unstandardised regression coefficients (B) for sexual permissiveness are higher than for the other countries. Even in Model IV in both tables, Ireland retains a B coefficient of over 1, in contrast to the other four countries. Furthermore, the standard errors are small, marking a lack of overlapping between Ireland and other countries and emphasises the B coefficients as being representative of the true population value. Sexual permissiveness is a strong predictor of multiple partnerships in Ireland for both the one year and the five year periods. Thus indicating that sexual attitudes and behaviours are more in line with each other in Ireland than in the other countries. The USA, which has a greater diversity of sexual behaviours and had high means and medians of sexual partners over the three measures of time, displays much lower B coefficients of sexual permissiveness than the other countries in the final models in the two tables (0.391 and 0.656). Additionally, the historical account of Irish sexuality in Chapter 6 showed that in spite of Irish sexual morality, ‘deviant’ sexual behaviours persisted. Perhaps the regression models are showing us that in the 1990s, sexual attitudes have changed to suit the patterns of sexual behaviours. People are more tolerant and more open about sexual behaviours. This would also mean a destigmatisation of STIs resulting in a greater proportion of the Irish population seeking medical help if suspicious of having an STI.

Gender.

Looking at Table 6 and 7, gender did not have a significant effect in the Irish models. This is not surprising as gender was previously found not to be a confounding factor. Gender does have an effect on the likelihood of multiple partnerships for the other countries. Males have significantly higher log odds of having two or more sexual

partners in both time periods for all countries, although the significance of these effects vary from $P < 0.0005$ to $P < 0.05$. Furthermore, the log odds are only over 1 for Poland and Spain, thus suggesting a big difference between males and females having multiple partnerships in these countries. It is possible that the difference can be accounted for by gender biases in reporting – i.e. males tend to overestimate their number of partners, while females tend to underestimate. However, there could still be a traditional division in social expectations of gender roles in sexual relations. Spanish and Polish women could be influenced by the need to restrict sexual partners, whilst males are encouraged to be sexually promiscuous. Both countries displayed higher levels of paid sex than the other three countries. Although they are a small proportion of the countries' populations, the presence of homosexual men could also be affecting the difference between the genders. Homosexual men do tend to lead a different sexual lifestyle to that of homosexual women (Wilton, 2000) and this can contribute to the greater likelihood of accumulating two or more sexual partners within a specific time period than heterosexual or homosexual women.

Marital Status.

Similar to Chapter 5, the effects of age group membership disappear when marital status is controlled for in the Irish models. However, the significance of sexual permissiveness remains. If the regression models in Chapter 5 – i.e. models including the independent variables of age group membership, educational level reached, area of residence, attendance at religious services and marital status – were run again including the sexual permissiveness variable, religious attendance becomes insignificant in the last two models for both time periods. This is anticipated, as levels of religious devotion are negatively associated with degree of sexual permissiveness. The sexual permissiveness variable would have an intervening effect on the relationship between attendance at religious services and likelihood of multiple partnerships. As in Chapter 5, those who were single and unmarried had higher log odds of two or more partners of 2.64 (for the last 5 years) and 2.183 (for the last year) than those who are married or living as married. A similar situation was seen in each of the other four countries. For both time periods, being single and unmarried significantly increased the log odds of multiple partnerships, when controlling for gender, age and sexual permissiveness. With the exception of Ireland, those who had been married but were now separated, divorced or widowed also significantly increased their log odds of two or more sexual partners for both time frames. This confirms the common practice in western societies of individuals re-entering the 'dating market' after a long-term relationship ends. This social group has recently been found to have increasing incidences of STIs in a British study on GUM clinic attendees (Merryn Gott et al, 2000). Since divorce and the right to separate was not legalised at the time of this survey, it is possible that over the proceeding years, the numbers in this category would have increased and Ireland may thus see a similar effect of this social group on its sexual behaviours.

Age.

Age group membership had varying effects across the regression models for each country over the two time frames. Spain displayed similar effects to Ireland. For both countries, there are no generational differences in the risk-taking sexual behaviour of multiple partnerships when controlling for marital status. Irrespective of

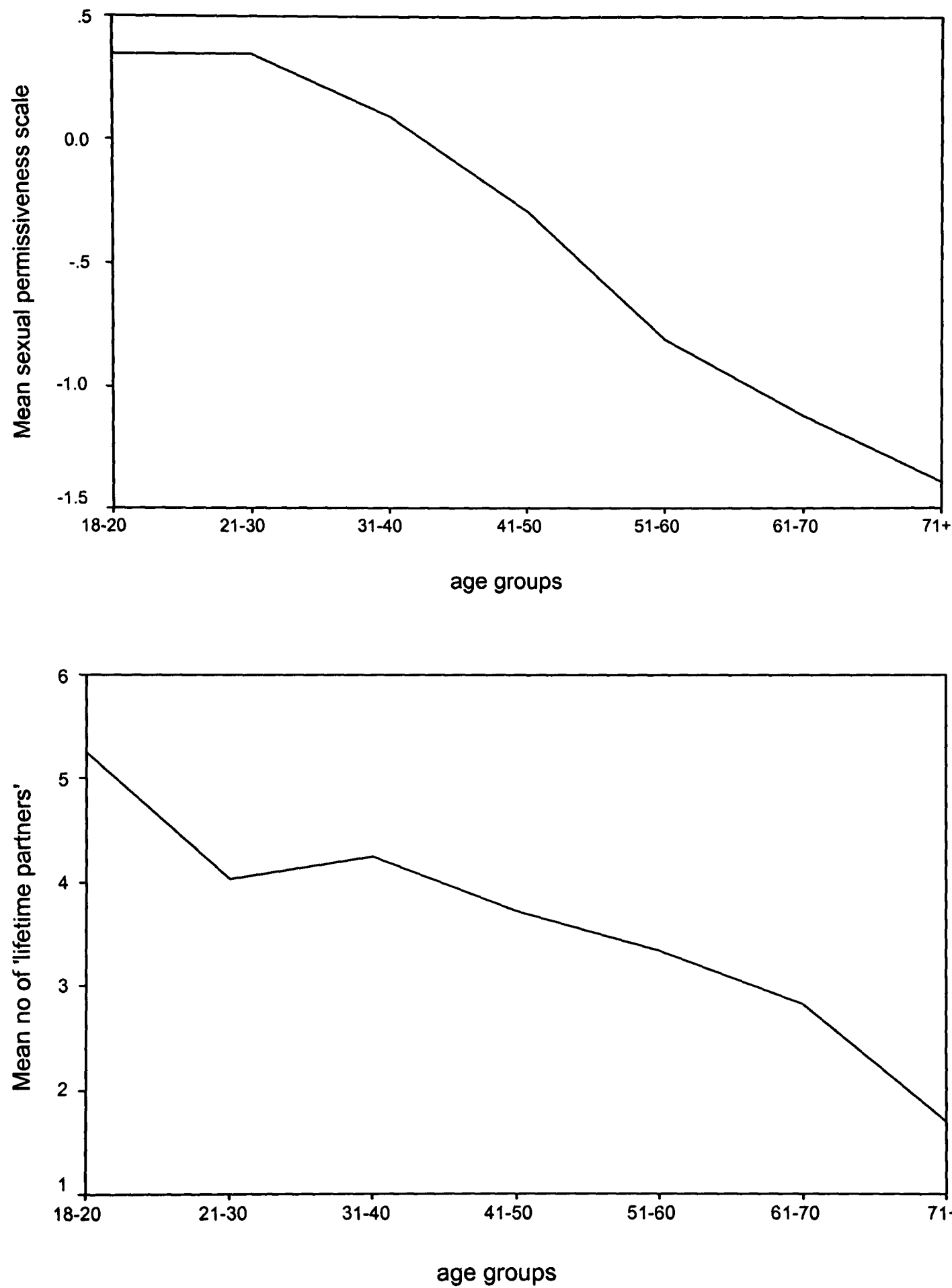
age, Irish and Spanish respondents had higher log odds of having two or more sexual partners within a year or the past five years if they were single and unmarried. Those under the age of 30 were as likely as those aged 31 and older to respect the monogamy of marriage or cohabitation. In the Polish models, age group membership also ceased to have an effect once the influence of marital status was controlled but only in the last year period. For the five year period, those aged 18 to 30 retained significantly higher log odds of multiple partnerships. This could be mediated by individuals in the younger age group marrying or settling into a long-term monogamous relationship in the last year, which would explain their difference between the two time periods. In the USA and Australian models, age group membership remained significant irrespective of marital status, level of sexual permissiveness and gender. Those under the age of 30 had a higher log likelihood of having two or more sexual partners in the last year or five years than those aged 31 and older. This indicates a strong presence of the sexually experimental stage of individuals' early sexual careers. This is in keeping with the findings of Lear (1997) where USA college students had high levels of sexual experimentation.

It is also interesting to note that in Model III in Table 6 (i.e. before the effects of age are explained away by marital status in the Irish models), the B coefficients for age group membership for the last year are smaller for Ireland than for the other countries (although it does overlap with USA). When controlling for sexual permissiveness (and gender, though that had no significant effect) in Ireland, being under 30 years has a lesser determining effect on numbers of partners in one year than other countries. This indicates that despite younger age groups being more sexually active in terms of premarital sex, their age group membership does not lead them to a greater likelihood of the risk-taking sexual behaviour of multiple partnerships. In comparison to Ireland, American and Australian individuals who are sexually permissive, under the age of 30, male and who are not married have a greater likelihood of multiple partnerships and thus run a greater risk of being exposed to STIs. Irish individuals meanwhile increase their likelihood of multiple partnerships by being single and by increasing levels of sexual permissiveness.

Conclusion:

This chapter has revealed that Irish sexual behaviours are typical of the patterns of western societies. In the logistic regression models on the prediction of the log-likelihood of having two or more sexual partners in the last year or five years, Ireland shared the same predicting variables as Australia, USA, Poland and Spain. With the exception of sexual permissiveness, the predicting variables of age, gender and marital status for the five year period yielded B coefficients for Ireland, which when compared to the other countries, placed Ireland in the middle of the five countries' results. The variables varied in their effects on multiple partnerships within each country and where Ireland differs in terms of predicting log-likelihood of multiple partnerships in the past year or five years, is the bigger effect of sexual permissiveness in Ireland. Bearing in mind that Irish sexual attitudes were more conservative than other countries, we can infer that the proportion of the population engaging in multiple partnerships is quite small (which is also substantiated by the findings of Chapter 5). Furthermore, the fact that the age effect disappears once we controlled for marital status reveals that there are not generational differences in the sexual risk taking of the Irish population. In other words, the age group who are the

Figure 4
Graphs of Mean Sexual Permissiveness and Mean Number of Life time Partners
Across Age Groups for Ireland.



most likely to report STIs (i.e. those between 18 and 30) do not as a social group mainly account for the differences in number of sexual partners within the time frames of a year or five years. Increasing the likelihood of multiple partners for an Irish individual requires sexual permissive views and a single marital status. This can be found in any age group and thus, we can conclude that those under the age of 30 are more likely to report STIs because they are more likely to be single and to hold higher levels of sexual permissiveness. Thus, they are much more likely to present themselves at GUM clinics.

Whilst we do not support the hypothesis that there has been a change in the proportion of sexual risk-taking in the Irish population nor can we affirm that there has been an increase in the actual levels of STIs, it is evident that there are generational differences in sexual attitudes and premarital sex in Ireland. Figure 4 displays the mean sexual permissive scores by age group and the mean number of lifetime partners across generations. Both graphs reveal a sharp decline from the younger age groups (those under 40). We can conclude that Irish society has encountered the trend of sexual permissiveness and the growth of premarital sex, as seen across western countries. Moreover, comparisons with the other four countries reveal that Irish development is later, which is evident from the number of sexual partners and sexual permissiveness decreasing abruptly after the age of 40. Thus, in the 1990s, Irish sexuality and behaviours were falling in line with the sexual trends as seen in other western societies.

Chapter 9: Conclusion - Explanations for the Spread of Sexually Transmitted Infections.

[Sex] happens when you're young, middle-aged, old. It happens between men and women, women and women, men and men and let's not forget, on your own. It has different meanings in different cultures. It has different boundaries and rules attached to it in different cultures and different historical times. It is not separate from the rest of our lives or concerns. We see it around us constantly, we read about it, we talk about it. And yet it remains, for the most part, an act between two people carried out in private.
(O'Sullivan, 1992: 266).

Conclusions of Thesis:

The aim of this thesis was to investigate the increased national reported rates of STIs in Ireland and the Irish sexual culture of the 1990s. Reported rates are often used by medical professionals, public health officials and epidemiologists, as proxy measures for changes in the proportion of 'high risk' sexual behaviours. This situation has arisen in Ireland with the reported rates of STIs being used as evidence of changes in sexual lifestyles and behaviours. As discussed in Chapters 1 to 3, reported rates are not adequate indicators of STIs. Moreover, if observations are to be made about sexual behaviours, then the behaviours themselves should be directly addressed rather than through proxy measures. While we cannot ascertain that the proportion of the Irish population engaging in 'high risk' behaviour has increased over the 1990s (nor can we assess whether the prevalence and incidences of STIs have risen), we can however offer a depiction of Irish sexual culture in the mid 1990s. Such an examination provides an insight into Irish sexuality and into the risk-taking sexual behaviours, which would contribute to the production of levels and rates of STIs in the Irish population.

In Chapter 1, we stated three research questions, which the thesis attempted to answer. These questions were concerned with (1) the Irish reported rates being adequate measures of 'high risk' behaviours; (2) finding differences in sexual behaviours between age group that reports the largest proportion of STI rates and other age groups and (3) discovering if Irish society held sexual attitudes and behaviours, which were typical of western societies. In relation to the first question, we found in Chapters 2 and 3 that the reported national rates are unduly affected by the collection of data from the GUM clinics. National rates are reported grossly and do not distinguish between repeat episodes and new incidences. Additionally, they include rates of 'thrush', which distort the total rates. Since the emergence of HIV/AIDS, GUM services have been extended, allowing greater accessibility for clinic attendees and GUM clinic staffs have been actively involved in secondary prevention campaigns. We also found in Chapters 2 and 3 that throughout the 1990s, the number of attendees at GUM clinics increased. This was probably fuelled by a growth in sexual permissiveness and sexual health awareness. Indeed, as seen in Chapter 7, the age group which reports the highest proportion of rates (20 to 30 years old) were amongst the most sexually permissive of the Irish respondents. With more people encouraged to seek medical help at GUM clinics rather than from their private GPs,

greater rates of attendance will lead to a greater number of diagnoses and subsequently, more episodes will be recorded. Hence the reported rates are not a direct measure of changes in risk-taking behaviours. Furthermore, as seen in Chapter 6, 'high risk' behaviours have always existed in the Irish population but the previous dominance of Irish sexual morality meant a masking of their presence.

In relation to the sexual behaviours of those aged between 18 and 30 years, we found that this age group was more likely to have had more than one lifetime sexual partner and to be more sexually permissive than the older age groups. However, the proportion of Irish heterosexual and homosexual populations exposing themselves to the potential risk of STIs through multiple partnerships were a minority. Age group membership also did not predict likelihood of two or more sexual partners within specific time frames once marital status was taken into consideration. So once an Irish individual marries or cohabitates, irrespective of age, he or she is more likely to maintain just one partner in the last year. This contrasts with the USA and Australia, where those under the age of 30 are still likely to have two or more sexual partners in the last year or five years. This suggests a climate of sexual experimentation amongst those in their early stages of their sexual careers in these countries.

In comparison with other western countries – namely Australia, USA, Poland and Spain – Ireland, overall, displayed a more conservative sexuality. However, when focusing on the sexual attitudes and behaviours individually and when examining the factors involved in predicting multiple partnerships, Irish sexual culture shared a number of traits with the other countries. Spain was the most sexually permissive of the five countries and in terms of 'high risk' behaviours, Spain had higher percentages of paid sex and homosexual sex. USA had a similar level of sexual permissiveness to Ireland, yet had a greater diversity of sexual behaviours. Furthermore, there was a strong relationship between the level of sexual permissiveness and likelihood of multiple partnerships in Ireland, indicating a greater openness about behaviours than in the other countries. When looking at one of the measures for premarital sex (i.e. lifetime sexual partners), the comparison suggests a later development in the trend of premarital sex in Irish society, with pronounced differences between those under the age of 40 and older age groups. We can thus conclude that in Irish society in the mid 1990s, younger cohorts (i.e. 40 years and under) had higher levels of sexual permissiveness and were more likely to accumulate more than one lifetime sexual partner than older age groups but, the proportion of the population engaging in sexual risk taking behaviours (i.e. multiple partnerships, homosexual sex, prostitution and concurrency) was small.

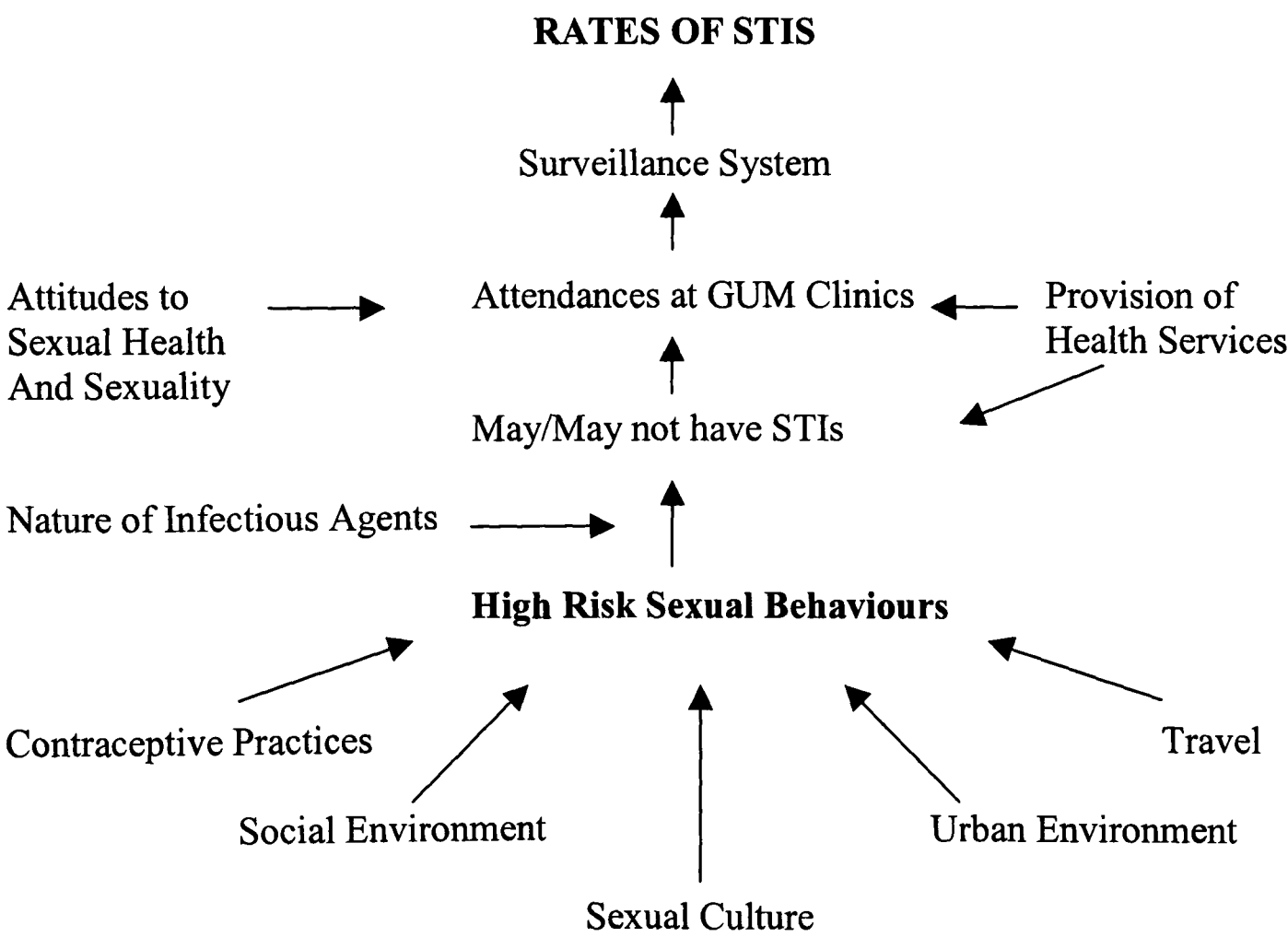
Through the comparative and socio-historical analyses of Irish sexual culture, it is clear that Irish sexual culture is in transition. Within the last two decades of the 20th century, Irish sexual culture has moved from being very conservative (arguably unusual) to being a sexual culture that is in keeping with the rest of western societies. This observation is compounded with what Coleman (2000) and White (1999) concluded about the sudden emergence and growth of the second demographic transition in Irish society before the first demographic transition had even finished. As seen in Chapter 8, levels of sexual permissiveness are strongly associated with likelihood of multiple partners, which suggests that the Irish sexual culture in the 1990s is more open about sexual behaviours than the other western countries. Moreover, this situation is in direct contrast to the past Irish sexual culture with its

repressive sexual morality. This positive change towards greater sexual tolerance has implications for the study of Irish sexuality. It has helped to enlighten our understanding of Irish sexual culture and its related social interactions in the past and during its transitional stage in the 1990s.

How do we account for the Production of Reported Rates of STIs?

This thesis has focused on three determinants of the reported rates of STIs in Ireland: Irish surveillance system, provision of GUM services and Irish sexual culture. It is appropriate in this final chapter to place these findings within the broader context –i.e. how are national reported rates of STIs produced? Figure 1 illustrates a proposed model for explaining the production of STI rates in Ireland. If we start at the rates of STIs and work down the model, we see that the rates are formed by the surveillance system, which in turn depends on the reported diagnoses from the attendees at GUM clinics. As seen in Chapter 3, attendance at the GUM clinics is fuelled by public attitudes to sexual health and sexuality and by the provision of sexual health services. In addition, individuals who present themselves at GUM clinics for STI testing perceive themselves to be at risk of the infections. This perception of risk is usually due to their engagement in ‘high risk’ sexual behaviours or they have had a partner who may be infected and/or had multiple partners with unprotected sex.

Figure 1.
The combination of mechanisms involved in the Spread of STIs in the Irish population.



The spread of STIs in a population are not solely due to individuals’ choices and behaviours. Individuals may be targeted through health promotion to instill changes in people’s sexual behaviours and contraceptive practices, but this line of reasoning

ignores what causes the specific behaviours. Engaging in 'high risk' behaviours may or may not lead to the acquisition of STIs. This is because the transmission also depends on the nature of the organism, the infectiousness of the partner and the vulnerability of an individual to infection. STIs are also socially produced. Patterns of interpersonal contact between individuals are socially regulated (Morris, 1994). The cultural and societal factors of travel, contraceptive practices, social environment and sexual culture influence an individual's sexual behaviour and perception of risk. Societal structuring also needs to be taken into account. Inequalities in the distribution of resources are reflected in health and, just like other communicable diseases, STIs are more abundant in the socially deprived. Effects of social class membership on sexual behaviour were not found to be significant in this thesis (see Chapters 5 and 7) but relating class and health statistically does not reveal the reasons for this association (Hedstrom & Swedberg, 1998). The influences of socio-economic or ethnic group membership may be mediated through the effects of urbanisation, which organises people into communities with varying societal structures, hence constituting sexual sub-cultures. We shall now explore these mechanisms that enable the risk-taking done during sexual acts to result in the acquisition of a sexually transmitted infections.

Nature of Infectious Agents:

Irrespective of society or culture, prevalence and incidences of sexually transmitted infections will be affected by the nature of the sexually transmitted organisms. The biological efficiency of transmission of organisms and their duration of infection affect the incidence of STIs in a community as much as the effectiveness of control programmes (Johnson, 1998). Micro-organisms, like other living beings, evolve and adapt to their environments in order to survive. Despite the global decline in bacterial infections, the gonorrhoea organism, *neisseria gonorrhoea* has been developing a resistance to penicillin. This has resulted in an augmentation of rates in some countries with the emergence of resistant strains being further facilitated by the growth in international travel. Furthermore, new sexually transmitted infections are constantly emerging. Since the 1960s, genital warts, herpes virus, chlamydia and other genital infections have joined the original venereal diseases. These organisms must have always been in the environment (Learmouth, 1988). Their symptoms may have previously been dismissed or misdiagnosed as those of the bacterial infections until medical research advanced enough to detect them. Modifications to their environment would also have brought them to the foreground. These include the liberalisation of sexual mores and the fall in birth-rates since the nineteenth century. The associated changes in reproductive behaviours have also quite possibly contributed to new diseases of the reproductive system and to the prevalence of breast cancer (McKeown, 1979). This means that the new diseases may have appeared as a consequence of the conditions, which led to the decline of the venereal diseases (McKeown, 1979). With societies continually undergoing change, micro-organisms which feed or rely on humans will attempt to protect their survival.

Sexually transmitted infections, like other infectious diseases, retreat after their initial epidemic stage. As previously mentioned, syphilis had shifted to a milder form of the disease by the start of the 20th century. Ironically, the fall in death rates from syphilis – like smallpox and tetanus – has been attributed to the applications of medical science, when these measures arguably made only a small contribution to the total

duction of infectious deaths (McKeown, 1979). Although, aided by societal initiatives in the improvement of public health, for example, reforms in social hygiene, the decline in severity of the bacterial infections would have been fuelled by the biological development of certain immunity from the human hosts. The viral infections are still in their epidemic phase and have not yet reached a stable endemic equilibrium incidence level in western countries (Renton et al, 1997). Until this stage is reached and further curtailed by preventative measures and effective treatments, viral infections will continue to rise. Since viral infections account for the largest proportion of STI rates in Ireland, it is probable that they will continue to augment in future years. This rise is further accommodated by the viruses causing repeat episodes and the ability of the micro-organisms to spread through close contact and not necessarily via copulation.

Spread of STIs also depends on the genetic disposition of the individual. Some people are more susceptible to getting an infection than others (Aral & Peterman, 1996). Additionally, misuse of medication has been shown to aid transmission. Sexually transmitted infections are generally seen by individuals as a threat to the quality of life not to life itself (Berer & Ravindren, 1995). People then risk infection with the perception that 'modern medicine' has developed the cures to combat life's morbidities. Advances in medicine aimed at making treatments as simple, quick and effective as possible can lead people to risk infection. The common practice of self-administered medication (antibiotics and other drugs) in western countries can compromise the immune system and leave people more vulnerable to several communicable diseases (Turshen, 1989). It can also aid the organisms, like *nesseria gonorrhoea*, to develop resilience to the effects of antibiotics. If the infected individual does not finish his or her course of antibiotics, the organism can not only become immune to the effects of the medication but can produce more aggressive strands of the organism. The results of this practice can be seen in the increase of gonorrhoea rates internationally and a similar trend can be observed in the outbreaks of more hardy TB strands in some cities in western countries. Self administered medication also has the effect of prolonging the organisms in the community (or within a network) as a high proportion of clinic attendees use available, accessible remedies before seeking professional help. Russell et al (1990) found that over half their sample, who had tried self-medication, had waited 10 days or more before seeking clinical aid. The use of self-administered medication is affected by cultural beliefs and by the elements and perceptions of doctor-patient relationships. This further illustrates the effect of social behaviours other than sexual interactions on the spread of sexually transmitted infections.

Travel/Population Movements:

Population movement has a huge impact on the spread of sexually transmitted infections. International travel and travel within countries aids the transmission of STIs and HIV. Populations are more mobile now due to improved transportation and globalisation and certain groups, such as the army forces, professional travellers, immigrants and tourists are at risk (Adler, 1995). In Africa, STIs are known to spread to rural areas through returning male migrants after temporary work in the cities (Learmouth, 1988). This also happens in many European countries, where large migrant workforces, deprived of their normal sexual partners, tend to have multiple casual sexual relationships (Barlow, 1979). As Carter et al (1997) point out,

international travel can increase STIs in three main ways: (1) geographical mobility connects sexual networks that otherwise would not have come into contact and conveys rare STIs to Europe; (2) tourism is associated with behaviour change and the possibility of risk-taking; (3) international travel is now more common than at any other period of history. Air travel also brings people in contact with countries that lack resources to monitor and control their STIs effectively. The result is a larger network through which STIs can be transmitted.

In the United Kingdom, 55% of cases of infectious syphilis were reported to have been acquired outside the country. Twenty per cent of these cases were associated with transmission in Russia or elsewhere in Eastern Europe (Ratcliffe et al, 1998). The majority of cases were transmitted heterosexually and men were twice as likely to have been infected abroad than in the UK. Women were 1.5 times more likely to have been infected in the United Kingdom. This difference was explained by male UK residents over the age of 24 being more likely to engage in unsafe casual sexual activity when travelling (Ratcliffe et al, 1998). Irish people also travel abroad whether on business or on holiday and are just as likely to encounter STIs. Increased affluence will undoubtedly bring about a growth in travel and this will have an effect on the reported incidences and prevalence of STIs in the Irish population. Unfortunately, the Irish rates currently do not differentiate between those who were infected abroad and those at home. Given the rise in package holidays - which for many involves nights of being drunk on cheap alcohol - one can speculate that travelling is contributing to the spread of STIs in the Irish population. International travel also affects HIV transmission. Since 1984, 75% of heterosexually acquired HIV infections in the UK have been associated with living in or travelling to countries in which this mode of transmission was most common (Carter et al, 1997).

Contraceptive Practices:

When looking at health seeking or health maintenance behaviours, one perplexing question lurks in the background. Why do people, who are informed about STIs, continue to risk being infected and re-infected with sexually transmitted infections? It is less hassle to avoid the infections than to get them treated. Wight (1992) reckons that health related behaviours are not simply the outcome of conscious, rational choice. Sexually transmitted infections are spread via intimate encounters, where rationale is generally viewed as the undoing of the romance. No information on sexual histories is exchanged and more importantly, the topic of contraception is often avoided. When faced with a sexual encounter, individuals draw either sub-consciously or consciously on their surrounding contraceptive culture. The meanings attached to contraceptive practices vary over time and place and between the different sexual networks of various social groups. Cultural norms regarding contraceptives do influence an individual's sexual behaviour, as what the individual perceives to be the norm of his or her immediate surroundings will influence his or her sexual practices. Moreover, they incorporate beliefs about condoms and lack of trust and intimacy.

During the HIV/AIDS pandemic, condoms were widely promoted and distributed and were regarded to have contributed to the decline in the overall prevalence of HIV (Benagiano et al, 2000). It was believed that the HIV/AIDS pandemic would make people more conscientious about preventive measures, but the recent rise in incidences of ano-genital warts and genital herpes in western countries have

suggested that there has not been as big a movement towards 'safer sex' in the population as had been anticipated (Renton et al, 1997). As the 1990s progressed, signs of 'behavioural' backsliding (i.e. termination of condom usage and increase in lifestyles of multiple partnering) were identified amongst gay men and there was an emergence of younger cohorts, who were less aware of the AIDS pandemic and its effects (Benagiano et al, 2000). Since the pandemic of HIV/AIDS, condom usage has overall increased but HIV/AIDS appears to have had little impact on sexual activities (Wight, 1992). This can be explained by a gap between public prevention campaigns and the intricacies of contraceptive cultures. The simple equation of condom with prevention of STIs can be difficult for individuals to implement when they sexually and socially interact within different circles of contraceptive acceptability. Preference for other contraceptives, gendered power relationships and condoms symbolising distrust of partner are just some of the cultural beliefs perpetuated. An understanding of these practices is necessary for effective intervention.

In Europe, there is a general tendency to bypass condoms in favour of oral contraceptive pills. The predominant use of oral contraceptives was partly fuelled by the woman's movement to take control of their reproduction and as a consequence, contraception has become equated with female responsibility. Simultaneously, the development of family planning services helped bring about a division between contraception and the prevention of STIs (Berer, 1997). Contraceptive services were aimed at women with non-barrier methods, while condom promotion and STI prevention were mainly directed at men. This results in the distinction between relationships and casual sex. Moreover, it avoids the issue that those at risk from STIs are also at risk from unintended pregnancies, this is especially true of the under 25 year olds (Berer, 1997). Contemporary commentators, such as Barlow (1979) viewed the popularity of the oral contraceptive pill and the subsequent decline of the condom as contraceptive practice as a major contributor to the rise in STIs throughout the 1960s and 1970s. Given the emphasis on contraceptives as the female's responsibility, such observations have become tainted with objections to active female sexualities. Aside from the sexual political infusion, there is some truth in the fact that people do tend to use condom or pill and hardly ever both. Condoms are more effective than pills, acting as a barrier to spermatozoa and bacteria. In relation to genital warts, use of oral contraceptives and intrauterine devices have been associated with an increased risk of genital warts (British Medical Journal, 1996; Adler, 1995). However, a recent study suggests that condoms are also ineffective against the transmission of genital warts. Apart from the ability of the human papillomavirus to spread through activities other than sexual intercourse, the virus cannot be inactivated by nonoxynol-9 (McClean & Hillman, 1997). Despite this claim, condoms do continue to offer the best protection against sexually transmitted infections. A recent systematic review of studies done on the effectiveness of spermicides containing nonoxynol-9 show that they have a protective effect against both gonorrhoea and chlamydial infection and can help to reduce the incidence of these diseases (Cook & Rosenberg, 1998).

Condoms are utilised differently in different countries, although there is a general tendency for non-Catholics to use condoms more than Catholics (Ross, 1992). Despite this observation, 39.8% of the Irish adult population are estimated to use condoms (WHO, 2000b). The largest proportion were those between the ages of 18 and 34, 54.6% of which used condoms. A gender difference did exist, with 67.7% of

18 to 34 year old males using condoms compared to 50.6% of females in the same age group. The high percentages suggest that the most fertile age group are actively using contraceptives despite religious condemnation. According to the Durex (2000) survey, condoms are also the most popular method of contraception in the other Catholic countries of Poland and Spain (40% and 58% respectively). The USA also had a high proportion of condom users – 52% in 2000, while Australian contraceptive usage was more evenly spread across the contraceptive varieties, although condoms were the most popular form at 31%. A similar situation occurred in the United Kingdom with 30% reporting to have used condoms. According to WHO (2000b), 80% of Australians and Polish people had used a condom during 1997 and 38% of Spaniards over the age of 15 used condoms during their most recent sexual intercourse in 1996. While all of these figures suggest wide usage of condoms, none of them reveal how regularly condoms are being used. Even over a short period of time – such as one sexual episode – people can engage in both safe and unsafe sex (Green et al, 2000). Such information is essential if STIs and HIV are to be prevented through ‘safe’ sex. Health promoters need to know the meanings and various practices people attach to the use of contraceptives.

During the mid-1970s, it emerged that access to and knowledge of new contraceptive methods were not enough to ensure their use (Heise, 1997). Since then, the field of contraceptive research has attempted to address the acceptability of contraceptives. Although this line of research has suffered from problems of conceptual clarity and measurement, nevertheless they have revealed some worthwhile information on the perspectives of men and women who use contraceptives. In recent years, the focus has been on the choices women make in relation to contraceptives, because they bear the highest morbidity from STIs and are more concerned about minimising unintended pregnancies. Apart from life-course effects, women’s preferences vary according to the relationship she is in (e.g. casual, new, marriage), her reproductive intentions, the power dynamics in the relationship, her sexual experience and the frequency of sexual intercourse (Heise, 1997). Studies on British women reveal that women also made decisions on contraceptives based on the ‘least worst’ option rather than making a positive choice (Walsh, 1997). This attitude prevailed in relation to condoms, where women viewed condoms as interrupting spontaneity of sex, dissatisfying their sexual partners and being unpleasant and difficult to use (Walsh, 1997). Men have similar dislikes. Condoms are considered expensive and are believed to be ineffective, reduce pleasure, create psychological impotence and interrupt the ‘naturalness’ of sexual intercourse (Benagiano et al, 2000; Aroney & Jones, 1992). Men also cited that when using the male condom, they experienced decreased sensitivity and were embarrassed about removing them afterwards (Wight, 1992). Availability of condoms is also a problem. Both the female and the male condoms are mostly available in the daytime hours and not during the hours that people would be more likely to need them (Wight, 1992).

Condom usage is greatly infused with the gendered power dynamics of the general European sexual culture. Gender-role expectations can be ascribed to sexual intercourse. Men are expected to take the initiative and women are to decide how far the sexual activity will progress (Wight, 1992). Women are also considered to be the decision makers in use of contraceptives (Berer & Ravindran, 1995). While there are exceptions, men and women are largely encouraged to conform to the stereotypes. Sexual relations have been described as social sites in which men routinely have

power over women, whether or not they consciously know it or intend to exercise their power (Aggleton & Parker, 1999; Zeidenstein & Moore, 1996). This gendered power relationship means that emphasis is placed on a man's sexual pleasure being paramount in a sexual encounter (Wight, 1992). Since many men equate condoms with decreased pleasure, women may be reluctant to mention them and men may be unwilling to try condoms. Berer & Ravindran (1995) in their study on women's views on contraceptives found that many women knew that they should protect themselves but were self-negating when confronted with a condom. Women are at ease talking about sex to their female friends but have difficulties approaching the subject of wearing a condom with their partners (O'Sullivan, 1992). An ideology persists that women who carry condoms are planning to have sex and can face being labelled as a 'slut'. She can be seen as a sexually experienced woman who takes risk and does not trust the man she is with (Aggleton & Parker, 1999). Using this theory of gendered power relationships, both women and men may find it difficult to individually control the risks. Furthermore, there tends to be little verbal communication during the varying stages of a sexual encounter. Any talking that does occur can be perceived as a sexual act in itself (Wight, 1992). This not only constrains the negotiation of sexual encounters but condoms and sexual histories are not discussed.

There is an association of the contraceptive pill with monogamy and love and the condom with multiple partners, 'one night' stands or casual relationships (Benagiano et al, 2000; Guillebaud, 1989). A similar belief persists amongst homosexual males where the use of condoms in a steady relationship is viewed as a breach of trust (Ross, 1990). Requesting the use of condoms during a sexual encounter can imply either one is promiscuous or carrying a sexually transmitted infection (Wight, 1992). Condoms can be viewed as symbols of risk and the discarding of the condom has come to mean a demonstration of trust, even if the relationship has not stabilised. Lear (1997) found that amongst USA college students, the transition from dating to relationship becomes a declaration of trust and this is shown in the change in contraceptive methods. In Ireland, low levels of contraceptive use and high levels of contraceptive failure have been reported amongst unmarried women as opposed to married women, who subsequently became pregnant (Hyde, 1996). Explanations for the levels included the deregularisation of contraceptive use as a relationship became more long-term (Hyde, 1996).

Most studies done on condom usage tend to be small-scale, qualitative and geographically limited and when viewed cohesively, offer contradictory results. Benagiano et al (2000) found systematic condom use was high amongst occasional partners and low amongst regular sexual partners. Wellings et al (1994) substantiated this in their national sex survey, where condom usage increased with the number of sexual partners within a specific unit of time. However, Ross (1992) argued that those who were in a steady relationship with one partner were more likely to use condoms than those with multiple partners. Wight (1992) also found that condom use was lower amongst those with higher rates of sexual partners. In some studies, people who insisted on using condoms were seen more positively by their partners than those who did not (Benagiano et al, 2000). Yet in others, the use of the contraceptive pill symbolized serious commitment and steady relationships generally moved towards the use of oral contraceptives from condoms (Wight, 1992). Leonard & Ross (1997) found that men and women were more likely to use condoms with new partners than

with partners with whom they previously had sex with. Furthermore as sexual intercourse becomes more frequent, condom usage generally decreases (Lagrange et al, 2000).

The varying results are not surprising when one considers that people not only differ in their sexual behaviours and contraceptive usage but long-term condom use is more difficult to practise than many people feel willing or able to do (Berer & Ravindran, 1995). Additionally, condom usage is connected to perceived personal risk of HIV, pregnancy and STIs (Wellings et al, 1994; O'Mahony, 1989; Fitzpatrick, Boulton & Hart, 1989). Individuals will decide upon usage of contraceptives in relation to how big or small they think that their probability of getting infected will be. This perception of risk will vary from person to person and hence the dual findings of condom use in both high risk and low risk groups. Yet, as a body of research, contraceptive studies can evoke insight into some general trends. One consistent finding is that the usage of condoms is negatively correlated with age. Teenagers are more likely to use condoms than older age groups (Langrange et al, 2000; Dunne et al, 1994; Giesecke et al, 1989). These reports also highlighted a decrease in condom usage as the number of sexual partners and the frequency of sex within partnerships increased. Investigations into this age-related trend can help to provide information into the reasons why individuals move away from condom usage and how the use of condoms can be prolonged for longer periods of time.

In relation to Ireland, there is a lack of information regarding people's usage of condoms and other contraceptives within their relationships, even amongst GUM clinic attendees. This information should be yielded in order to reveal how contraceptive practices could be influencing the reported incidences and prevalence. Condom usage needs to be eroticised for heterosexuals. As Gavey, McPhilips and Bain (1999) pointed out, constructions of homosexual safer sex around pleasure have had some success in changing sexual behaviours. Encouraging acceptance of condoms as part of an intimate sexual encounter can help to lower future rates of sexually transmitted infections.

Social Environment:

Sexual behaviours are influenced by a range of cultural practices outside those of sexual cultures. One important cultural influence is that of alcohol consumption, which has a large effect on sexual behaviours. This association has long been established throughout the history of sexually transmitted infections (Davidson, 2001). Current studies, such as Leigh & Stall (1993) have found that young people who drink alcohol were more likely to participate in high-risk sexual activity than people who abstained from drinking. In other words, the custom of socialising in a bar, pub and night-club, where high levels of alcohol are consumed, can lead to sexual interactions, which are mostly of the casual kind and are quite likely to be unprotected. Leonard & Ross (1997) reported that 50% of the men they surveyed in Houston, Texas, USA (an area where syphilis is roughly five times the national rate) were drunk or high the last time they had sex. These sexual interludes largely consisted of casual sexual encounters with misused or absent condoms. Unprotected sexual encounters with prostitutes are often related to alcohol consumption (Lim et al, 1995).

In most European countries, there has been a growth in the consumption of beer, a stable consumption of spirits and a lower consumption of wine (World Drink Trends, 1995). This trend is replicated in Ireland and over the last decade of the 20th century, Irish consumption of alcohol increased enormously, in particular the intake of beer. In 1995, Ireland ranked 11th in total alcohol consumption per capita consumption by country but by 1998, it had moved to 4th position (ALCOWEB, 2000). This jump is remarkable when in the same period Spain moved from 5th to 7th place, United Kingdom remained unchanged at 21st rank, the USA fell from 24th to 27th position and Poland dropped from 27th to 29th place. Consuming over 10 litres of pure alcohol is considered a level of risk for a country and in 1997, Ireland had reached a level of 10.7 and it has continued to escalate (ALCOWEB, 2000).

Ireland certainly has a tradition of drinking. In the 1970s, over one million pounds a day was spent on alcohol in Ireland (Sweetman, 1979). However, the recent growth in bars, alcohol consumption and in the popularity of watching sports on wide-screens in pubs, have attracted even more regulars to the pub social scene. The rise in consumption can be associated with the growth in affluence in Ireland, which allows for more disposable income for social occasions. Furthermore, the largest percentage of people drinking more than the recommended limits of alcohol were in the 18 to 34 age group (Department of Health and Children, 1999). This age group incorporates the highest risk group of STIs in Ireland and the majority of cases seen at Irish GUM clinics are between the ages of 20 and 30 years. Urban centres do attract concentrations of young, single people under the age of 35 and socialising is to a large extent reserved to public bars, nightclubs, parties or dining. A large proportion of cases seen at Dublin clinics in the 1990s were the result of casual sex after an alcohol-fuelled night at a nightclub (Quinlan, 2000). It is very probable that the increase in alcohol consumption throughout the age groups most likely to engage in casual and short-term relationships (that is the under 30s) has affected the rates of sexually transmitted infections. Jonsson et al (1997) found that 'binge' drinking was more widespread in the under 30s and more socially accepted. Furthermore, 'binge' drinkers were found to be more likely to engage in unplanned sex. They concluded that high-risk sexual behaviours and the general pattern of risk-taking behaviours such as the use of alcohol tend to occur together.

Another common aspect of the pub or social culture, which is worth mentioning in relation to STIs, is smoking. Smoking tobacco has recently been associated with diagnoses of genital herpes (Schofield et al, 2000). It can make a person more vulnerable to an attack either by its prolonged use making the physiological system unhealthy or through short-term increased usage as a stress-relieving channel. Stress is a major catalyst for genital herpes (Posner, 1998). In 1994, the estimated annual consumption of cigarettes in Ireland per person was 1,722. The EU average was higher at 1,749 (Department of Health and Children, 1999). Smoking is most prevalent amongst teenagers and college students in Ireland. The use of cigarettes is not only connected with peer pressure to be seen as 'cool' but with the academic competitiveness at school and college (Johnson & Hoffman, 2000). This combination of stress, cigarettes and can help make young adults very vulnerable to sexually transmitted infections.

While it is common knowledge that injecting drugs aids the transmission of HIV, general drug use can help to increase the risk of other sexually transmitted infections.

Use of cocaine was closely associated with increased rates of syphilis in the early 1990s in the USA (Drusin, 1996). In the early stages of addiction, 'crack' (the form of cocaine that can be smoked) can stimulate sexual drive. Other drugs such as ecstasy and cannabis also enhance sexual desire and feelings (Headon, 1999). A US study on the use of drugs amongst 18 to 24 year olds in inner city neighbourhoods found that users of non-injected heroin, 'crack' and injected drugs were more likely to report a sexual history of concurrent sex partners, commercial sex work and unprotected sex (Flom et al, 2001). With media reports of increased drug taking amongst young people in Ireland and the establishment of drug use in many popular sub-cultures (for example, 'raves'), it is likely that the use of drugs when socialising is having an effect on the rise in reported sexually transmitted infection. This assumption does need further investigation.

Urban Environment:

Socio-economic and ethnic groups vary in their risk of infection (Lacey et al, 1997; McKeown, 1979). The lower the socio-economic group, the higher the risk. Studies done on the rates of gonorrhoea in Britain during the 1990s, have revealed that despite the national decline in rates of gonorrhoea since the 1970s, it is disproportionately prevalent and is increasing amongst deprived inner city populations (Lacey et al, 1997; Day et al, 1998; Hughes & Fenton, 2000). Transmission of HIV in western societies is also endemic within socially disadvantaged groups (Nicoll & Gill, 1999). Some commentators have argued that socio-economically disadvantaged groups persistently have had the highest morbidity in relation to sexually transmitted infections throughout industrialised countries (Adler, 1997; McKeown, 1979). Others point out that it is problematic to link social class to STIs, when the transmission of the infections also takes place within groups who are not disadvantaged and have access to information, condoms and treatment (Klouda, 1992). Certainly, there has been a bias in some of the data pertaining to the link between social class and sexually transmitted infections. During the 1960s, private physicians in the USA treated about 80% of the patients with sexually transmitted infections, yet only the remaining 20% got reported. (Drusin, 1996). These reported cases usually represented those patients treated in public clinics. Since lower socio-economic and minority groups are more likely than affluent people to be treated in public clinics, there was thus a greater representation of the disadvantaged (Drusin, 1996). Lacey et al (1997) also maintained that the free, open access services of GUM clinics in the United Kingdom had an influence on their case ascertainment in their study on the socio-demography of gonorrhoea in Leeds, UK. However, it should be pointed out distribution of health services varies geographically and poorer facilities largely exist in decaying inner cities, which ethnic and lower socio-economic groups frequent. This has repercussions about the kind of treatment the patients receive. Furthermore, social inequalities in health have been stable or increasing since the advent of universal access to health care systems, which implies that the causes of socio-economic differentials are outside the medical system (Ross & Mirowsky, 2000).

The distribution of ethnic minorities in industrialised countries, such as Britain tends to be concentrated in urban centres, with a large proportion living in socially and economically disadvantaged areas. Studies on British cities, such as Lacey et al in Leeds (1997), routinely show that STIs are more common amongst the black community, with black men aged 20 to 29 usually being the highest risk group.

Reported rates of some sexually transmitted infections, like gonorrhoea and syphilis are about thirty times higher for African Americans than for whites in the USA. The history of slavery and racism in USA has contributed to the present social environment of Afro-Americans, which places them as the most disadvantaged members of the society (Thomas & Quinn, 2000). In Australia, Aboriginal women were seen to have extremely high levels of STIs by world standards (Schofield et al, 2000). STIs are disproportionately high amongst the Maori people in New Zealand and while this is partially due to an increase in attendance at sexual health clinics and improved contact tracing, there is a link between the sexual-mixing patterns of the ethnic group. Maori teenagers have sexual intercourse at an early age, high rates of pregnancy, a large number of life-time partners and tend to avoid contraceptives (Turley et al, 2000). Moreover, they have limited access to health services and are affected by their low socio-economic status (Turley et al, 2000).

While these studies consisted of small samples from discrete urban areas and may not in themselves represent the population from which they are derived, together they do highlight inequalities in sexual health in relation to ethnic groups. Ireland has seen its ethnic minorities grow extensively throughout the 1990s with the arrival of asylum seekers from war-torn or economically deprived countries. Given that the Irish GUM clinics are free and situated in large urban centres, which attract asylum seekers, asylum seekers are attending the clinics and their growing numbers do contribute to the rising rates. The Irish newspaper, *The Irish Examiner* reported on January 7th 2002 that half of all new HIV cases at Dublin's GUM clinics were found amongst asylum seekers. However, instead of instigating methods of investigating the social factors involved in the prevalence and incidences of STIs in these groups, health board officials have called for mandatory medical testing of all asylum seekers entering the country. This move can have further ostracising effects for the people involved. It could be argued that surveillance data should include ethnic details and this could guide interventions to reduce inequalities in health between different ethnic groups (De Cock & Low, 1997). However, the use of data analyses by ethnicity when investigating sexual behaviour or STIs is in danger of associating disease with racial groups. Such an analysis could suggest a spurious biological connect and can lead to detrimental social and political consequences such as stereotyping, quarantining and 'blaming the victim' (Ross, 1998)¹.

Despite the fact that a disproportionate number of Afro-Americans live in poverty, Low et al (1997) and Jolly et al (2001) found that the inequality in STI rates still persisted after adjustment for the effects of socio-economic status. The same results were found for inner London, where black African and Caribbean heterosexual men and teenage women were the most heavily affected by the complications of STIs than others of the same socio-economic group (Low et al, 1997). Dynamics of ethnic sub-cultures have a strong role to play in determining the transmission of STIs through

¹ The prevalence of sexually transmitted infections amongst Afro-Americans has already been the subject of racial exploitation. The longest running human experiment ever was the Tuskegee Syphilis Experiment in Alabama, USA. A group of Afro-American men from a low socio-economic were purposefully left untreated with syphilis in order to study the effects of the infection and the physical pain it caused (Gilmore & Somerville, 1994). The experiment ran for 40 years between 1932 and 1972. Its participants, who were ignorant of the study, initially sought treatment for their condition but only received minimal help in the pursuit to study the characteristics of the disease (Thomas & Quinn, 2000).

norms, values and beliefs on sexual lifestyles and health seeking behaviours. Jolly et al (2001) explained that the high rates of STIs amongst Afro-Americans were due to the limited sexual mixing between Afro-Americans and other ethnic groups. This confined STIs to within their sexual networks, resulting in those with low rates of partner change being more likely to mix with those with high rates of partner changes. Settlements in urban neighbourhoods do create communities, the characteristics of which are perpetuated in the social networking of their members.

In relation to STIs, it is predominantly urban areas that report the highest rates of sexually transmitted infections. Static geographical distributions of STIs in western societies demonstrate distance decay round main urban centres with concentrations in inner city and suburbia and clusters among main travel routes (Learmouth, 1988). In conjunction with this, studies on prevalence of 'high risk' sexual behaviours, such as Johnson (1998), discovered that urban centres like inner London had marked variability in sexual behaviour when compared with residents elsewhere in the country. Area of residence plays a huge role in mediating the relationship between an individual's socio-economic status and having poor health (Mitchell et al, 2000). This is because health is affected by contextual factors (Ham, 1992; Turshen, 1989). These relate to the environmental context² of an individual and the surrounding social structure³ (Shaw, Dorling & Mitchell, 2002). Residing in an urban area can be bad for sexual health.

Urbanisation groups people into neighbourhoods of similar income or social status. These neighbourhoods vary in their allocation of state services, schools, shops and housing. The lower the socio-economic area, the poorer the access to social capital and provision of health services. Furthermore, the poorest tend to reside in inner-city areas, which are marked by their lack of social resources and social disintegration. In Ireland, inner-city dwellers are among the poorest in Irish society and tend to be unemployed and live in mostly rented accommodation in deteriorating buildings (McKeown, 1986). Urban renewal and movement to suburbia by the middle classes and by industry have depleted the stock of social capital available in inner-city areas, thus impairing school performance, job renewal, drug and crime avoidance and access to health services. This social disintegration has been recognised as a crucial co-factor in the spread of HIV infection in western societies (Gillies, Tolley & Wolstenholme, 2000). Wallace (1993) argued that the displacement of population from disadvantaged areas fragments the social network of the neighbourhood. This weakens informal and formal access to social capital, resulting in lower economic opportunities, poor access to services, drug dependency and multiple sexual partners (Wallace, 1993, as cited in Gillies, Tolley and Wolstenholme, 2000). When examining why the 1990 syphilis rates in the USA were the highest for 40 years, Drusin (1996) found that the largest proportion of these cases were amongst the heterosexual, lower socio-economic black men and women. Like Wallace (1993), the transmission of sexually transmitted infections was argued to have been facilitated by residence in a disadvantaged area.

How are people's sexual behaviours influenced by social circumstances? Individuals, when confronted with the probability of a sexual act, do consciously

² This addresses whether or not an area is urban or rural and the level of pollution.

³ Social structural effects include income, education, nutrition, housing, access to amenities and the social support of the community.

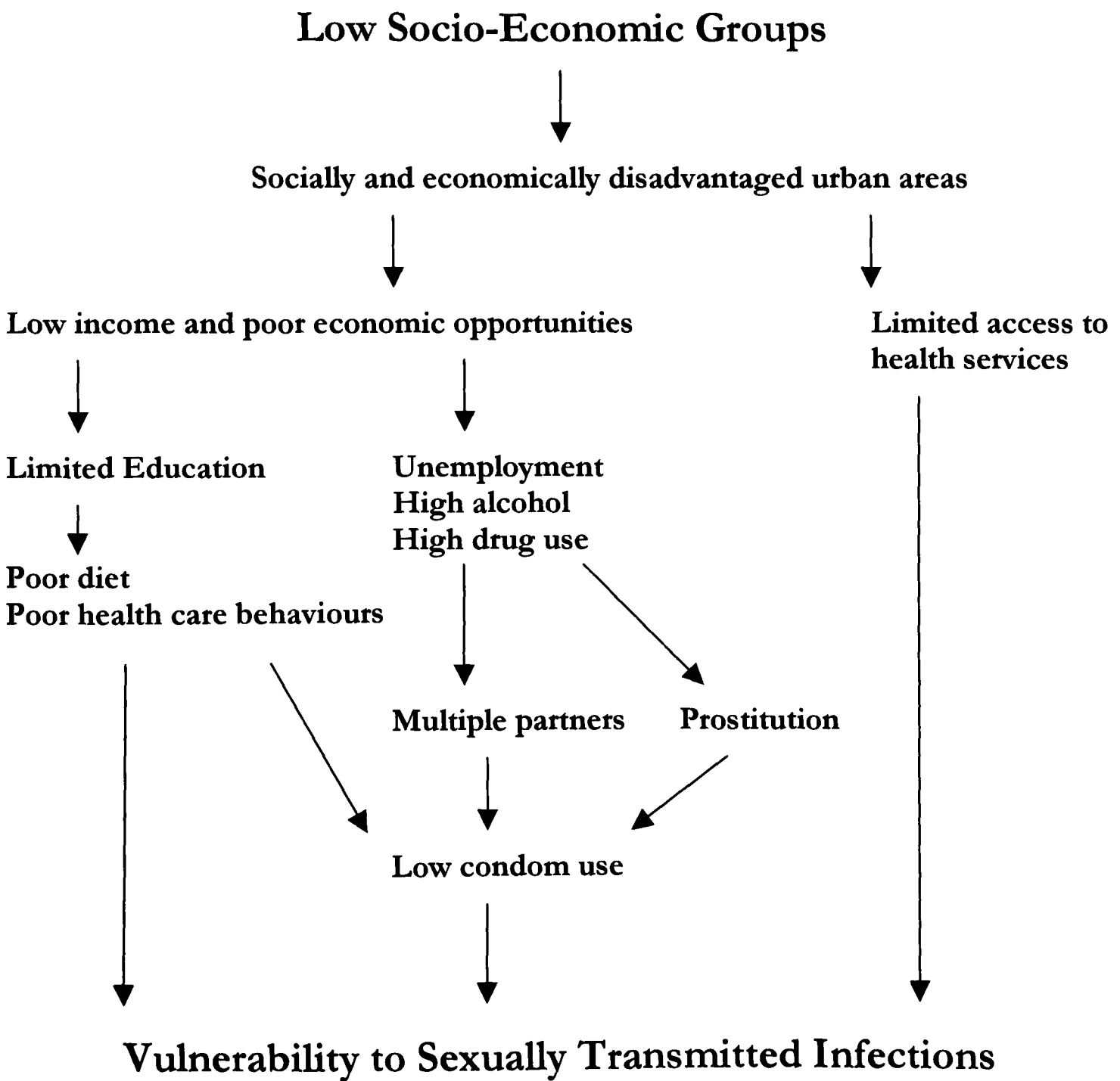
assess their risk-taking, however, sexual encounters are usually not deemed appropriate moments to be rational by the participants. Many times what drives people to certain behaviours is not entirely within their control. As illustrated in Figure 2, vulnerability to being exposed to STIs is facilitated by a number of mechanisms arising from the congregation of low social economic groups, including ethnic minorities and immigrants, in socially and economically disadvantaged areas. These areas are characterised by low income, poor economic opportunities and limited access to health services. Allocation of health services' resources does vary between urban areas and commonly, the provision of services is lacking in low socio-economic residential areas. Often, patients have to travel to a suitable GUM clinic elsewhere in a city for free treatment and this inconvenience can help prolong an STI in the population whilst a patient waits to do the journey or uses self-medication instead. In Ireland, where the number of GUM clinics is small, patients may wait until they can no longer bear the symptoms before travelling across a city for treatment. Furthermore, people with low income can only access free medical care at certain times at certain medical centres, many of which cater for a large number of urban communities. When people delay in seeking medical help and continue to engage in sexual activities, they place their community at risk from infection via the sexual and social networks of the neighbourhood. By delaying to seek medical attention, they help to increase the prevalence and the incidences of STIs in the community.

In relation to low income and poor economic opportunities, the pressures of these factors can lead to limited education, unemployment, drug and alcohol abuse and prostitution, all of which aid the spread of sexually transmitted infections. Limited access to education plays a determining role in the spread of sexually transmitted infections. Schofield et al (2000) found that the higher the education status, the lower the prevalence of syphilis in a female population. People in lower socio-economic groups do tend to have lower education status and limited access to education. Therefore poor education can affect preventive measures. As Morgan et al (1985) remarked, lower socio-economic groups tend to make less use of preventive health services than other groups, for example childhood immunisations. This could mean that there is a limited acceptance of contraceptives as well as little knowledge of sexually transmitted infections. Additionally, lower socio-economic groups, in particular ethnic minorities within this grouping, have been associated with poor health care behaviours. Israelski et al (2001) measured the adherence to treatment regimens amongst HIV seropositive patients and discovered that African-Americans from lower socio-economic groups were more likely to miss scheduled appointments and heterosexual females were not consistently accessing medical care. They connected this behaviour with a prevalent cultural notion that people should only visit the clinics when very ill. This lack of health seeking behaviour not only results in HIV remaining unmonitored in the community (and the possible development of drug-resistant HIV strains) but it also means that those suffering from STIs may not attend clinics until the symptoms are severe. This can allow the infection to spread further through a sexual network. Furthermore, limited education can mean limited information about the use of condoms in HIV prevention. Condoms are expensive and without persuasive education and provision of free condoms, people may be deterred from using them. Combined with low income, limited education about health does also lead to meagre nutrition. Poor diet is common amongst the lower socio-economic groups. Lacking in some essential food groups or malnutrition can

lower resistance to disease by depressing the immune response to common diseases which are tied to economic status, for example TB. These diseases weaken the immune system and aid the transmission of STIs (Green, 1999; Turshen, 1989).

Unemployment has also been found to be a risk factor for ill health, including infectious diseases (Fitzpatrick & Chandola, 2000). The longer people are out of work, the longer there is a lack of household resources and the more stressful the environment. Moreover, recent research on health and the unemployed in Britain found high rates of smoking, alcohol and poor diet amongst the unemployed (Bartley, 1994) - factors which have an effect on the vulnerability of an individual to sexually transmitted infections. High levels of alcohol and drugs are associated with disadvantaged areas. House (2002) argued that immoderate drinking is significantly most prevalent amongst lower socio-economic groups in western countries. In Ireland, the largest consumption of alcohol is amongst males in lower socio-economic groups (Department of Health and Children, 1999). The recreational use of drugs along with high levels of alcohol consumption creates opportunities for the transmission of STIs, as people are less inclined to protect themselves and are more

Figure 2
The Socio-Economic Production of Sexually Transmitted Infections.



likely to risk take. Drug dependency is affected by damaged mechanisms of social control and by the breakdown of social and familial networks within neighbourhoods. Many resort to drugs to escape the pressures of everyday life. Moreover, individualism is heightened by the disintegration of networks and besides indulgence in crime and drugs, individuals partake in short-term sexual relationships. Sex can be viewed as an intimate interaction whereby condoms are foregone in an effort to produce trust. The length of a relationship can be affected by the pressure of the social circumstances and with the combination of drugs and alcohol, sexual activities can end up being casual encounters.

Unemployment, low income and status can lead the impoverished to seek work in prostitution. Traditionally the disadvantaged have been disproportionately recruited into prostitution (Day & Ward, 1997). Prostitution in Ireland is reported to be on the rise due to the country's economic prosperity, which increases the amount of disposal income available for the market of sexual services. Many, in particular refugees, are turning to prostitution or work in the sex industry as a means to improve their standard of living (O'Brien, 2000). Irish teenagers often enter street prostitution due to a weakening of familial financial circumstances or addiction to hard-core drugs (O'Brien, 1999). Sex workers are further internally stratified by STIs, by the type of sex work. Drug users tend to be attracted to street prostitution, where the risk of acquiring a STI is much greater. Street prostitutes have weaker bargaining power for condom usage than those in off-street prostitution, where the clients have to adhere to certain sanctions in the pursuit of sexual services. The structure of off-street prostitution, such as brothels, masseuse bars and sex clubs does mean better access to preventative measures. In Australia, sex workers working in brothels reported low rates of STIs and HIV due to the wide availability of condoms (Day & Ward, 1997). Male, transsexual and transvestite prostitutes generally report higher rates of STIs than the female sex workers (Day & Ward, 1997). This could be linked to their greater recruitment into street prostitution or to the fact that they meet their clients in public places such as parks, clubs and toilets. Irish male prostitutes between the ages of 12 and 25 get involved in this form of sex work as a means to aid their drug addiction (O'Sullivan, 1998). They are often poorly educated and have frequently been the victims of sexual and physical violence (O'Sullivan, 1998). The effect of prostitution on the sexual network involves both commercial and non-commercial partners and the risk of STIs can be further augmented by alcohol and drug use.

STIs are affected by factors other than individuals' choices of lifestyles. The social structure and environmental context surrounding an individual can influence his or her behaviour regarding exposure to sexually transmitted infections. When faced with a sexual encounter, an individual acts according to feelings and thoughts that have been moulded by his or her social and cultural environment. For people who have poor access to social capital and live in disadvantaged urban areas, they are more likely to be exposed to the risk of STIs due to a variety of social factors. Sexual health programmes should take this into account and more research is needed to yield further explanations and to determine effective intervention methods.

Sexual Culture:

Whilst this thesis does refer to the national sexual culture of Ireland, a nation contains a number of sexual cultures or sub-cultures, which vary by geographical location,

social class, social context, age group and even by occupation. Sexual behaviour is the outcome of social interaction, not only individual attitudes and beliefs. Moreover, sexual activity and risk related behaviour are influenced by social and cultural phenomena (Flowers et al, 2000). As a result, the use of safe sex is constrained by the immediate context of sexual encounters, such as negotiation with a partner while intoxicated, the availability of condoms and prior perception of risk. This stems from the cultural values that are formulated from the shared lifestyle of people with similar future expectations and other social behaviours (Wight, 1999). Lear (1997) has argued that amongst US teenagers, the sexual culture is one of sexual experimentation, alcohol use and socialisation with people who share similar sexual values. Additionally, the US teenagers in her study moved in a sub-culture that had been supplied with inadequate sex education at school and a lack of information from parents, leaving the teenagers with little understanding of the intricacies of sexual relationships. Most discussions on HIV and risk-taking have focused on the determination of an individual's perception of risk as a measure of 'high risk' behaviours. Such explanations draw on the Health Beliefs Model and from Social Psychology, the Theory of Reasoned Action and the Theory of Planned Behaviour (Green et al, 2000). These models argue that individuals' perceptions of susceptibility to a health threat influence their sexual behaviours. People's perceptions of STIs will affect whether or not they seek medical help (Duncan & Hart, 1999). However, these models overlook the fact that individuals are not necessarily rational in terms of their response to risk and more importantly, they ignore the constraining influence of social factors (Gabe, 1995). In popular accounts on HIV, subjective cultures were viewed as protecting the individuals from infection (Jones, 1999). Hickey et al (1994) found in their study of HIV infected drug users that, despite possessing knowledge of the disease, people were unrealistic about the possibility of transmitting or contracting HIV from those of their own age or social group.

Sexual networks and culture shape the characteristics of sexual partnerships. These have recently been shown to affect risk-taking sexual behaviours. Although limited to GUM clinic populations, studies focusing on STIs and high risk behaviours have identified the following partnership characteristics as important contributors to exposure to STIs: (1) setting where partners meet; (2) duration of pre-sexual period; (3) frequency of sexual activity and (4) condom usage (Lindblade et al, 1994). Setting where partners meet and duration of pre-sexual period affects the nature of trust. For example, people who met through friends may be less likely to practise safe sex and have a shorter pre-sexual period than partners who meet in a nightclub. Shorter pre-sexual periods can lead to lesser knowledge of sexual histories. A greater frequency of sexual activity may also occur because the relationship is defined sexually due to the limited time spent acquainting with each other non-sexually.

The social circle within which the couple met, may affect the use of condoms. The couple are not only surrounded by the values and beliefs of the localised sexual culture but familiarity with those who introduced the couple to each other may indirectly influence the couple to forego condoms in an effort to symbolise trust. Sexual intercourse that occurred amongst heterosexual friends in a US college population was less likely to be protected as either the partners trusted each other on the virtue of being friends or had consumed alcohol (Lear, 1997). In a study on GUM attendees in two of Dublin's clinics, heterosexuals who had syphilis met their sexual partners primarily through friends, whilst a third of them regularly met their sexual

partners at nightclubs (Hopkins et al, 2001). People with multiple partners have been shown to express partnership characteristics, which are considered to aid the spread of sexually transmitted infections. Jonsson et al (1997) demonstrated that sexual intercourse on the first date mostly occurred between partners who indulged in risky behaviours including multiple partners in a specified period of time and were also more likely to be infected with a sexually transmitted infection. In a US college population, as the number of sexual partners increased, women were more likely to report partnership characteristics associated with an increased risk of acquiring a sexually transmitted infection (Lindblade et al, 1994). Partnership characteristics are useful for tracking the spread of STIs through the use of network analysis (Riolo et al, 2001).

When considering the spread of STIs in a population, external factors to the individual play an important role. These factors are both social and cultural and despite sex being an intimate encounter in the private sphere, individuals do not always act as rational beings. Behaviour can be influenced by the surrounding culture of alcohol, drugs, sexual experimentation, peer groups as well as social pressures such as work-related stress and the psychological need to be wanted. Increases of STIs in sub-populations can be thus explained by changes in cultural or behavioural practices and/or social structural factors. Unfortunately, in Ireland, information is not available on differences in the epidemiology of STIs between groups and research is warranted on the sexual practices of different social groups.

In this chapter, we proposed a model for explaining the production of rates of STIs. However, in doing so, we have unearthed the complicated relationship between sexual behaviours and rates of STIs. This thesis tackled the Irish national sexual culture and the role of the GUM services in the production of rates. Viewed in terms of the model, it may seem like a small contribution but nevertheless, it is an initial step towards understanding STIs and sexual behaviours in the Irish population.

Conclusion: Can the Spread of STIs in the Irish Population be Understood?

Reported rates of STIs have gone up but information on the true levels of STIs and on the 'high risk' groups evades us. Having utilised the available data on Irish sexual culture and STIs, it is evident that further sociological investigation is greatly needed to address the issue of STIs and Irish sexual culture. Given their role in the rates of STIs, a study on the operation and provision of GUM services would help to address issues of preventing and treating STIs. You cannot disentangle rates of STIs from changes in provision of GUM services. The two things are intertwined so until the effects of the improved services are understood, any conclusions about the rates may be flawed. Furthermore future preventative strategies need to be mindful of the purveying hindrances of STIs prevention as discussed in Chapter 4. Campaigns that are tailored to target the 'core' groups should be based on the current evidence. Information needs to be relevant to the lifestyles of the social group in which the intervention is trying to instill change. Apart from a national sex survey (which could depict contraceptive usage, sexual risk taking, the variety of sexual practices as well as general sexual attitudes and behaviours), the study of the spread of STIs in Ireland would benefit from a sexual network analysis.

Through the utilisation of the ISSP dataset, the assessment of the likelihood of multiple partnerships provided an indication of the proportion of risk taking sexual behaviour in the population. However, the risk of transmission of STIs is better understood through the analysis of sexual networks within populations than through analysis of 'individual' risk factors (Day et al, 1998). Such an examination involves the techniques of social network analysis. Instead of analysing individual behaviours, attitudes and beliefs, social network analysis focuses on social actors in interaction with one another (Galaskiewicz & Wasserman, 1994). A population is described as a collection of individuals who are connected by links that represent social partnerships (Scott, 2000; Kretzschmar, 2000). In sexual network analysis, these links represent sexual encounters and through the study of these connections between individuals, we can map the channels of transmission of STIs from the micro (individual) to the macro (national) levels. The network models can describe the position of individuals within the network of sexual partnerships (Garnett, 2002). Through an examination of where people are placed, we can identify the groups and individuals most likely to be affected by STIs. This allows for a more complete identification of the risks for acquiring and transmitting infections. Despite the fact that the mathematical models are labour intensive and costly to run (Day et al, 1998), social network analysis is becoming more popular amidst the fields of HIV/AIDS and STIs (Friedman & Aral, 2001). Furthermore, contact tracing embodies network concepts (i.e. contains information on sexual partners, their partners, length of relationships and duration of infectious period). This could provide a good source of data for network analysis if the data is centralised, computerized and data management is efficient and consistent (Jolly et al, 2001).

Explaining the reasons for the increase in the rates of sexually transmitted infections has always been a complex task. In the 1970s, Leeson & Gray (1978) tried to account for the rise in STIs in Britain and concluded that the increase in an affluent era was paradoxical as previously, increases had occurred in times of war or economic crises. They considered possible changes in sexual behaviours, especially in women, and the growth in the popularity of oral contraceptives. Acquisition of sexually transmitted infections is determined by a number of mechanisms. The nature of the organisms, the effects of cultural behaviours, international travel and societal factors all contribute to the transmission of STIs in a population. However, it is the increase in the reported national rates in Ireland that is under investigation here and while all the mechanisms mentioned in this chapter play a role, none of them have influenced the rates to the same degree as the organisation of the Irish GUM services and the surveillance system.

Appendix I: Appendix to Chapter 1 - Definitions of Sexually Transmitted Infections.

For the purpose of the study on the Irish rates of sexually transmitted infections, only those infections that are likely to be reported in Europe will be defined.

HIV/AIDS and Hepatitis.

Two strains of the human immunodeficiency virus (HIV) are responsible for acquired immune deficiency syndrome (AIDS). HIV type 1 is the most common cause of AIDS worldwide and evolved from a subspecies of chimpanzee *Pan troglodytes troglodytes*. HIV type 2, which is relatively widespread in West Africa, is very similar genetically to the simian immunodeficiency virus endemic amongst Sooty Mangabeys (Thin, 2000). It is believed that the HIV virus has been present in Africa for decades and that there may have been sporadic human-to-human transmission. Since local populations remained stable, these transmissions would have gone unnoticed and the virus would have died with the host. The changes in demographic and social conditions with urban development, such as migration from rural to urban areas, family break up, prostitution and increased numbers of sexual partners, are considered the reasons for the current modern epidemic in Africa (Thin, 2000).

HIV is a retrovirus (RNA virus). This means that it lacks DNA and depends on the DNA in other bodily cells to reproduce. It infects the lymph glands and destroys lymphocytes through gene alteration, i.e. it randomly transcribes and inserts its RNA into the DNA of the host cells. Lymphocytes have an important role to play in the human immune system. They are responsible for producing the antibodies needed to fight diseases and infections. Because HIV develops in these cells, the body cannot become immune to the virus and the immune system is weakened by the destruction of the lymphocytes. When there is another disease or infection present, the lymphocytes are activated but this will also increase the production of HIV. Another important factor in the spread of HIV virus is the fact that lymphocytes are the most common migrating cells in the body. They reproduce at such a rapid rate that all lymphocytes can be replaced by the body within a 48 hour period. This also means that HIV positive people can become more infectious to others as time passes (Cox, 1999). People do not die from HIV but from one of the many opportunistic diseases, infections or cancers that develop because of a weakened immune system. These include pneumonia, chronic diarrhoea and the rare cancer, Kaposi's sarcoma. Eventually, HIV causes cell (lymphocyte) death, resulting in AIDS. Although most HIV positive people will develop AIDS, it is unknown if all such carriers will develop AIDS. To date, approximately 5% of HIV positive people remain free from progressive disease and maintain normal cell counts for a decade or more (Cox, 1999).

Despite the decline in deaths from AIDS due to the Highly Active Antiretroviral Therapy (HAART), the immune system cannot be repaired once it has been damaged by HIV. The virus can remain in the body for 10 years or longer before the immune system weakens to the point where the virus takes over. Once AIDS symptoms appear, the typical life span is 18 to 24 months. HIV is transmitted sexually via receptive anal-rectal intercourse, fellatio, cunilingus, vaginal intercourse. While the

lining and environment of the vagina is not hospitable to HIV, sperm or lymphocytes, the cervix and the uterus have a single layer of cells that are easily penetrated by the HIV virus. The risk of transmission for a single episode of sexual intercourse with a known HIV-infected partner is actually small and depends on the existence of other variables. Variables associated with increased risk of sexual HIV transmission include anal intercourse, duration of sexual relationship, cervical ectopy, frequency of sexual contact, lack of antiretroviral therapy, lack of condom use, low CD4 count, presence of other STIs and sex during menses (Haverkos & Quinn, 1995). Uncircumcised men are also 10 times more likely to become infected than circumcised males (Cox, 1999). Male to female transmission is about 50% greater than female to male transmission (Haverkos & Quinn, 1995).

Hepatitis A is a form of viral hepatitis, that is, it causes inflammation of the liver. It is also known as 'infectious hepatitis', due to its ability to be spread through personal contact with oral secretions or stools. It can be spread through kissing and by sharing a toothbrush. In relation to its sexual transmission, it has been named the 'homosexual disease', due to its spread by faecal-oral route. Its symptoms are similar to influenza but the skin and eyes may turn yellow. It has a short incubation period of 4 to 5 days and there is no specific treatment. Hepatitis B is known as 'serum hepatitis', as it can be spread through contact with infected blood products. It can be spread from mother to child or can be transmitted sexually as it is related to trauma during sexual intercourse. Its infection can be much more severe than Hepatitis A and can cause chronic infection or cirrhosis of the liver. It can also be carried asymptotically and has an incubation period of 2 to 3 months. A preventive vaccine exists, although there is no cure. Most people do recover fully but it can sometimes cause death (Fowler, 1997).

Bacterial Infections.

Syphilis, gonorrhoea and chancroid are the oldest known sexually transmitted infections and were previously referred to as the venereal diseases. For much of the 19th century, clinicians mistakenly viewed these infections as simply being modifications of one disease (Green, 1999). This was partially due to the publication of *A Treatise on the Venereal Disease*, by the influential British surgeon, John Hunter in 1786, who concluded that syphilis and gonorrhoea were the same, having carried out his experiments on a patient infected with both. It was not until 1838 that Philippe Ricord, the French clinician, proved that syphilis and gonorrhoea were different diseases. However, it was a German bacteriologist, Fritz Schaudinn in 1905 who isolated the bacterial organism that causes syphilis, the spiral shaped *treponema pallidum* (Learmouth, 1988).

Every time someone has sex with an infected person, they have a 50% chance of acquiring syphilis (Llewellyn-Jones, 1990). The first stage of syphilis causes a hard-edged ulcer, usually on a man's penis or a woman's vulva. This appears between 3 and 10 weeks after sexual intercourse with an infected person. Occasionally, the ulcer ('chancre') can develop on a person's lips after oral sex or in his or her rectum after anal sex. Women can develop a chancre on the cervix, where it cannot be seen but is very infectious. If untreated, the chancre heals in 3 to 4 weeks. The second stage commences with the person becoming ill with headaches or joint pains. A pale pink skin rash appears which persists for about 6 weeks and slowly fades. A few infected

people develop ulcers in the mouth or the vulva or in the anus. These lesions usually disappear in 3 to 12 months. Two to twenty years later, the tertiary stage occurs with symptoms such as painful skin ulcers, gnawing bone pain, damage to the heart or rupture of the main blood vessels (Llewellyn-Jones, 1990). The main manifestations of this stage of the disease include general paralysis of the insane, locomotor ataxia and aneurysm. Deaths are usually due to cardiovascular syphilis and syphilitic valvular disease.

Gonorrhoea, ('the clap') is the commonest of the bacterial diseases and is caused by *neisseria gonorrhoeae* (also known as 'gonococcus'). Men usually have urethral discharges and burning sensations 3 to 5 days after sex. The majority of women (and 20% of men) have no symptoms (Llewellyn-Jones, 1990). Any woman who does develop symptoms, will do so within a month after having sex with an infected partner. Such symptoms include bleeding between menstrual periods (Fowler, 1997). Like syphilis, *chlamydia trachomatis* and chancroid, gonorrhoea can be acquired through orogenital contact (Adler, 1997) and can affect the throat (Llewellyn-Jones, 1990). Gonococcal infection will be passed to and fro between a couple until they are both treated at the same time (Leeson & Gray, 1978). Unlike other communicable diseases, such as rubella, mumps or measles, treatment for an attack does not mean protective immunity from another. It is even possible to be cleared of gonorrhoea in the morning and reinfected that evening (Barlow, 1979).

The remaining three bacterial infections are termed 'tropical STIs', as they are rare in Europe but very common in tropical countries, especially India, Guyana and New Guinea. Chancroid is caused by the small organism, *haemophilus ducreyi* (Barlow, 1979). It has an incubation period of 1 to 8 days and symptoms appear 3 to 7 days after sex. At first, a number of sore pimples occur but they grow quickly into multiple soft, excruciating ulcers. The lymph nodes in the groin also swell (Llewellyn-Jones, 1990). Chancroid's ulcers are painful and soft on palpation, unlike syphilis' hard and painless one (Green, 1999). Granuloma inguinale is caused by *donovania granulomatis* and it has an incubation period lasting a few days to two months (Barlow, 1979). Its symptoms include a small red nodule on the genitalia, which forms elevated masses of reddened tissue or lesions. These continue to spread and destroy genital tissue. Men are more likely to be affected than women and it is thought to be most commonly acquired through anal intercourse. It also requires repeated contact for infection to be transmitted. (Llewellyn-Jones, 1990). Treatment involves antibiotics. *Lymphogranuloma venereum* (LGV), which resembles *chlamydia trachomatis* (see below) has an incubation period of 4 to 35 days (Llewellyn-Jones, 1990). Symptoms usually begin 1 to 3 weeks after contact and include lymph node swelling in the groin, fever, headache, chills and skin ulcers.

Viral Infections.

The most common forms of viral infections are genital warts. These can look like tiny cauliflowers, small bumps or can be invisible to the naked eye. In women, genital warts appear on the vulva, vagina or on cervix. On men, they appear on foreskin, glans or shaft of penis. There are also a group of warts, known as ano-rectal warts, which are found mostly on homosexual men but can develop on heterosexual men and women. However, ano-genital warts, which are largely spread heterosexually, tend to be the most frequently recorded viral infection in western

countries. Genital warts are caused by a family of viruses, known as the human papilloma viruses (HPV), of which there are 30 strains, which can cause warts on the body. The genital warts are caused by viruses 6, 16, 18 and 32. The incubation period is 3 weeks to 8 months. Human papilloma viruses 16 and 18 have a causal role in cervical cancer in women and in the development of penile cancer in men (Llewellyn-Jones, 1990; Thin, 2000). The human papilloma viruses are spread via hand-genital transmission and orogenital transmission (Edwards and Caine, 1998). Warts can be removed but with no cure for the viruses, recurrent attacks are likely and can be triggered by stress, pregnancy and ill health. It is difficult to effectively treat and prevent genital warts in the absence of an antiviral (Thin, 2000). Genital warts may also be caused by *condylomata acuminata* (Green, 1999).

Herpes simplex ('herpes') is a virus which can enter body cells and 'reprogram' them to make multiple copies of the virus and spread to other organs. There are two strains or types of herpes. Type I is usually responsible for the infection of the mouth and lips (known as 'cold sores'), while type II affects the genitalia and ano-rectal region. Symptoms usually show 5 to 10 days after being infected. Firstly, a small area on the shaft of the penis or vulva begins to burn or itch. Within 24 hours a crop of reddish bumps appear and blister. In women, the whole external genitals may swell making urination very painful. These ulcers last 7 to 12 days, they then 'crust' for another 4 to 5 days and after that, take up to a week to heal. Like genital warts, herpes can have skin-to-skin transmission and can occur on parts of the body not covered by a condom (Fowler, 1997). Herpes can be treated but like genital warts, it cannot be cured. Antiviral therapy is available and this acts on the replicating virus, shortens the individual recurrences and if used continuously, will suppress the disease (Thin, 2000). The human immune system will develop antibodies against the virus and this shortens subsequent attacks. About 50% of people have a second attack and less than 5 % have further recurrences (Llewellyn-Jones, 1990). Outbreaks can be triggered by stress, fatigue, sunburn, diet, menstruation, illness, or vigorous sexual intercourse (Fowler, 1997). Although it was previously believed that genital herpes could only spread through sex when the infected partner has acute genital blistering and ulceration, it is now maintained that the spread can also occur during periods of presumed sub-clinical viral shedding (Patel et al, 1997). Cytomegalovirus disease (CMV) is another member of the herpes virus group but it is rare in Europe (Barlow, 1979). It produces a disease like glandular fever in adults, although it is usually asymptomatic.

The final viral infection is *molluscum contagiosum* ('the pox'). This is a skin condition caused by a pox-like virus infection and has an incubation period of 3 weeks to several months (Barlow, 1979). The pox is distinguished by small dome-shaped bumps on the face and other parts of the body. The pox usually starts in the pubic region before spreading across the skin on the lower part of the body and upwards through the body. *Molluscum contagiosum* can be treated and cured by means of applying liquid nitrogen to the bumps.

Parasitic Infections.

The two main parasitic infections are pediculosis pubis ('pubic lice' or 'crabs') and scabies ('the itch'). Pediculosis pubis are parasites that live on the pubic hair and lay their eggs in the skin. They are spread through close sexual encounters and the person

is affected immediately. Scabies (the 'itch') is a contagious skin disease caused by a mite *sarcoptes scabiei* and its incubation period is 3 to 6 weeks (Barlow, 1979). The itch is the result of the female mite digging into the upper layer of the skin to lay her eggs. Sometimes eczema and secondary bacterial infection can occur. As a point of interest, the synonym, 'the seven year itch', is derived from the experience of scabies. Both scabies and pediculosis can be spread by other forms of close contact (Llewellyn-Jones, 1990).

Trichomoniasis ('trich') is caused by the single-celled parasite *trichomonas vaginalis* and is responsible for a vaginal infection in women and more commonly, urethritis in men (Barlow, 1979). It lives in the paraurethral glands in both sexes but can survive up to 24 hours in tap water, hot tubs, urine, on toilet seats and in swimming pools. Usually it is spread via the semen in sexual intercourse. Trichomoniasis can be easily treated and there are no known long term consequences (Fowler, 1997).

Non-Specific Genital Infection.

Non-specific genital infection was first diagnosed in 1951 (Thin, 1982). It is caused by the obligate intracellular parasite, *chlamydia trachomatis* ('chlamydia') and is responsible for an infection in the man's urethra and in the woman's cervix. Men's symptoms present themselves 7 to 14 days after infection and involve a burning sensation when urinating and a discharge (Llewellyn-Jones, 1990). The infection in women is usually asymptomatic, although they often get a burning sensation when urinating or a smelly discharge. If left untreated, chlamydia can cause pelvic inflammatory disease (PID), the infection of the pelvic organs in the female, which includes salpingitis, the infection of the fallopian tubes. PID occurs when the infection in the cervix spreads to the upper genital tract. This can take between several days to several months. The symptoms can be severe enough to require hospitalisation and PID can cause infertility and damage to the reproductive organs (Fowler, 1997). Non-specific genital infection in men is called non-gonococcal genital urethritis (NGU) or non-specific urethritis (NSU) and is termed non-gonococcal infection in women (NGGI). Non-specific proctitis occurs in homosexual men.

Candidiasis ('thrush') is caused by the yeast-like fungus, *candida albicans*, and is responsible for vaginal discharge and balanitis in women (Barlow, 1979). Although, candidiasis is a condition that most women develop without it being passed to them sexually, candidiasis can be transmitted to the male and cause an itchy penis. If untreated, it can be spread back to the female partner or onto another. This is the reason for its inclusion in the rates of sexually transmitted infections (Llewellyn-Jones, 1990). Additionally, cunnilingus appears to contribute to recurrent vaginal candidiasis although the mechanism is unclear (Edwards & Carne, 1998b).

There are thought to be more sexually transmitted infections emerging. During the 1990s, human herpes virus type 8 (HHV 8) was connected to the sexual transmission of Kaposi's sarcoma¹. The previously considered benign bacterial vaginosis (BIV) was found to be associated with miscarriage, pre-term birth, pelvic inflammatory disease, infertility and cerebral palsy (Thin, 2000).

¹ This is a rare form of cancer that usually manifests in AIDS sufferers.

Appendix II: Appendix to Chapter 7.

Table 1 – Tables of Factor Analysis.

(a) Component Loadings for Factor Extracted from Factor Analysis – Combined Sample.

Attitudes On:	Component Loading
Couples living together without getting married	.802
Couples living together before getting married	.766
Divorce is the best solution for an unhappy marriage	.358
Abortion for any legal reason	.422
Sexual relations before marriage	.767
Sexual relations outside marriage	.526
Sexual relations between teenagers	.605
Sexual relations between adults of the same sex	.657

(b) Component Loadings for Factor Extracted from Factor Analysis – Australian Sample.

Attitudes On:	Component Loading
Couples living together without getting married	.829
Couples living together before getting married	.794
Divorce is the best solution for an unhappy marriage	.292
Abortion for any legal reason	.504
Sexual relations before marriage	.769
Sexual relations outside marriage	.582
Sexual relations between teenagers	.607
Sexual relations between adults of the same sex	.677

(c) Component Loadings for Factor Extracted from Factor Analysis – USA Sample.

Attitudes On:	Component Loading
Couples living together without getting married	.856
Couples living together before getting married	.789
Divorce is the best solution for an unhappy marriage	.335
Abortion for any legal reason	.488
Sexual relations before marriage	.812
Sexual relations outside marriage	.547
Sexual relations between teenagers	.613
Sexual relations between adults of the same sex	.652

(c) Component Loadings for Factor Extracted from Factor Analysis – Irish Sample.

Attitudes On:	Component Loading
Couples living together without getting married	.814
Couples living together before getting married	.797
Divorce is the best solution for an unhappy marriage	.489
Abortion for any legal reason	.423
Sexual relations before marriage	.823
Sexual relations outside marriage	.527
Sexual relations between teenagers	.516
Sexual relations between adults of the same sex	.602

(d) Component Loadings for Factor Extracted from Factor Analysis – Polish Sample.

Attitudes On:	Component Loading
Couples living together without getting married	.776
Couples living together before getting married	.776
Divorce is the best solution for an unhappy marriage	.406
Abortion for any legal reason	.317
Sexual relations before marriage	.723
Sexual relations outside marriage	.516
Sexual relations between teenagers	.487
Sexual relations between adults of the same sex	.560

(e) Component Loadings for Factor Extracted from Factor Analysis – Spanish Sample.

Attitudes On:	Component Loading
Couples living together without getting married	.787
Couples living together before getting married	.768
Divorce is the best solution for an unhappy marriage	.257
Abortion for any legal reason	.400
Sexual relations before marriage	.782
Sexual relations outside marriage	.490
Sexual relations between teenagers	.647
Sexual relations between adults of the same sex	.721

Table 2
Levels of Tolerance (percentage of agreement) on Couples Living Together Without Getting Married.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	227 (50.2%)	528 (58.1%)	272 (45.6%)	375 (51.7%)	754 (63%)
Females	238 (49%)	474 (54.7%)	315 (37%)	396 (45.4%)	728 (56.3%)
Age Group					
18 – 20	28 (80%)	N/a	27 (67.5%)	42 (62.7%)	137 (80.6%)
21 – 30	128 (77.6%)	140 (75.7%)	132 (56.9%)	155 (63%)	444 (85.7%)
31 – 40	129 (69.7%)	275 (73.9%)	209 (58.7%)	196 (59.9%)	352 (79.5%)
41 – 50	106 (51.7%)	272 (64.9%)	128 (43.2%)	182 (61.7%)	236 (65.4%)
51 – 60	45 (31.5%)	135 (46.1%)	55 (31.6%)	105 (45.1%)	144 (43.1%)
61 – 70	23 (21.1%)	113 (40.5%)	21 (15%)	59 (33.3%)	115 (38.6%)
71+	6 (8.5%)	68 (32.1%)	15 (9%)	32 (27.1%)	57 (28.9%)
Marital Status					
Married/living as Married	263 (45.9%)	747 (54%)	257 (34.7%)	489 (46.9%)	804 (53.3%)
Widowed	33 (37.1%)	17 (32.7%)	20 (14.5%)	75 (40.1%)	51 (28.8%)
Separated	0	24 (75%)	18 (42.9%)	9 (52.9%)	45 (86.5%)
Divorced	5 (100%)	42 (63.6%)	112 (50.7%)	47 (61.8%)	26 (74.3%)
Never married	60 (60.8%)	164 (70.1%)	180 (59.2%)	151 (55.1%)	555 (77.6%)
Education					
Incomplete primary	6 (20.7%)	14 (56%)	0	18 (20.5%)	N/a
Primary Completed	64 (28.6%)	48 (36.1%)	20 (26.3%)	143 (35.7%)	N/a
Incomplete Secondary	85 (56.7%)	419 (51%)	66 (40%)	250 (49.8%)	N/a
Secondary completed	188 (55.3%)	298 (63.8%)	309 (41.2%)	219 (57.3%)	N/a
Incomplete university level	76 (66.1%)	0	137 (41%)	47 (61.8%)	N/a
University degree	41 (62.1%)	210 (68%)	53 (49.5%)	93 (66.4%)	N/a
Area of residence					
Urban	282 (55.8%)	827 (57.5%)	364 (39%)	N/a	N/a
Rural	183 (42.3%)	167 (51.5%)	41 (31.5%)	N/a	N/a
Religious practice					
Once a week or more	242 (36.7%)	35 (15.6%)	74 (15.8%)	254 (34.9%)	N/a
2-3 times a month	39 (75%)	45 (31.7%)	63 (43.4%)	165 (47.1%)	N/a
Once a month	20 (66.7%)	15 (36.6%)	47 (48%)	86 (56.6%)	N/a
Several times a year	44 (77.2%)	76 (53.1%)	77 (45.8%)	116 (70.3%)	N/a
Less frequently a year	72 (90%)	349 (65.7%)	166 (54.8%)	84 (75.7%)	N/a
Never	33 (86.8%)	380 (72%)	151 (64.5%)	63 (76.8%)	N/a

Table 3
Levels of Tolerance (percentage of agreement) on Couples Living Together Before Getting Married.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	223 (49.3%)	434 (47.7%)	246 (41.3%)	315 (43.4%)	658 (55%)
Females	240 (49.4%)	400 (46.2%)	225 (26.4%)	305 (35%)	647 (50.1%)
Age Group					
18 – 20	31 (88.6%)	N/a	27 (65.9%)	38 (57.6%)	129 (76.3%)
21 – 30	124 (75.2%)	115 (62.5%)	112 (48.1%)	132 (56.2%)	395 (76.7%)
31 – 40	126 (68.1%)	228 (61.8%)	166 (46.8%)	134 (43.1%)	306 (69.7%)
41 – 50	100 (49.3%)	207 (50%)	89 (30.6%)	146 (50.9%)	195 (54.3%)
51 – 60	43 (30.7%)	133 (45.7%)	43 (24.9%)	96 (44%)	130 (39.5%)
61 – 70	31 (27.7%)	95 (34.4%)	19 (13.6%)	51 (28.8%)	104 (34.8%)
71+	8 (11.6%)	57 (26.9%)	15 (9%)	23 (20.4%)	48 (24.9%)
Marital Status					
Married/living as Married	261 (45.5%)	613 (44.3%)	196 (26.5%)	401 (38.4%)	712 (47.2%)
Widowed	34 (38.2%)	18 (34.6%)	17 (12.3.%)	46 (24.6%)	38 (21.5%)
Separated	0	23 (71.9%)	16 (38.1%)	8 (47.1%)	32 (61.5%)
Divorced	3 (60%)	47 (71.2%)	91 (41.2%)	35 (46.1%)	27 (77.1%)
Never married	161 (61.2%)	127 (54.3%)	151 (49.7%)	130 (47.4%)	495 (69.2%)
Education					
Incomplete primary	9 (31%)	10 (40%)	3 (25%)	12 (13.6%)	N/a
Primary Completed	72 (32.1%)	48 (36.1%)	17 (22.4%)	136 (33.9%)	N/a
Incomplete Secondary	82 (54.7%)	363 (44.2%)	69 (41.8%)	200 (39.8%)	N/a
Secondary completed	185 (54.4%)	247 (52.9%)	249 (33.2%)	173 (45.3%)	N/a
Incomplete university level	74 (64.3%)	0	94 (28.1%)	38 (50%)	N/a
University degree	35 (53%)	154 (49.8%)	37 (34.6%)	61 (43.6%)	N/a
Area of residence					
Urban	271 (53.7%)	682 (47.4%)	299 (32%)	N/a	N/a
Rural	192 (44.3%)	145 (44.8%)	38 (29.2%)	N/a	N/a
Religious practice					
Once a week or more	255 (38.7%)	30 (13.3%)	65 (13.9%)	225 (30.9%)	N/a
2-3 times a month	38 (73.1%)	39 (27.5%)	41 (28.3%)	131 (37.4%)	N/a
Once a month	19 (63.3%)	15 (36.6%)	41 (41.8%)	61 (40.1%)	N/a
Several times a year	45 (78.9%)	56 (39.2%)	68 (40.5%)	89 (53.9%)	N/a
Less frequently a year	63 (78.8%)	268 (50.5%)	136 (44.9%)	74 (66.7%)	N/a
Never	29 (76.3%)	338 (64%)	115 (49.1%)	37 (45.1%)	N/a

Table 4
Levels of Tolerance (percentage of agreement) on
Divorce Being the Best Solution for Marital Problems.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	238 (52.7%)	529 (58.2%)	283 (47.5%)	358 (49.4%)	866 (72.3%)
Females	226 (46.5%)	479 (55.3%)	391 (45.9%)	427 (49%)	936 (72.4%)
Age Group					
18 – 20	16 (44.4%)	N/a	16 (39%)	35 (52.2%)	123 (72.8%)
21 – 30	109 (66.1%)	74 (40.7%)	86 (36.8%)	97 (44.9%)	406 (79.9%)
31 – 40	113 (61.1%)	183 (49.6%)	158 (44.5%)	168 (54.7%)	368 (82.5%)
41 – 50	112 (55.2%)	243 (58.7%)	145 (49.8%)	167 (61.6%)	302 (82.5%)
51 – 60	61 (43%)	182 (61.7%)	99 (57.9%)	149 (70%)	257 (77.2%)
61 – 70	36 (35%)	177 (63.7%)	76 (55.1%)	105 (58%)	210 (71.7%)
71+	17 (24.3%)	151 (71.9%)	94 (58%)	64 (54.7%)	140 (70.4%)
Marital Status					
Married/living as Married	276 (48.2%)	794 (57.4%)	330 (44.5%)	507 (48.6%)	1111 (73.6%)
Widowed	35 (39.3%)	35 (67.3%)	78 (56.5%)	97 (51.9%)	98 (55.4%)
Separated	0	16 (50%)	26 (61.9%)	11 (64.7%)	48 (92.3%)
Divorced	5 (100%)	49 (74.2%)	116 (52.5%)	54 (71.1%)	26 (74.3%)
Never married	144 (54.8%)	107 (45.7%)	124 (40.8%)	116 (42.3%)	517 (72.3%)
Education					
Incomplete primary	8 (27.6%)	18 (72%)	6 (50%)	37 (42%)	N/a
Primary Completed	96 (42.9%)	94 (70.7%)	41 (53.9%)	201 (50.1%)	N/a
Incomplete Secondary	75 (50%)	472 (57.5%)	86 (52.1%)	229 (45.6%)	N/a
Secondary completed	188 (55.3%)	246 (52.7%)	351 (46.8%)	192 (50.3%)	N/a
Incomplete university level	59 (51.3%)	0	139 (41.6%)	42 (55.3%)	N/a
University degree	33 (50%)	165 (53.4%)	49 (45.8%)	83 (59.3%)	N/a
Area of residence					
Urban	239 (47.3%)	806 (56%)	447 (47.9%)	N/a	N/a
Rural	225 (52%)	192 (59.3%)	66 (50.8%)	N/a	N/a
Religious practice					
Once a week or more	285 (43.2%)	81 (36%)	179 (38.2%)	310 (42.6%)	N/a
2-3 times a month	27 (51.9%)	63 (44.4%)	66 (45.5%)	176 (50.3%)	N/a
Once a month	17 (56.7%)	21 (51.2%)	48 (49%)	80 (52.6%)	N/a
Several times a year	35 (61.4%)	68 (47.6%)	83 (49.4%)	92 (55.8%)	N/a
Less frequently a year	59 (73.8%)	325 (61.2%)	141 (46.5%)	74 (66.7%)	N/a
Never	26 (68.4%)	358 (67.8%)	139 (59.4%)	46 (56.1%)	N/a

Table 5
Levels of Tolerance (percentage of agreement) on Legal Abortion for Any Reason.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	121 (26.8%)	490 (53.9%)	250 (41.9%)	335 (46.2%)	547 (45.7%)
Females	125 (25.7%)	456 (52.7%)	356 (41.8%)	379 (43.5%)	549 (42.5%)
Age Group					
18 – 20	13 (37.1%)	N/a	19 (52.8%)	23 (34.8%)	104 (62.3%)
21 – 30	76 (47.8%)	111 (60%)	111 (50.5%)	116 (48.1%)	318 (64%)
31 – 40	73 (39%)	215 (58.4%)	175 (52.7%)	187 (58.1%)	259 (57.9%)
41 – 50	58 (29.1%)	252 (60.1%)	131 (45.6%)	174 (59%)	185 (51.5%)
51 – 60	14 (10.3%)	138 (46.5%)	66 (40%)	111 (48.9%)	118 (35.6%)
61 – 70	8 (7.8%)	134 (48.7%)	54 (40.9%)	69 (38.3%)	73 (25.1%)
71+	4 (6.3%)	98 (46.7%)	50 (31.3%)	34 (31.2%)	41 (20.6%)
Marital Status					
Married/living as Married	132 (23%)	722 (52.2%)	309 (41.7%)	483 (46.3%)	598 (39.6%)
Widowed	19 (21.3%)	24 (46.2%)	35 (25.4%)	68 (36.4%)	31 (17.5%)
Separated	0	23 (71.9%)	15 (35.7%)	8 (47.1%)	34 (65.4%)
Divorced	3 (60%)	39 (59.1%)	101 (45.7%)	44 (57.9%)	19 (54.3%)
Never married	90 (34.2%)	131 (56%)	145 (47.7%)	111 (40.5%)	413 (57.8%)
Education					
Incomplete primary	5 (17.2%)	16 (64%)	2 (16.7%)	14 (15.9%)	N/a
Primary Completed	25 (11.2%)	56 (42.1%)	18 (23.7%)	148 (36.9%)	N/a
Incomplete Secondary	43 (28.7%)	424 (51.6%)	44 (26.7%)	228 (45.4%)	N/a
Secondary completed	109 (32.1%)	268 (57.4%)	324 (43.2%)	206 (53.9%)	N/a
Incomplete university level	38 (33%)	0	155 (46.4%)	41 (53.9%)	N/a
University degree	23 (34.8%)	172 (55.7%)	63 (58.9%)	76 (54.3%)	N/a
Area of residence					
Urban	153 (30.3%)	778 (54.1%)	369 (39.5%)	N/a	N/a
Rural	93 (21.5%)	160 (49.4%)	34 (26.2%)	N/a	N/a
Religious practice					
Once a week or more	115 (17.5%)	32 (14.2%)	102 (21.7%)	222 (30.5%)	N/a
2-3 times a month	19 (36.5%)	39 (27.5%)	63 (43.4%)	151 (43.1%)	N/a
Once a month	15 (50%)	21 (51.2%)	43 (43.9%)	82 (53.9%)	N/a
Several times a year	26 (45.6%)	67 (46.9%)	92 (54.8%)	112 (67.9%)	N/a
Less frequently a year	38 (47.5%)	333 (62.7%)	158 (52.1%)	82 (73.9%)	N/a
Never	22 (57.9%)	364 (68.9%)	137 (58.5%)	62 (75.6%)	N/a

Table 6
Levels of Tolerance on Premarital Sex (those who did not think it was wrong at all).

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	190 (45.7%)	539 (62.5%)	244 (47.6%)	443 (66.4%)	747 (64.8%)
Females	167 (38.3%)	455 (56.2%)	265 (36.4%)	413 (54.6%)	698 (56.8%)
Age Group					
18 – 20	20 (58.8%)	N/a	19 (52.8%)	36 (52.2%)	151 (84.4%)
21 – 30	120 (76.4%)	130 (71.8%)	100 (49.3%)	166 (67.8%)	465 (87.9%)
31 – 40	107 (61.8%)	275 (76.8%)	179 (56.3%)	212 (68.2%)	353 (78.8%)
41 – 50	75 (39.9%)	272 (66.2%)	116 (43.9%)	199 (69.8%)	223 (61.3%)
51 – 60	23 (18%)	152 (55.5%)	50 (33.6%)	137 (61.7%)	118 (34.6%)
61 – 70	7 (6.5%)	104 (40.6%)	26 (21%)	75 (42.9%)	98 (32.5%)
71+	5 (7.8%)	63 (32.3%)	19 (12.8%)	31 (26.5%)	37 (16.7%)
Marital Status					
Married/living as Married	196 (37.5%)	752 (57.8%)	240 (36.3%)	578 (62.2%)	763 (53.4%)
Widowed	21 (27.3%)	19 (39.6%)	22 (18.8%)	73 (44.8%)	35 (20.8%)
Separated	0	23 (74.2%)	15 (41.7%)	8 (50%)	39 (78%)
Divorced	3 (75%)	41 (66.1%)	98 (54.4%)	43 (67.2%)	28 (82.4%)
Never married	133 (55%)	153 (68.9%)	134 (54.3%)	154 (61.4%)	578 (82.9%)
Education					
Incomplete primary	7 (25%)	8 (36.4%)	1 (9.1%)	22 (28.9%)	N/a
Primary Completed	45 (22.2%)	55 (45.5%)	23 (34.8%)	181 (52.2%)	N/a
Incomplete Secondary	65 (47.1%)	444 (58%)	44 (934.1%)	280 (62.6%)	N/a
Secondary completed	142 (46.4%)	285 (63.2%)	267 (41.7%)	230 (66.5%)	N/a
Incomplete university	59 (54.6%)	0	127 (43.1%)	52 (74.3%)	N/a
University degree	35 (61.4%)	193 (65.4%)	46 (47.4%)	90 (68.7%)	N/a
Area of residence					
Urban	224 (49.6%)	812 (59.8%)	311 (39.6%)	N/a	N/a
Rural	133 (33.3%)	175 (57.8%)	38 (32.8%)	N/a	N/a
Religious practice					
Once a week or more	170 (28.4%)	36 (17%)	79 (19%)	321 (50%)	N/a
2-3 times a month	32 (71.1%)	39 (31%)	46 (38.7%)	184 (59.5%)	N/a
Once a month	14 (51.9%)	16 (40%)	39 (45.9%)	96 (73.3%)	N/a
Several times a year	38 (71.7%)	70 (51.9%)	72 (50.7%)	118 (78.1%)	N/a
Less frequently a year	61 (85.9%)	359 (71.4%)	142 (55.5%)	80 (74.1%)	N/a
Never	33 (89.2%)	384 (76.2%)	122 (61.9%)	53 (69.7%)	N/a

Table 7
Levels of Tolerance (percentage of agreement) on Homosexual Sex.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	63 (17.3%)	213 (25%)	86 (16.5%)	87 (12.8%)	439 (39.5%)
Females	66 (17.1%)	225 (29.1%)	148 (21%)	107 (14.3%)	466 (39.4%)
Age Group					
18 – 20	7 (28%)	N/a	7 (21.2%)	19 (29.2%)	100 (58.1%)
21 – 30	41 (32%)	65 (38%)	53 (26.6%)	48 (20%)	333 (66.3%)
31 – 40	39 (26%)	114 (33.4%)	80 (25.6%)	49 (15.4%)	238 (66.3%)
41 – 50	30 (17.8%)	117 (30.4%)	52 (20.1%)	49 (17.1%)	125 (35.9%)
51 – 60	9 (7.3%)	61 (22.3%)	25 (16.6%)	16 (7.2%)	59 (17.6%)
61 – 70	3 (3.2%)	37 (14.3%)	12 (10%)	10 (5.6%)	41 (13.8%)
71+	0	45 (22.5%)	5 (3.3%)	3 (2.6%)	10 (4.6%)
Marital Status					
Married/living as Married	63 (13.8%)	319 (25.1%)	107 (16%)	112 (11.9%)	441 (31.9%)
Widowed	8 (10.5%)	8 (17%)	8 (6.9%)	13 (7.9%)	14 (8.5%)
Separated	0	12 (41.4%)	5 (15.2%)	1 (7.1%)	31 (62%)
Divorced	2 (40%)	18 (29.5%)	39 (22.8%)	12 (18.5%)	20 (62%)
Never married	54 (25.8%)	80 (38.5%)	75 (31.8%)	56 (23.1%)	398 (59.6%)
Education					
Incomplete primary	3 (11.1%)	7 (30.4%)	0	3 (4.1%)	N/a
Primary Completed	6 (3.1%)	30 (24.6%)	8 (11.8%)	26 (7.4%)	N/a
Incomplete Secondary	23 (19.8%)	161 (21.7%)	16 (11.7%)	44 (9.6%)	N/a
Secondary completed	50 (18.7%)	121 (28.3%)	108 (16.9%)	72 (21%)	N/a
Incomplete university level	33 (35.9%)	0	72 (26.4%)	17 (25.4%)	N/a
University degree	13 (27.7%)	111 (38.3%)	29 (30.9%)	32 (25.4%)	N/a
Area of residence					
Urban	86 (22.6%)	359 (27.4%)	157 (19.8%)	N/a	N/a
Rural	43 (11.6%)	75 (24.6%)	8 (7%)	N/a	N/a
Religious practice					
Once a week or more	56 (10.3%)	17 (8.2%)	32 (7.8%)	55 (8.4%)	N/a
2-3 times a month	5 (14.3%)	20 (16%)	20 (17.2%)	33 (10.6%)	N/a
Once a month	3 (15%)	6 (16.2%)	24 (28.9%)	19 (14.5%)	N/a
Several times a year	14 (35%)	31 (23.7%)	32 (22.5%)	44 (29.5%)	N/a
Less frequently a year	27 (42.9%)	147 (30.6%)	58 (22.6%)	23 (22.8%)	N/a
Never	20 (62.5%)	177 (35.5%)	61 (31.8%)	18 (24.7%)	N/a

Table 8
Levels of Tolerance (percentage of agreement) on sex between teenagers under the age of sixteen.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	9 (2.1%)	92 (10.5%)	33 (6.2%)	43 (6.6%)	206 (18%)
Females	4 (0.8%)	64 (7.7%)	21 (2.7%)	15 (1.9%)	103 (8.4%)
Age Group					
18 – 20	0	N/a	4 (11.5%)	1 (1.6%)	49 (28.2%)
21 – 30	6 (3.8%)	15 (8.5%)	16 (7.6%)	14 (6.3%)	133 (26%)
31 – 40	2 (1.1%)	30 (8.2%)	16 (4.8%)	18 (5.7%)	62 (14.3%)
41 – 50	4 (2%)	39 (9.9%)	13 (4.7%)	13 (4.4%)	35 (9.5%)
51 – 60	1 (0.7%)	24 (8.5%)	3 (1.8%)	7 (3%)	13 (3.7%)
61 – 70	0	23 (8.5%)	2 (1.6%)	5 (2.7%)	13 (4.2%)
71+	0	26 (12.7%)	0	0	5 (2.2%)
Marital Status					
Married/living as Married	6 (1.1%)	121 (9%)	23 (3.3%)	41 (4.4%)	110 (7.7%)
Widowed	0	6 (12%)	1 (0.8%)	2 (1.2%)	6 (3.5%)
Separated	0	4 (13.3%)	0	2 (11.8%)	12 (23.1%)
Divorced	0	7 (10.8%)	6 (3.2%)	4 (5.5%)	9 (29%)
Never married	7 (2.8%)	18 (8.2%)	24 (9.4%)	9 (3.9%)	172 (25.3%)
Education					
Incomplete primary	1 (3.4%)	2 (8.3%)	0	2 (2.4%)	N/a
Primary Completed	2 (0.9%)	21 (16.7%)	7 (10%)	16 (4.5%)	N/a
Incomplete Secondary	0	72 (9.2%)	7 (5%)	19 (4.3%)	N/a
Secondary completed	6 (1.8%)	35 (7.7%)	23 (3.4%)	13 (3.8%)	N/a
Incomplete university level	2 (1.8%)	0	12 (3.9%)	3 (4.2%)	N/a
University degree	2 (3.2%)	22 (7.3%)	5 (4.8%)	5 (3.7%)	N/a
Area of residence					
Urban	10 (2.1%)	119 (8.6%)	29 (3.5%)	N/a	N/a
Rural	3 (0.7%)	35 (11.2%)	8 (6.7%)	N/a	N/a
Religious practice					
Once a week or more	6 (0.9%)	11 (5.1%)	9 (8.8%)	18 (2.7%)	N/a
2-3 times a month	2 (4.1%)	6 (4.5%)	2 (1.5%)	9 (2.8%)	N/a
Once a month	0	0	4 (4.5%)	10 (7.8%)	N/a
Several times a year	1 (1.9%)	13 (9.3%)	6 (4.1%)	4 (2.8%)	N/a
Less frequently a year	1 (1.4%)	45 (8.8%)	14 (5.1%)	9 (9.4%)	N/a
Never	2 (5.3%)	62 (11.9%)	17 (8.2%)	7 (9.6%)	N/a

Table 9
Levels of Tolerance (percentage of agreement) on Extramarital Sex.

	Ireland	Australia	USA	Poland	Spain
Gender					
Males	12 (2.8%)	66 (7.4%)	14 (2.6%)	49 (7.3%)	68 (5.9%)
Females	5 (1.1%)	55 (6.5%)	11 (1.4%)	30 (3.7%)	43 (3.4%)
Age Group					
18 – 20	2 (5.9%)	N/a	1 (2.8%)	2 (2.9%)	13 (7.6%)
21 – 30	4 (2.5%)	3 (1.6%)	6 (2.8%)	10 (4.1%)	38 (7.3%)
31 – 40	4 (2.3%)	19 (5.2%)	6 (1.8%)	18 (5.6%)	26 (5.95)
41 – 50	4 (2%)	27 (6.6%)	6 (2.2%)	25 (8.5%)	17 (4.5%)
51 – 60	2 (1.4%)	23 (8%)	1 (0.6%)	13 (5.7%)	10 (2.8%)
61 – 70	0	22 (8.1%)	4 (3.1%)	7 (3.7%)	5 (1.6%)
71+	1 (1.4%)	27 (13%)	1 (0.6%)	4 (3.2%)	2 (0.9%)
Marital Status					
Married/living as Married	7 (1.3%)	99 (7.4%)	7 (1%)	52 (5.4%)	44 (3%)
Widowed	2 (2.4%)	6 (12%)	1 (0.8%)	12 (6.9%)	2 (1.1%)
Separated	0	2 (6.7%)	0	1 (6.7%)	2 (3.8%)
Divorced	1 (20%)	7 (10.9%)	8 (4.1%)	3 (4.5%)	5 (15.2%)
Never married	7 (2.9%)	6 (2.6%)	9 (3.5%)	11 (4.4%)	58 (8.5%)
Education					
Incomplete primary	1 (3.6%)	2 (8.7%)	0	5 (6.2%)	N/a
Primary Completed	4 (1.9%)	20 (16%)	3 (4.2%)	12 (3.3%)	N/a
Incomplete Secondary	3 (2.1%)	66 (8.3%)	5 (3.4%)	21 (4.5%)	N/a
Secondary completed	7 (2.2%)	15 (3.3%)	10 (1.4%)	20 (5.7%)	N/a
Incomplete university level	0	0	6 (2%)	6 (8.3%)	N/a
University degree	2 (3.3%)	13 (4.3%)	1 (1%)	15 (11.1%)	N/a
Area of residence					
Urban	13 (2.8%)	91 (6.5%)	14 (1.6%)	N/a	N/a
Rural	4 (1%)	28 (9%)	3 (2.4%)	N/a	N/a
Religious practice					
Once a week or more	8 (1.3%)	11 (5.1%)	5 (1.1%)	33 (4.9%)	N/a
2-3 times a month	0	8 (5.8%)	2 (1.5%)	10 (3.1%)	N/a
Once a month	1 (3.4%)	0	2 (2.2%)	10 (7.1%)	N/a
Several times a year	2 (4%)	9 (6.4%)	0	10 (6.6%)	N/a
Less frequently a year	2 (2.8%)	33 (6.4%)	2 (0.7%)	9 (8.9%)	N/a
Never	2 (5.4%)	47 (9.1%)	14 (6.5%)	6 (8.7%)	N/a

Appendix III:

**Copy of Questionnaire Distributed in Ireland as
Part of the International Social Survey Programme –
Attitudes to Family and Changing Gender Roles,
1994.**



The Economic and Social Research Institute

Limited Company No. 18269 CHY 5335

4 Burlington Road Dublin 4 Ireland

Telephone: 353-1-676 0115 Fax: 353-1-668 6231

International Social Survey - Ireland March 1994

(Attitudes to Women, Work and the Family and Attitudes to the Police)

Interviewer's name _____ Interviewer's Number _____

Area code _____ Respondent code _____

Date of interview: Day _____ Month _____

INTVR.

ID1, ID2

MONTH

Introduction (Ask for named respondent)

Good morning/afternoon/evening. I am from the Economic and Social Research Institute in Dublin. We are carrying out a survey of people's opinions on a variety of social issues. You were included in a national sample taken at random from the Electoral Register. This is an international study whose aim is to find out exactly what the public thinks on these issues, so that planning by the Government and other bodies can be made as effective as possible. It is only the help of many people like yourself in answering some questions that makes this work possible. The interview will take about forty minutes to complete. I can assure you that all answers will be treated in the strictest confidence by the Economic and Social Research Institute. We are interested in the number of people who think in various ways, not in any individual's views as such.

To begin, we have some questions about women.

1. Do you agree or disagree . . .

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Can't Choose	
a. A working mother can establish just as warm and secure a relationship with her children as a mother who does not work.	1	2	3	4	5	8	W1.1
b. A pre-school child is likely to suffer if his or her mother works.	1	2	3	4	5	8	W1.2
c. All in all, family life suffers when the woman has a full-time job.	1	2	3	4	5	8	W1.3
d. A job is alright, but what most women really want is a home and children.	1	2	3	4	5	8	W1.4
e. Being a house wife is just as fulfilling as working for pay.	1	2	3	4	5	8	W1.5
f. Having a job is the best way for a woman to be an independent person.	1	2	3	4	5	8	W1.6
g. Most women have to work these days to support their families.	1	2	3	4	5	8	W1.7

2. And, do you agree or disagree . . .

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Can't Choose	
a. Both the man and woman should contribute to the household income.	1	2	3	4	5	8	W2.1
b. A man's job is to earn money; a woman's job is to look after the home and family.	1	2	3	4	5	8	W2.2

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Can't Choose	
c. It is not good if the man stays at home and cares for the children and the woman goes out to work.	1	2	3	4	5	8	W2.3

d. Family life often suffers because men concentrate too much on their work.	1	2	3	4	5	8	W2.4
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3. **Do you think that women should work outside the home full-time, part-time or not at all under these circumstances: (Please circle one answer on each line.)**

	Work Full-time	Work Part-time	Stay Home	Can't Choose	
a. After marrying and before there are children.	1	2	3	8	W3.1

b. When there is a child under school age.	1	2	3	8	W3.2
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c. After the youngest child starts school.	1	2	3	8	W3.3
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d. After the children leave home.	1	2	3	8	W3.4
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4. **Do you agree or disagree . . .**

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Can't Choose	
a. Married people are generally happier than unmarried people.	1	2	3	4	5	8	W4.1

b. The main advantage of marriage is that it gives financial security.	1	2	3	4	5	8	W4.2
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c. The main purpose of marriage these days is to have children.	1	2	3	4	5	8	W4.3
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d. It is better to have a bad marriage than no marriage at all.	1	2	3	4	5	8	W4.4
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e. People who want children ought to get married.	1	2	3	4	5	8	W4.5
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f. One parent can bring up a child as well as two parents together.	1	2	3	4	5	8	W4.6
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g. It is alright for a couple to live together without intending to get married.	1	2	3	4	5	8	W4.7
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h. It's a good idea for a couple who intend to get married to live together first.	1	2	3	4	5	8	W4.8
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i. Divorce is usually the best solution when a couple can't seem to work out their marriage problems.	1	2	3	4	5	8	W4.9
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5. **All in all, what do you think is the ideal number of children for a family to have? Please just write a number on the line below.**

Ideal number of children for a family _____

W5.1

6. Do you agree or disagree . . .

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Can't Choose	
a. Watching children grow up is life's greatest joy.	1	2	3	4	5	6	W6.1
b. Having children interferes too much with the freedom of parents.	1	2	3	4	5	6	W6.2
c. People who have never had children lead empty lives.	1	2	3	4	5	6	W6.3
d. When there are children in the family, parents should stay together even if they don't get along.	1	2	3	4	5	6	W6.4
e. Even when there are no children, a married couple should stay together even if they don't get along.	1	2	3	4	5	6	W6.5

7. Which of these would you say is more important in preparing children for life . . . (Please circle one number only.)

To be obedient	1	
OR		W7.1
To think for themselves?	2	
Can't choose	8	

8. Did your mother ever work for pay for as long as one year after you were born and before you were 14?

Yes, she worked	1	
No	2	W8.1
Did not live with mother	3	

9. A. Is your mother still alive?

Yes (Go to B.)	1	W9.1
No (Go to Q. 10)	2	

B. How often do you see or visit with your mother?

She lives in the same household	1	
Daily	2	
At least several times a week	3	W9.2
At least once a week	4	
At least once a month	5	
Several times a year	6	
Less often	7	

10. Were you ever divorced?

Yes	1	
No	2	W10.1
Never married	3	

11. A. Are you married (or living as married)? Yes 1 ↓ Go to B No 2 → Go to Q. 13 W11.1
- B. Was your (current) spouse/partner ever divorced?
- My partner has married and has divorced 1 W11.2
- My partner has married but has never divorced 2
- My partner has never married 3
12. A. Are you married? Yes 1 ↓ Go to B No 2 → Go to Q. 13 W12.1
- B. Did you live with your husband/wife before you got married?
- Yes 1 W12.2
- No 2
13. Did you ever live together with a partner you didn't marry?
- Yes, with a previous partner 1
- Yes, with my present partner 2 W13.1
- Yes, both with a previous partner and with my present partner 3
- No, never 4
14. Do you agree or disagree . . .
- | | Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree | Can't Choose | |
|---|----------------|-------|----------------------------|----------|-------------------|--------------|-------|
| a. Working women should receive paid maternity leave when they have a baby. | 1 | 2 | 3 | 4 | 5 | 8 | W14.1 |
| b. Families should receive financial benefits for child care when both parents work. | 1 | 2 | 3 | 4 | 5 | 8 | W14.2 |
| c. A pregnant woman should be able to obtain a legal abortion for any reason whatsoever, if she chooses not to have the baby. | 1 | 2 | 3 | 4 | 5 | 8 | W14.3 |
15. Do you think it is wrong or not wrong if a man and a woman have sexual relations before marriage?
- Always wrong 1
- Almost always wrong 2 W15.1
- Wrong only sometimes 3
- Not wrong at all 4
- Can't choose 8
16. What if they are in their early teens, say under 16 years old, in that case is it . . .
- Always wrong 1
- Almost always wrong 2 W16.1
- Wrong only sometimes 3
- Not wrong at all 4
- Can't choose 8
17. What about a married person having sexual relations with someone other than his or her husband or wife, is it . . .
- Always wrong 1
- Almost always wrong 2 W17.1
- Wrong only sometimes 3
- Not wrong at all 4
- Can't choose 8

18. **And what about sexual relations between two adults of the same sex, is it .**

- | | |
|----------------------|---|
| Always wrong | 1 |
| Almost always wrong | 2 |
| Wrong only sometimes | 3 |
| Not wrong at all | 4 |
| Can't choose | 8 |

W18.1

19. **Sometimes at work people find themselves the object of sexual advances, propositions, or unwanted sexual discussions from co-workers or supervisors. The advances sometimes involve physical contact and sometimes just involve sexual conversations. Has this ever happened to you?**

- | | |
|-------------------|---|
| Yes | 1 |
| No | 2 |
| Have never worked | 3 |

W19.1

20. **A. Are you married (or living as married)?** Yes 1 ↓ Go to B No 2 → Go to Q. 23

W20.1

B. How do you and your spouse/partner organise the income that one or both of you receive?
Please choose the option that comes closest.

- | | |
|--|---|
| I manage all the money and give my partner his/her share | 1 |
| My partner manages all the money and gives me my share | 2 |
| We pool all the money and each take out what we need | 3 |
| We pool some of the money and keep the rest separate | 4 |
| We each keep our own money separate | 5 |

W20.2

21. **In your household who does the following things . . .**

- | | Always
the
Woman | Usually
the
Woman | About Equal
or Both
Together | Usually
the
Man | Always
the
Man | Is Done
by a Third
Person | Can't
Choose |
|--|------------------------|-------------------------|------------------------------------|-----------------------|----------------------|---------------------------------|-----------------|
| a. Does the laundry | 1 | 2 | 3 | 4 | 5 | 6 | 8 |
| b. Makes small repairs
around the house | 1 | 2 | 3 | 4 | 5 | 6 | 8 |
| c. Cares for sick family
members | 1 | 2 | 3 | 4 | 5 | 6 | 8 |
| d. Shops for groceries | 1 | 2 | 3 | 4 | 5 | 6 | 8 |
| e. Decides what to have for
dinner | 1 | 2 | 3 | 4 | 5 | 6 | 8 |

W21.1

W21.2

W21.3

W21.4

W21.5

22. **A. Are both you and your spouse working for pay?** Yes 1 ↓ Go to B No 2 → Go to Q. 24

W22.1

B. Who earns more money?

- | | |
|-------------------------------|---|
| The man earns much more | 1 |
| The man earns a bit more | 2 |
| We earn about the same amount | 3 |
| The woman earns a bit more | 4 |
| The woman earns much more | 5 |

W22.2

23. A. Have you ever had children? Yes 1 ↓ Go to B No 2 → Go to Q. 24 W23.1

B. Did you work outside the home full-time, part-time, or not at all . . .

	Worked Full-time	Worked Part-time	Stayed Home	Does Not Apply	
a. After marrying and before you had children?	1	2	3	8	W23.2
b. And what about when a child was under school age?	1	2	3	8	W23.3
c. After the youngest child started school?	1	2	3	8	W23.4
d. And how about after the children left home?	1	2	3	8	W23.5

C. What about your spouse/partner at that time - did he or she work outside the home full-time, part-time, or not at all?

	Worked Full-time	Worked Part-time	Stayed Home	Does Not Apply	
a. After marrying and before you had children?	1	2	3	8	W23.6
b. And what about when a child was under school age?	1	2	3	8	W23.7
c. After the youngest child started school?	1	2	3	8	W23.8
d. And how about after the children left home?	1	2	3	8	W23.9

The level of crime in our society is of concern to many people today. I'd now like to ask you a few questions on this subject.

24. Have you or any member of your household been a victim of crime within the past three years?

Yes 1 No 2 → Go to Q. 28 W24.1

25. Please indicate the type of crime:

Burglary (breaking in to your home/business)	1	W25.1
Theft of/damage to car/van	2	W25.2
Street crime (mugging, handbag snatching, etc.)	3	W25.3
Other type of robbery	4	W25.4
Sexual crime	5	W25.5
Domestic violence	6	W25.6
Other (specify) _____	7	W25.7

26. Was the crime reported to the Garda Síochána?

Yes 1 → Go to Q. 28 No 2 W26.1

27. Please indicate why the crime was not reported:

_____ W27.1

_____ W27.2

_____ W27.3

28. A. Have you had any contact with the Garda Síochána over the past two years?

Yes 1 No 2 → Go to Q. 39 W28.1

B. About how many times have you been in contact with the Gardaí?

Once	1	
2 - 3 times	2	
4 - 8 times	3	
more than 8 times	4	W28.2

28. C. What was the reason for your contact? (Code all reasons that apply in column (a). Insert ONE code for the most recent contact in column (b)).

	(a) All contacts (code all that apply)	(b) Most recent contact (code one only)	
Report a crime	1	1	W28.3
Suspect of a crime	2	2	W28.4
Disturbance/nuisance	3	3	W28.5
A general enquiry	4	4	W28.6
Make a complaint	5	5	W28.7
Enquire about a person in custody	6	6	W28.8
To be a witness	7	7	W28.9
A traffic incident	8	8	W28.10
Suspicious activity	9	9	W28.11
Lost/found property	10	10	W28.12
Production of driving documents	11	11	W28.13
Other Garda Services (signing passports, witness documents etc.)	12	12	W28.14
Any other reason (specify) _____	13 _____	13 _____	W28.15
			W28.16
			W28.17
			W28.18

29. A. Thinking now of this most recent contact, what form did this contact take?

Visit to a Garda station	1	
Telephone call	2	
Spoke to a Garda on patrol	3 → Go to Q. 31	
Garda called to my home/work	4 → Go to Q. 31	

W29.1

- B. Did you initiate it or did the Gardai?

I contacted Gardai	1	
Gardai contacted me	2	

W29.2

30. A. If you telephoned was your call answered:

Promptly	1	
Following a short delay	2	
With an unacceptable delay	3	

W30.1

- B. If you visited a Garda station were you dealt with:

Quicker than expected	1	
Within the time expected	2	
Slower than expected	3	

W30.2

31. To what extent did the manner of the Garda with whom you spoke meet your expectations?

	Better than you expected	As you expected	Worse than you expected	
Helpfulness	1	2	3	W31.1
Competence	1	2	3	W31.2
Sensitivity	1	2	3	W31.3
Politeness	1	2	3	W31.4
Interest	1	2	3	W31.5

32. A. Thinking of this most recent contact, do you think this matter required that a Garda call on you?

W32.1

Yes	1	No	2 → Go to Q. 34
-----	---	----	-----------------

- B. When you first contacted the Garda Siochana on this matter, were you told approximately how long it would be before someone would call on you?

W32.2

Yes	1	No	2
-----	---	----	---

33.	Did someone call on you within the time they said they would?						
	Yes	1	No	2	This amount of time not yet elapsed	3	W33.1
34.	Did the Garda Siochana get in touch later to inform you about the outcome of your contact?						
	Yes	1	→ Go to Q. 37	No	2		W34.1
35.	Do you think you should have been contacted?						
	Yes	1	No	2			W35.1
36.	Why do you think the Gardai should have contacted you? (Code one only)						
	I should have been kept informed					1	
	The Gardai should have shown concern for my welfare					2	
	I should have been thanked for my help					3	W36.1
	Courtesy					4	
	Other (please specify) _____					5	
37.	Having regard to all the circumstances, how satisfied or dissatisfied were you with the service you received?						
	Very satisfied					1	
	Satisfied					2	W37.1
	Dissatisfied					3	
	Very dissatisfied					4	
38.	Can you suggest how the service might be improved?						
	_____						W38.1
	_____						W38.2
	_____						W38.3
39.	In general how approachable do you think the Gardai are at your local station?						
	Approachable					1	
	Unapproachable					2	W39.1
	Don't know					3	
40.	Do you know by name, any member of the Garda Siochana at your local Garda station?						
	Yes	1	No	2			W40.1
41.	When was the last time you remember seeing a Garda in your locality?						
	Today					1	
	Yesterday					2	
	3 - 7 days ago					3	
	1 - 4 weeks					4	
	Longer ago					5	
	Can't remember					6	W41.1

42. **The Garda Síochána has a limited number of guards and are faced with a wide range of demands. What do you consider as being the tasks on which they should concentrate? Please indicate the level of importance using a scale of 1 to 5 by circling the number of your choice.**

	Very Unimportant	Unimportant	Moderately Important	Very Important	Extremely Important	
Investigating crime	1	2	3	4	5	W42.1
Foot patrolling	1	2	3	4	5	W42.2
Car patrolling	1	2	3	4	5	W42.3
Motor cycle patrolling	1	2	3	4	5	W42.4
Enforcement of drink/drive laws	1	2	3	4	5	W42.5
Enforcement of other traffic laws	1	2	3	4	5	W42.6
Enforcement of speed laws	1	2	3	4	5	W42.7
Crime prevention advice	1	2	3	4	5	W42.8
Enforcement of laws relating to drugs	1	2	3	4	5	W42.9
Ensuring an immediate response to emergencies	1	2	3	4	5	W42.10
Dealing with annoyance to residents	1	2	3	4	5	W42.11
Dealing with vandalism	1	2	3	4	5	W42.12
Providing help and support to victims of crime	1	2	3	4	5	W42.13
Supervision of licensed premises	1	2	3	4	5	W42.14
Involvement with the community (neighbourhood watch, youth clubs, schools, senior citizens)	1	2	3	4	5	W42.15

43. **Is your household in a neighbourhood watch or community alert scheme?**

Yes	1	No	2	Don't know	3	W43.1
-----	---	----	---	------------	---	-------

44. **Do your scheme coordinators keep residents informed of information relating to criminal activity in your area?**

Regularly	1	Occasionally	2	Never	3	W44.1
-----------	---	--------------	---	-------	---	-------

45. **How successful do you think such schemes are in preventing crime?**

Very successful	1					
Successful	2					W45.1
Make no difference	3					
Don't know	4					

Thank You

Finally, I'd like to ask just a few questions which will help us to classify the answers given above.

46.	What is respondent's sex?	Male	1	Female	2	W46.1
47.	What is your age last birthday?	_____ years				W47.1
48.	What is the highest level of education you attained?					
	None		1			
	Incomplete primary		2			
	Primary completed		3			
	Incomplete secondary		4			W48.1
	Secondary completed		5			
	Third level incomplete		6			
	Third level Certificate or Diploma		7			
	Third level Degree		8			
49.	What is your labour force status?					
	at work as an employee		1			
	self-employed with employees		2			
	self-employed without employees		3			
	relative assisting (not receiving regular wage)		4			
	looking for first regular job		5			W49.1
	unemployed having lost or given up a previous job		6			
	student		7			
	home duties		8			
	retired from employment		9			
	unable to work due to permanent sickness/disability		10			
	other		11			
50.	A. What is your usual occupation? (Describe fully; if farmer state acreage. If unemployed or retired, give last occupation. If Named Respondent is a housewife, student, looking for first regular job or never worked, ask "What is the occupation of the main earner in the household?" and refer to main earner at B to F below.)					

	_____					W50.1

	B. Do (did) you supervise or are (were) you responsible for the work of any other people?					
	Yes	1	No	2		W50.2
	C. (If working) What are your usual working hours in a week?	_____ hours/week				W50.3
	D. (If self-employed) Do you have any employees?					
	Yes	1	No	2		W50.4
	E. If yes, how many?	_____				W50.5
	F. Do you work for:					
	Civil Service		1			
	Local Authority, Health Board or VEC		2			
	Non-commercial Semi-State body		3			W50.6
	Semi-State body		4			
	Private sector (i.e. all others)		5			

51. Are you yourself a member of a trade union?

Yes 1

No 2

W51.1

52. A. Are you .

Single 1

Married 2

Widowed/Separated 3

Divorced 4

W52.1

52. B. (If married) What is your spouse's employment status?

at work as an employee 1

self-employed with employees 2

self-employed without employees 3

relative assisting (not receiving regular wage) 4

looking for first regular job 5

unemployed having lost or given up a previous job 6

student 7

home duties 8

retired from employment 9

unable to work due to permanent sickness/disability 10

other 11

W52.2

53. (If spouse working) What is his/her occupation? (Describe fully, if farmer state acreage. If unemployed or retired, give last occupation)

W53.1

54. Thinking now of all the other people in the household, could you tell me quickly their ages and sexes, starting with the eldest and working down. (Do not include the respondent.)

Age

Sex

M F

Eldest other person

1 2

080

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

Next eldest other person

1 2

W54-

- 1, 2

- 3, 4

- 5, 6

- 7, 8

- 9, 10

- 11, 12

- 13, 14

- 15, 16

- 17, 18

- 19, 20

- 21, 22

55. A. What is your Religion?

Roman Catholic	10
Church of Ireland	44
Presbyterian	43
Methodist	41
None	90
Other	xx

W55.1

B. How often would you say you attend Mass or Religious Services?

More than once a week	1
Once a week	2
Two or three times a month	3
Once a month	4
Several times a year	5
Less frequently	6
Never	7
Refused	8
Don't know	9
No answer	10

W55.2

56. Looking at this card, (Show Card B) into which category would you say your own net weekly earnings fall? How about the net income of the household i.e. the figure you would get if you added together the net incomes of all the members of the household? Be sure to include all pensions, social welfare payments, interest income etc.

<u>£/week</u>	<u>own earnings</u>	<u>net household income</u>
0-50	1	1
51-99	2	2
100-149	3	3
150-199	4	4
200-299	5	5
300-399	6	6
400-499	7	7
500-699	8	8
700+	9	9

W56.1
ownW56.2
hsld

57. If there were a general election tomorrow, which party do you think you would support?

Fianna Fail	1
Fine Gael	2
Labour	3
Progressive Democrats	4
Democratic Left	5
Green Party	6
Workers Party	7
Sinn Fein	8
Other	9

W57.1

58. People have different ideas about social classes and who belongs to them. In your own case, if you had to classify yourself in to one of the categories, which would it be?

Lower class	1
Working class	2
Middle class	3
Upper middle class	4
Upper class	5

W58.1



ECONOMIC AND SOCIAL RESEARCH INSTITUTE

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STRICTLY CONFIDENTIAL

There is a great deal of concern today about the AIDS epidemic and how to deal with it. Because of the grave nature of this problem, we are going to ask you some personal questions and we need your frank and honest responses. Your answers are confidential and will be used only for statistical reports. Co-operation with this part of the survey is, of course, entirely optional. Your answers will not be known to the interviewers and will be placed in a sealed envelope.

The past 12 months:

1. How many sex partners have you had in the last 12 months? Please circle ONE answer.

- | | |
|------------------------|-----------------------|
| No partners | 00 → Go to Question 6 |
| 1 partner | 01 |
| 2 partners | 02 |
| 3 partners | 03 |
| 4 partners | 04 |
| 5-10 partners | 05 |
| 11-20 partners | 06 |
| 21-100 partners | 07 |
| More than 100 partners | 08 |

Q1.1

2. Was one of the partners your husband or wife or regular sexual partner?

- | | |
|-----|---|
| Yes | 1 |
| No | 2 |

Q2.1

If you had NO other partners beside your husband or wife or regular sexual partner, please go to Question 4.

3. If you had other partners, please indicate all categories that apply to them. Please circle ALL the answers that apply.

- | | |
|---|---|
| Close personal friend | 1 |
| Neighbour, co-worker, or long-term acquaintance | 2 |
| Casual date or pick-up | 3 |
| Person you paid or paid you for sex | 4 |
| Other (Please specify) | 5 |

Q3.1
Q3.2
Q3.3
Q3.4
Q3.5

4. Have your sex partners in the last 12 months been ... Please circle ONE answer.

- | | |
|----------------------|---|
| Exclusively male | 1 |
| Both male and female | 2 |
| Exclusively female | 3 |

Q4.1

5. About how often did you have sex during the past 12 months?

- | | |
|----------------------------|---|
| Not at all | 0 |
| Once or twice | 1 |
| About once a month | 2 |
| Two or three times a month | 3 |
| About once a week | 4 |
| Two or three times a week | 5 |
| Four or more times a week | 6 |

Q5.1

PLEASE TURN OVER

The past 5 years:

6. Now thinking about the past five years, the time since March/April 1989, and including the past 12 months, how many sex partners have you had in that five year period?

- No partners 00 → Go to Question 8
- 1 partner 01
- 2 partners 02
- 3 partners 03
- 4 partners 04
- 5-10 partners 05
- 11-20 partners 06
- 21-100 partners 07
- More than 100 partners 08

Q6.1

7. Have your sex partners in the last five years been . . . Please circle ONE answer only.

- Exclusively male 1
- Both male and female 2
- Exclusively female 3

Q7.1

Since your 18th birthday:

8. Now thinking about the time since your 18th birthday, (again, including the recent past that you have already told us about) how many FEMALE partners have you had sex with?

_____ Female Partners

Q8.1

9. Now thinking about the time since your 18th birthday, (again, including the recent past that you have already told us about) how many MALE partners have you had sex with?

_____ Male Partners

Q9.1

10. Thinking about the time since your 18th birthday, have you ever had sex with a person you paid or who paid you for sex?

- Yes 1
- No 2

Q10.1

While married:

11. Have you ever had sex with someone other than your husband or wife while you were married?

- Yes 1
- No 2
- Never married 3

Q11.1

Thank you for your co-operation. Please place form in envelope, seal it, and give it to the interviewer or return it to us in the post.

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