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The Intersection of Reproductive, Work-Life Balance and Early-Education and Care Policies: 'Solo' Mothers by Choice in the UK and Spain

Ana Bravo-Moreno

Social Research Institute, Institute of Education, University College of London, London WC1H 0AA, UK; a.bravo-moreno@ucl.ac.uk

Abstract: This article focuses on women who have opted to be mothers on their own by choice in the UK and Spain, and how their access to assisted reproductive technologies in the National Health Service was affected because they were 35 years old or older, forcing them to go to private clinics for their treatment. Having given birth to their children, the participants face a second obstacle: the lack of policies that support work-life balance. A third obstacle also arises, in the form of a lack of childcare and early-education provision, particularly in the UK. The last two obstacles affect the whole population, but they are intensified in the case of solo-mother-families where the mother is responsible for simultaneously being the caregiver and the sole economic provider. Solo motherhood by choice highlights the impact of the absence of these policies, and the inequalities that result from current contemporary conceptualizations of family, woman and early-childhood-care and education. This article draws on ethnographic research that took place in the UK and Spain where I conducted 60 in-depth interviews and participant observations. The aim is to provide an analysis capable of capturing and confronting how inequalities affect women-mothers-workers and their children.

Keywords: public policies; assisted reproductive policies; work-life balance policies; early-education and care policies; UK and Spain; ethnography; solo-mothers-by-choice families

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1. Introduction

Single motherhood is on the rise everywhere in the world. A Pew Research Center study of 130 countries and territories shows that the USA has one of the world's highest rate of children living in single-mother households (Pew Research Center 2019). Single parents now constitute about 19% of the households with children in the EU. In the overwhelming majority of cases, this phenomenon concerns women. Only 15% of single parents are fathers, and their socioeconomic condition is better than that of single mothers. Not only are single mothers on the rise, but their situation is in many ways more challenging than that of other women. Indeed, single mothers are more likely to fall into poverty (their risk of poverty is 30%, compared to 17% for couples with children), to have taken a part-time job in order to combine professional and family life and to suffer poorer physical and mental health (Heine 2016). The newest type of single-mother family comprises solo heterosexual women who have chosen to parent alone and have had children through ART or adoption. These women are generally referred to as "single mothers by choice" (Weinraub et al. 2002). Exact figures are yet to be provided for this type of family formation, even in countries with detailed records on ART treatments (European Society of Human Reproduction and Embriology 2017). The number of single-mother-by-choice families has risen sharply since the millennium and is likely to grow given the demographic shift toward older first-time motherhood. Indeed, a significant proportion of those who now seek fertility treatment are women without a male partner (De Wert et al. 2014). Studies have shown that single mothers by choice are generally well-educated women in professional occupations who become mothers in their late 30s or early 40s (Hertz 2006). Children of single mothers by

choice, however, have not been exposed to parental conflict and are less likely to experience the financial difficulties or maternal psychological issues that often occur as a consequence of marital breakdown or unplanned single motherhood (Jadva et al. 2009).

Thus, the purpose of this article is to fill in the knowledge gap and our understanding of the complex interaction between women-mothers-workers, socio-cultural contexts, states, and social policies on reproduction, work-life balance and early-childhood education and care. What barriers do women in the UK and Spain face on the road to becoming solo mothers by choice, and how do they navigate these challenges? Hence this article has the following aims: first, to identify the dominant approaches and the ways in which the normative assumptions and lack of reproductive, work-life balance and early-education and care policies are challenged in the UK and Spain. Second, to examine the unequal access to assisted reproductive technology (ART) as a reproductive right to form a family. Third, to analyse the gendering of policies and the way responsibilities for caring needs are allocated between families and the state. Finally, it aims to explore how women juggle both earning a living and mothering their children, and how the welfare state and policy paradigms do not consider the unpaid care work, which contributes to gender inequalities in the labour market and other spheres of life. I will draw on an ethnographic study that focuses on the UK and Spain to examine the effects of these policies, the social contexts in which they are applied and the desires, frustrations and needs expressed by the women interviewed. The data produced by this study reflects the different expectations the participants harbour in each country. I will argue that both in the UK and in Spain, women aged 35 and older who wish to have a child by themselves with the help of ART are discriminated against. In general, these women cannot access ART in their public health systems because they are considered "too old". Thus, those who decide to be solo mothers by choice have to plan years in advance, researching this option while saving money so as to be able both to pay for their ART treatment in private clinics and have a financial cushion to be able to afford early education and care for their children from 0 to 5 years old, particularly in the UK. These women then have to worry about whether they can balance their full-time job with motherhood. In some cases, they try to meet the expectations of their employers of working 70 h a week, while in others, they are forced to opt for part-time employment because their employers give no consideration to work-life balance. Some are even pushed to the brink of becoming homeless. The article is divided into four sections. Firstly, I describe the context of public policies in relation to work-family balance, and early education and childcare in the UK and Spain. Secondly, I explain the research methodology and theoretical approach. Thirdly, I examine the first obstacle that women encounter when they decide to start a family on their own using assisted reproductive technologies in the UK and Spain. Lastly, I analyse the interrelation of the second and third obstacles: how women juggle work and family life while managing the care and education of their children in the UK and in Spain.

2. Context

Within post-war Western Europe, the prevailing view of gender roles and responsibilities has been that of the woman as mother and primary caregiver, and the man as head of the household and principal breadwinner. These assumptions pervade all aspects of social and political behaviour and sustain far-reaching political and socio-economic inequalities between men and women (Doepke and Zilibotti 2019). In the context of policy-making, these assumptions give rise to "policy paradigms" based upon particular norms and values that help to define the policy problem as well as possible solutions. As Bacchi and Goodwin (2016) argue, policy problems do not exist "out there", but are socially constructed. Comparative analysis of childcare policy illustrates that childcare provision has typically been constructed as an educational policy issue and handled by policymakers who have focused upon the educational needs of pre-school-age children. In consequence, the employment needs of parents, and their needs regarding childcare, have rarely been considered (Randall 2011). This is because many social rights of citizenship are dependent on participation in paid employment in the public sphere, whereas many women undertake

unpaid care work in the household. Within the context of this policy paradigm, women are perceived primarily as mothers and dependants and, as such, are disadvantaged vis-a-vis men in terms of social rights, labour market position and associated fiscal policies. Thus, the heterosexual nuclear family model has become the "great balancing mechanism" (Saraceno 2008, p. 31).

As Randall (2011) argues, without affordable childcare, women's capacity to participate in the labour market and to be economically independent is severely constrained. The report by the European Commission/EACEA/Eurydice (2019) on early childhood education and care confirms, notwithstanding the pressures for policy convergence within Europe, that significant national differences remain with regard to the amount, cost and type of childcare provision available. This diversity confirms the continuing importance of state national welfare regimes and deeply embedded "policy paradigms" regarding the family, which have an important impact upon policies affecting women in the UK and in Spain. Work-life balance policies are intended to smooth out imbalances and conflicts between the contradictory demands of the labour market and family and personal care needs. These tensions become evident in decisions such as having a baby, when to have them or where to live, and they affect aspects of our lives such as the care of our children and family members or our work careers. What we experience as individual problems and discomfort is embedded in deeper social and economic processes, which the design and application of public policies can help to shape, to one degree or another, according to their management and ambition.

To explore these questions, it is worth considering two related issues that dominate the popular discourse about motherhood and employment: (1) the difficulties of balancing motherhood and paid employment; and (2) the fact that mothers are having their first children later in life (Eurostat 2020; UNICEF 2011).

Recent studies of gender discrimination suggest that in addition to inequalities in pay, women experience discrimination in terms of workload and the kinds of work available to them and in terms of the inflexibility of working hours (Social Issues Research Centre 2012). According to the Global Gender Gap Report by The World Economic Forum (2016), it will take women 170 years to close the salary gap with men and to achieve equality in this area. A higher percentage of women are over-qualified for their position, while the low number of women that reach management positions is worrying. According to Conde-Ruiz and Marra de Artinano (2016, p. 21): "These glass ceilings are explained by the lack of work-family balance, the serious imbalance between qualification and job positions in the case of women, and gender stereotypes." Women suffer more from wage inequality and part-time work after the age of 35, when many of them choose to be mothers. This phenomenon is what experts call "the maternity penalty" (Correll et al. 2007) which carries with it a series of labour consequences for women: greater difficulty in finding employment, greater unwanted part-time work, and the request of practically all leaves of absence for reasons of family care, at 90.6% in Spain (INE 2019).

Sara de la Rica, professor of economics, asserts that after the age of 30, when the decision is made to be a mother, women are forced to turn to occupations that are compatible with family responsibilities (de la Rica and Gorjón 2016). Childcare and other caring tasks fall to women due to a lack of joint responsibility in the family unit and due to the shortfalls of public policies. Caring responsibilities are reasons for inactivity for almost 31% of inactive women, while this is only the case for 4.5% of men. The economic loss due to the gender employment gap amounts to around EUR 370 billion per year for the European Union as a whole: "Taking action is both a social and an economic imperative. Improving gender equality could lead to an increase in GDP of up to €3.15 trillion by 2050" (European Institute for Gender Equality 2021). In the case of the UK, in recent decades there has been a dramatic increase in the number of single-parent families. Thirty percent of households with children are headed by single parents, the large majority of whom are single mothers (Institute for Fiscal Studies 2017).

The reason for the trend towards delayed motherhood in industrialized countries is multi-layered. However, a combination of interrelated factors is likely to be influential, such as access to contraception, increased duration in full-time education and women's participation in the labour market (Broclchain and Beaujouan 2012; Cory and Stirling 2015). According to the OECD (2011), the UK spent 3.4% of GDP on family policies, Spain spent 1.2% and the average in OECD countries was 1.9%. However, in terms of better outcomes for families, such as the ability to lift children out of poverty and gender equality, the UK lagged behind countries that spent less. Childcare costs in the UK are considerably higher than the 13% of overall family income it costs on average across the OECD. The United Nations Children's Fund (UNICEF) states that in relation to the composition of income-poor families with children, the proportion of sole-parent families varies from 24% in the UK to 7% in Spain (UNICEF 2012).

Research Methodology and Theoretical Approach

This study employs a feminist-standpoint approach (Collins and Bilge 2020; Harding 2004; Yuval-Davis 2015) that makes three principal claims: (1) knowledge is socially situated; (2) research aims to study the terms and understandings of the target groups to give an in-depth insight into the particular settings where the participants' ideas on motherhood, mothering and their children's education have been formed and conditioned by multiple factors; and (3) research, particularly research that focuses on power relations, should begin with the lives of the marginalized. The epistemology and methodology are rooted in the idea that three levels of analysis should be considered: socio-cultural, institutional and experiential. This approach structures and limits the comparative research design, focusing upon diverse national policy issues and political developments in the UK and in Spain. Indeed, according to Purdon et al. (2001), qualitative approaches enable the investigation of the range of factors that can affect overall outcomes and provide detailed exploration of those that underpin participants' experiences of policy programmes.

In keeping with standpoint theory, I am drawing reflexively on my own position to inform the data analysis (Collins and Gallinat 2010; Ellingson and Ellis 2008; Hancock 2009). I am a solo mother by choice who has lived in the UK for a total of more than 16 years and in Spain for more than two decades, and worked most of my adult life in both countries. Throughout I have tried to square the circle of being a mother and a worker without having a family or social network in any of the cities where I found myself, faced with unjust policies of reproduction, work-life balance and early-childhood education. This article draws on ethnographic research that took place in London (UK), Madrid and Andalusia (Spain), where I have carried out 60 in-depth interviews and participant observations since 2017. These women were chosen through the snowball method which began among different groups of acquaintances and associations of single mothers by choice. Participant observation was undertaken in parks where mothers, for the most part, and their children, aged between one and eight, would gather, as well as my participation in parent meetings and children's parties over a nine-year period (2012–2021). I also kept a research diary and field notes of my interviews and observations made in different contexts: parks, schools, children's parties and outdoor excursions.

I conducted the interviews between January 2017 and 2021, thirty of which were with women in Spain, between the ages of 36 and 57 years old, who were heterosexual, university educated, middle class and white. The other thirty in-depth interviews took place in London, between September 2018 and 2021 (Table 1). Most of these women stated that they were heterosexuals, with one bisexual and another pansexual, university educated and between the ages of 35 and 65 years. In London, seventeen participants are white British, one is a white South African and twelve are white from European countries (Belgium, France, Ireland, Italy, Greece, Norway, Poland, Spain, Sweden, and Ukraine) who emigrated to London years ago.

Table 1. List of participants in the UK and in Spain.

SAMPLE IN THE UK						
Pseudonym	**Age**	**Colour (Participants' Self-Identification)/ Nationality**	**Sexual Orientation**	**Profession**	**ART Treatment**	**Children**
1. Hannah	43	White Sweden	Pansexual	Musician and Executive head-hunter tech industry	Her frozen eggs (at age 37) and non-anonymous sperm donation from the USA	1-year-old son
2. Ruby	48	White UK	Heterosexual	Film TV Agent	Double anonymous donation Spain	2-year-old son
3. Louise	47	White UK	Heterosexual	Director research company	Double donation, egg from her sister and non-anonymous sperm donation from the USA	2-year-old son
4. Mila	38	White France	Heterosexual	Human resources manager	Non-anonymous double donation, egg from the UK; sperm from abroad (she did not want to specify).	3-month-old son
5. Eleanor	37	White UK	Heterosexual	Project manager for high network travel	Non-anonymous double donation; donor sperm from Denmark and egg from donor in the UK.	8-month-old daughter
6. Martine	53	White Belgium	Heterosexual	Physiotherapist	Anonymous sperm donor from the UK and her own eggs.	10-year-old son
7. Katya	47	White Ukraine	Heterosexual	Mental health nurse	Anonymous embryo donation in Spain.	5-weeks-old daughter
8. Joyce	48	White UK	Heterosexual	Consultant for a multinational retailer	Non-anonymous sperm donor from the UK and her eggs	9-year-old son
9. Emerald	65	White UK	Heterosexual	Social worker	Anonymous sperm donor from the UK and her eggs	23-year-old son
10. Debbie	60	White South Africa	Heterosexual	Head-Midwife	Anonymous Jewish sperm donor from the UK and her eggs	17-year-old son
11. Claire	42	White UK	Heterosexual	Senior marketing consultant.	Non-anonymous donor sperm from the USA and her eggs.	19-month-old daughter
12. Ellen	35	White Ireland	Heterosexual	Patient safety manager	Non-anonymous sperm donor from the UK and her eggs.	9-month-old son
13. Susan	54	White UK	Heterosexual	Freelance solicitor, criminal law	Double anonymous donation (sperm and egg) from Spain	10-year-old son
14. Marina	49	White Italy	Bisexual	Yoga and Italian teacher	Double anonymous donation (sperm from Mexican donor in Denmark and egg donor from Greece) at a clinic in Greece.	3-year-old son

Table 1. *Cont.*

SAMPLE IN THE UK						
15. Emily	39	White UK	Heterosexual	Freelance for international NGOs	Non-anonymous sperm donor from Denmark and her own eggs.	2-month-old daughter
16. Nina	39	White Spain	Heterosexual	Manager at UK NGO	Mexican sperm donor from the USA and her own eggs, travelled to Spain for embryo implant.	1-month-old daughter
17. Melanie	53	White UK	Heterosexual	Headteacher	Anonymous double donation in Spain.	10-year-old daughter
18. Mia	40	White Poland	Heterosexual	Nurse	Non-anonymous sperm donor from Denmark and her own eggs.	4-year-old son
19. Isabelle	59	White France	Heterosexual	Accountant	Anonymous double donation in Spain	14-year-old daughter
20. Ella	45	White Ireland	Heterosexual	Software developer	Non-anonymous sperm donor from the UK and her eggs.	6-year-old son
21. Chloe	38	White UK	Heterosexual	Human resources manager	Non-anonymous sperm donor from Denmark and her eggs.	14-month-old son
22. Olivia	61	White Norway	Heterosexual	Purchasing manager	Anonymous double donation from Spain.	16-year-old daughter
23. Evelyn	46	White UK	Heterosexual	Taxation expert	Non-anonymous sperm donor from the UK and her eggs.	8-year-old son
24. Sophie	57	White UK	Heterosexual	Barrister	Non-anonymous sperm donor from the USA and anonymous egg donor from Spain, clinic in Spain	10-year-old daughter
25. Amelia	40	White Spain	Heterosexual	Teacher	Anonymous sperm donor in Spain	2-year-old son
26. Harper	44	White UK	Heterosexual	Associate professor	Non-anonymous sperm donor from the UK and anonymous egg donor from Spain, clinic in Spain	6-month-old daughter
27. Rosie	37	White UK	Heterosexual	Nurse	Non-anonymous donor UK and her eggs.	1-year-old son
28. Grace	51	White UK	Heterosexual	Analyst IT company	Non-anonymous sperm donor in the UK and her eggs	13-year-old son
29. Alice	43	White UK	Heterosexual	Mathematician	Non-anonymous donor in the USA and her eggs	8-year-old daughter
30. Clara	39	White UK	Heterosexual	Medical doctor	Non-anonymous sperm donor in the UK and her eggs.	3-year-old son

Table 1. *Cont.*

SAMPLE IN THE UK						
SAMPLE IN SPAIN						
	Age	**Colour (Participants' Self-Identification)/ Nationality**	**Sexual orientation**	**Profession**	**ART**	**Children**
1. Gema	43	White Spain	Heterosexual	Social worker	Anonymous sperm donor in Spain and her own eggs.	4-year-old daughter
2. Carol	51	White Spain	Heterosexual	Administrative	Anonymous double donation in Spain	5-year-old son
3. Lia	38	White Argentina	Heterosexual	Lecturer	Anonymous sperm donation in Spain and her eggs.	3-year-old son
4. Marta	38	White Spain	Heterosexual	Human Resources Manager	Anonymous sperm donor in Spain and her eggs.	10-month-old daughter
5. Raquel	55	White Argentina	Heterosexual	Psychoanalyst	Anonymous double donation in Spain	13-year-old son
6. Carmen	42	White Spain	Heterosexual	Pharmacist	Anonymous double donation in Spain	14-month-old son
7. Vera	47	White Spain	Heterosexual	Freelance, creative advertising company	Anonymous embryo donation, from a woman who used her egg and a sperm donor Spain.	7-month-old daughter
8. Eva	48	White Spain	Heterosexual	Translator	Anonymous sperm donor in Spain and her own eggs.	2-year-old son
9. Noelia	36	White Spain	Heterosexual	Teacher	Embryo donation from anonymous frozen gametes in Spain.	6-month-old daughter
10. Rosa	54	White Spain	Heterosexual	Journalist	Anonymous sperm donation in Spain and her eggs.	10-year-old daughter
11. Irene	39	White Spain	Heterosexual	Architect	Anonymous sperm donation in Spain and her eggs.	8-month-old son
12. Miriam	56	White Spain	Heterosexual	Biologist	Anonymous double donation in Spain	11-year-old daughter
13. Lidia	54	White Spain	Heterosexual	Solicitor	Anonymous sperm donor in Spain and her eggs	10-year-old son
14. Nerea	49	White Spain	Heterosexual	Sociologist	Anonymous sperm donor in Spain and her eggs.	14-year-old daughter
15. Sara	53	White Chile	Heterosexual	Entrepreneur	Anonymous double donation in Spain	12-year-old son
16. María	46	White Spain	Heterosexual	Civil servant	Two anonymous sperm donors in Spain and her eggs.	4 and 6 year old children
17. Julia	54	White Spain	Heterosexual	Secretary	Anonymous double donation in Spain	7-year-old daughter
18. Nuria	39	White Spain	Heterosexual	Economist	Anonymous double donation in Spain	10-month-old son

Table 1. *Cont.*

SAMPLE IN THE UK						
19. Alicia	57	White Argentina	Heterosexual	Graphic designer	Anonymous sperm donation in Spain	12-year-old daughter
20. Claudia	42	White Spain	Heterosexual	Psychiatrist	Anonymous sperm donation in Spain	2-year-old daughter
21. Mamen	53	White Spain	Heterosexual	Accountant	Anonymous donated embryo implant in Spain	9-year-old son
22. Flor	36	White Spain	Heterosexual	Speech therapist	Anonymous sperm donor in Spain	6-month-old daughter
23. Ainhoa	45	White Spain	Heterosexual	Web developer	Anonymous double donation in Spain	3-year-old daughter
24. Fátima	57	White Spain	Heterosexual	Dentist	Anonymous sperm donor in Spain	12-year-old son
25. Olga	38	White Spain	Heterosexual	Teacher	Anonymous sperm donor in Spain	18-month-old son
26. Alejandra	59	White Spain	Heterosexual	Medical doctor	Anonymous sperm donor in Spain	14-year-old daughter
27. Rocío	41	White Spain	Heterosexual	Medical doctor	Anonymous double donation in Spain	4-year-old son
28. Estela	53	White Spain	Heterosexual	Professor	Anonymous double donation in Spain	9-year-old daughter
29. Matilda	42	White Spain	Heterosexual	Chemist	Anonymous sperm donor in Spain	2-year-old daughter
30. Amparo	36	White Spain	Heterosexual	Teacher	Anonymous sperm donor in Spain	7-month-old son

The children of these women are between the ages of five weeks and 23 years old, and were conceived through sperm donation and in 21 cases also with egg donation, with four cases of embryo donation. For the first seven years of my own daughter's life I lived in Granada (Spain), before moving to London for two years. In both places, I enrolled my daughter in a state school in the urban centre. I participated in the educational communities of each school both as a mother and as an ethnographer. As a result of my fieldwork, I became a member of two associations: Madres Solteras por Elección (MSPE) (Single Mothers by Choice) in Spain, and the Donor Conceived Network (DCN) in the UK. I attended meetings, workshops and conferences both in Madrid and in London from 2018, and also participated in the WhatsApp groups of both associations.

3. First Obstacle: "Solo" Motherhood in Spain and the UK, Access to ART

The proliferation of ART has contributed to some of the major transformations in the Western kinship model over the past few decades. The use of biotechnologies has shifted the way reproduction is perceived and has impacted on contemporary family structures and dynamics. The new possibilities of reproduction, in-vitro fertilization, gamete donation and surrogacy have raised new opportunities for thinking about kinship that destabilise the nuclear heterosexual family framework. Even though heterosexual intercourse has ceased to be a necessary element for reproduction, it still operates as the global norm, from cultural customs, religious constraints to national laws. National laws mandate, for example, that in Europe the use of ART is allowed for heterosexual couples in every country, although many reserve it for married couples. Ten countries deny access to ART to solo women, up to thirteen to lesbian couples and surrogacy is banned in most countries in the world, and where it is allowed, strong restrictions against commercial surrogacy are in place (ESHRE 2017). The extent of ART usage varies widely across countries, largely because of differences in the laws, the affordability and the norms surrounding child-bearing and conception. While restrictive national legislation can be easily circumvented by crossing national boundaries for ART treatments, questions of equity of access have been raised, as not all prospective parents can afford the treatment or to travel for it (ESHRE 2018). These restrictions are a source of a number of reproductive mobilities both from and to different European nations and other regions in the world, depending on the practice that is banned for different groups of people in the individual country. Actual numbers of solo individuals and same sex couples using ART nationally or transnationally vary significantly across countries, there is not a reliable statistical picture. According to Salama et al. (2018), the major global markets for the cross border reproductive care (CBRC) industry are as follows: (1) Belgium and Israel for IVF, (2) Denmark for sperm donation, (3) Spain and Czech Republic for egg and embryo donation, and (4) Russia and the USA for commercial surrogacy.

Spain and the UK are amongst the few countries that are leaders in ART and two of the most advanced in the world in sexual and reproductive health rights (SRHR) in terms of access to ART by non-normative families. They have: (1) legislation governing ART, whether independently or part of broader legislative frameworks; (2) they supplement legislation with professional guidelines; (3) they are in the top 34 countries on the WHO's league table of the world's best national health systems (WHO 2000); and (4) they do not legally discriminate against individuals due to their sexuality or marital status.

However, a comparison of the regulations indicates that not only do diverse European countries have different regulations, but the laws in these two countries are not internally consistent or necessarily implemented at the national level (ESHRE 2018). Three examples stand out: (a) permissive legislation on one issue (e.g., solo women, same-sex couples) does not guarantee access to ART for all solo women or same-sex couples; (b) differences in regulations indicate complex contradictions at the national level, or long waiting lists for solo or same-sex couples in ART clinics in Spain and in the UK (Bravo-Moreno 2021); and (c) affordability affects access to ART treatment, with the cost per live birth being the highest in the UK (EUR 35,647) and the lowest in Spain (EUR 21,489) (Crawford et al.

2016). Due to a flexible legal framework and the safe, clinically efficient, patient-focused and evidence-based medical care offered, Spain ranks the highest in Europe for fertility treatment to non-nationals (ESHRE 2018) and third in the world (Ministerio de Sanidad, Consumo y Bienestar Social 2020). In 2006 it became legal for solo women and lesbian couples to access ART. Law 14/2006 on Human Assisted Human Reproduction in Spain (BOE 2006) is one of the most advanced throughout Europe. Spain became a popular destination for international patients seeking ART treatments abroad. With the passing of the General Health Care Act in 1986, the right to healthcare was defined through a universal and decentralized national health system, which follows the model of a quasi-federalist state across Spain's 17 regions (López-Casasnovas 2003). The Spanish law on gamete donations is different from that of other countries, protecting the anonymity of donors, which positively influences the high rate of egg and sperm donation, according to the experts. Although there are no accurate data on solo individuals or same-sex couples who use ART, medical practitioners indicate that the number is increasing.

For example, in 2012 in the Basque Country, Andalusia or the Balearic Islands, a lesbian or a solo woman could access an assisted reproduction centre on the national health system and undergo treatment to become a mother. However, in Madrid, Catalonia, Murcia or Castilla-La Mancha, this was not possible. In these regions women had no choice but to pay a private clinic to access ART. The law is the same for all, but their interpretation of the law may differ between the 17 regional health administrations, particularly the requirement that refers to the need for there to be "a diagnosis of sterility or a clinical indication". Furthermore, it depends on what the health departments understand by sterility: whether it is a strictly physiological question or if it goes further. If it is the latter, then it is not only about solving specific problems of reproductive disorders, but also making motherhood accessible to different family models. Hence the accusations that the most restrictive positions in different regional health administrations are fuelled by ideological arguments that limit the concept of family to the union formed by a man and a woman (Prats 2012). Women may face waiting lists that take years to access treatment on the national health system, depending on the regional health administration. In the case of Andalusia, if women are older than 35, they have to pay for treatment privately. In the case of Madrid, the deadlines for receiving treatment counting from the first visit to the general practitioner in the six public hospitals that perform it vary from just over two to around four years (Medina and Mateo 2019). On 5 November 2021, Spain's Health Minister in the socialist government signed an executive order reversing a ban on solo women and LGBTQ people from accessing free in vitro fertilisation (IVF) services. The order restores the right of solo women and transgender people to receive IVF, one of the many forms of assisted reproductive health services covered under the country's public health system. This move comes nearly six years after the right-wing Popular Party government imposed a discriminatory policy in 2014 that restricted the treatments to heterosexual couples with fertility disorders (Borra 2021).

In the United Kingdom, according to the National Health Service (NHS 2019), fertility treatment funded by the NHS varies across the UK and waiting lists for treatment can be very long in some areas. The eligibility criteria can also vary. The coverage is based on infertility guidance from the National Institute for Health and Clinical Excellence (NICE 2017). Nevertheless, individual NHS clinical commissioning groups (CCGs) make the final decision on who can have NHS-funded fertility treatment in their local area, and their criteria may be stricter than those recommended by NICE. This results in unequal access to treatment, as the final decision depends on local CCGs, which forces those potential mothers and parents who can afford it to go privately. As the price of private fertility treatment in the UK is high, some people go abroad for treatment where it is more affordable. Exact figures on just how much this group is growing are hard to find, as those who have treatment outside the formal clinic system in the UK are not captured in UK statistics. From 2005, the law was changed to allow children born through gamete donation to access identifying details of the donor. One of the consequences of this reform has been

an acute shortage of donors (Turkmendag Ilke and Murphy 2008) and patients travelling to other destinations for treatment (ESHRE 2017).

Debbie, a 60-year-old Jewish white South African and British citizen who arrived in London in her twenties, gave birth when she was 43, with her own ovum and sperm from an anonymous Jewish donor. She is a head midwife at a public hospital in London (where I interviewed her), earning GBP 40,000 per year:

> I think the policies about help with getting pregnant are awful, because they're postcode luxuries, so it depends where you live, how much you get, what support you get. Who decides who is going to be a mother? Some pen pusher has decided in Brent, you can be a mother if you are under 28, and if you are married. In Greenwich I know a 32 year old woman, and she's a lesbian and she got three IUIs (Intrauterine insemination—IUI—is a procedure that puts sperm directly inside the uterus, which helps healthy sperm get closer to the ovum). How do they decide this?

Estela, a 53-year-old university professor from Madrid, had her daughter when she was 44 years old through double anonymous ovum and sperm donation in a private clinic in the Spanish capital:

> I was told by my doctor that I could not receive treatment on the public health service. Only those women who were younger than 35 had access, and as there was a three-year waiting list, even those who were 32 years old when they applied for the treatment were not assured of getting it when they reached 35. It doesn't seem fair to me, since I've paid taxes my whole life. A smoker who's chosen to smoke all his life can receive treatment in public healthcare for any disease caused by his addiction. Why does he get it when I don't?

Professional legal advice warns that refusing treatment to patients based solely on sexual orientation, marital status or women's age, may constitute illegal discrimination and does not have a sound ethical basis. Historically, women have continued to bear children until the end of their reproductive age. What is different nowadays is that there is an increase in the age at which women give birth to their first child (Eurostat 2020). The global fertility rate has fallen rapidly for several major reasons: women's growing access to education and increasing labour market participation, their opportunities for family planning, technological, sociocultural and economic changes, as well as a rising cost of bringing up children, to which the decline of child labour contributed. As part of the changing field of motherhood, we also need to take into account the impact of ART and the fact that women live longer. Women are having their first baby later in life, and social and media debates tend to be played out through a discussion of the clinical problems regarding older women's ability to carry a pregnancy in their late thirties and forties and give birth to a healthy child. This tends to simplify and distort the science around fertility. Research by the British Pregnancy Advisory Service (BPAS 2015) shows that there is disproportionate concern among women about their fertility, and a tendency to overestimate the difficulties that may be encountered conceiving at the age of 35 or older.

All the study participants declared that they had a strong desire to be mothers. All had had couple relationships in which they had wanted to share their wish to be mothers with their then partners, but were unable to do so, for many reasons. They therefore chose to pursue their dream of being mothers on their own, using ART. In all cases, participants state that it took them years to reach this decision, and that they prepared themselves mentally and financially to be able to cope with the costs that the decision entailed. An example of this is Joyce, 48 years old, who had her son 10 years ago with her own egg and a UK non-anonymous sperm donor from a private clinic. She is white British, a former consultant for a British multinational merchandise retailer earning GBP 100,000 per year. She talks about her journey to get the money to be treated privately and to have time off when she had her child to be able to care for and be with him.

> I had worked from the age of 21 until I was 38, when I had my son, that is, for 17 years. I worked before I was 21, in all the holidays between school and university and all of that as well, but full-time, seventeen years. Had a great career, earning bucket-loads of money. I didn't go on holiday for three years. I saved it all. I then took my three years off after my son was born.

A second example is Mila, a 38-year-old white French woman who has lived in London for the past twenty years, and works in human resources earning GBP 100,000 a year. She underwent ART in a private clinic in London and had a non-anonymous double donation (egg from a London donor and sperm from a donor abroad). She gave birth 8 months ago to her son: "It took me literally six years to get pregnant. So, during that time, I've saved a lot of money to pay for treatments, it also allowed me to take two years off to look after my son." Up until the time of their pregnancy, all the interviewees worked full time, and used their pay, savings and family inheritance to invest their money in ART treatment. Emerald, who is white British from London, 65 years old with a 23-year-old son who was conceived through sperm donation and her own egg, used the IUI method for 30 cycles over three years. Isabelle, a white French resident in London, had seven IVFs over a five-year period.

However, one of the most obvious and long-standing ethical challenges surrounding assisted reproduction is the inequitable access to treatments and whether high costs interfere with procreative rights that include access to ART. Some argue that access to publicly funded ART is justified by the social advantages resulting from facilitating reproductive choice. A related argument is that state funding of ART fulfils the state's obligation to promote good health, including reproductive health (Zucker 2014). Another more practical argument is that the public funding of ART will help halt the declining fertility rates and promote the addition of productive members of society. This may be an increasingly acceptable justification for the public funding of ART in countries experiencing a negative or flat population growth rate and seeking to develop public policies to alleviate the financial dilemmas of an aging population (Hoorens et al. 2007). Spain and the UK have very low fertility rates, 1.3 and 1.7 respectively, which may jeopardize the future of their welfare systems (The World Bank 2019).

ART is viewed by the interviewees as a useful tool in achieving women's liberation and autonomy by allowing them to control their reproduction (Zucker 1999). From a socio-legal perspective, the use of ART may, for many reasons, become an opportunity for women, providing they have the means, to re-appropriate their bodies in order to access maternity on their own or with a lesbian partner. The European Society of Human Reproduction and Embryology (ESHRE) has publicly opposed the introduction of restrictive ART legislation. All treatments known to be safe and effective should be available to all patients, who should be given the opportunity to make informed reproductive choices on the basis of sound scientific evidence.

However, the constant reference to "infertility" by the World Health Organization relies on heterosexual sex as a reference point, excluding "solo" patients and same-sex couples who currently seek fertility treatment. The sociologists Fledderjohann and Barnes (2018) have pointed out that statistics about infertility, which tend to be based on the reports of heterosexual couples, ignore the single, less affluent, or non-heterosexual people who cannot have children for reasons that are only sometimes related to their bodies. On the surface, the effort to expand access to "infertility" treatment depends on the idea of equal rights. The World Medical Association's (WMA) Statement on ART, adopted by its General Assembly in October 2006, observes that "inability to become a parent without medical intervention (...) is a cause of major psychological illness and its treatment is clearly medical" (WMA 2006). ART treatment is undoubtedly justified as a medical service and medical attention assisting the achievement of the goal of reproductive health. Its prohibition or undue obstruction is a human rights violation (Schenker 2011).

The specific form taken by legislation with respect to the limits of reproductive technologies and the ways they are used can be interpreted as a reflection of the cultural

conception of what motherhood is and should be, as well as of the social perception of fatherhood. Some feminist bioethicists argue that because women carry greater burdens with regard to biological and social reproduction, bioethical issues surrounding medically assisted reproduction are essentially debates over women's rights to bodily integrity and reproductive autonomy (Scully et al. 2010). Other bioethicists argue that issues surrounding procreation involve human rights (Donchin 2004), regardless of gender, because the desire to have children and to participate in family life is a fundamental biological and social aspect of being human. Reproductive freedom or procreative liberty is essentially the individual right to have or avoid having children and to have the information and means to do so. Nevertheless, all the participants were denied access to ART on their national health services due to their age. If these women had not had the money to pay for their assisted reproduction treatment, they would not have been able to become mothers. Additionally, once they had confronted this first obstacle, a second and a third lay in wait: balancing the raising of a child with paid employment.

4. Second and Third Obstacles Intertwined: Work-Life Balance Policies and Early Education and Care Policies in the UK

Work-life balance policies are diverse due to the varying combination of public policy instruments that mobilise them, but also because of the cultural and institutional contexts that model them and are at the same time modelled by them. These contexts are known as "welfare-state regimes". More accurately, welfare regimes refer to qualitatively different arrangements between state, market and the family in welfare provision. Although there are different typologies, the most used is that formulated by Esping-Andersen (1990), which distinguishes three ideal types of welfare-state regimes: the liberal or Anglo-Saxon, the conservative or Continental and the social-democratic or Nordic regime. In European welfare studies, this classification is usually complemented by a fourth type, the Mediterranean welfare regime, which includes the southern European countries (Ferrera 1996).

Each of these regimes is characterized by a certain interaction between the public sector, the market and families, by fomenting a certain type of social stratification, by a different conception of citizens' social rights, and by a different significance of the meaning of the sexual division of labour and of gender relations. The so-called Anglo-Saxon regimes, such as the UK and Ireland, were historically characterized by an institutionalized individualist liberalism and familialism that have acted against universalist welfare policies. The private market and women have been the chief welfare providers with state social assistance reserved for those in marked poverty (Esping-Andersen 1990). In other words, the welfare of families in these countries has essentially depended upon participation in the market, purchasing power and family connections and inheritance. Female employment rates are relatively high in these countries, although the relation of women with employment has traditionally been characterized by discontinuity and high rates of part-time employment.

In the UK between April and June 2019, three in four mothers with dependent children (75.1%) were in work, although only 44% of women were in full-time employment. This compared with 92.6% of fathers with dependent children who were in full-time employment. Almost 3 in 10 mothers (28.5%) with a child aged 14 years and under said they had reduced their working hours because of childcare reasons. This compared with 1 in 20 fathers (4.8%) (Vizard 2019). In addition, a survey, conducted by Eurostat and published by the Office for National Statistics (UK), questioned more than 13,000 people in Britain, concluding that: "Mothers may be more likely than fathers to throw a sickie at work when their children are ill and off school, and mothers of young children are also likely to stay at home to care for young children sent home from a nursery or by a child-minder because they are ill" (Eurostat 2019). In the face of low state coverage, this labour pattern has become the prime balancing strategy of women and families. Hence the Anglo-Saxon balance model has been called the "one-and-a-half breadwinner" model (Lewis 2001). Families—meaning, in most cases, women—have to turn to private care services or to the help of other family members. However, only middle and high-income families can afford

the price of quality private care services, which creates a dual family stratification. The care service sector has traditionally been weak.

5. Pre-School Education and Care Policies: The UK

Early childhood education and care (ECEC) refers to the care provision and education of children below primary school age outside of their family and home setting. The use of external childcare services is based on the combination of two factors, parental choice and the availability of such services. Childcare provision is central to many policies—child welfare, education, social and even employment policies—and includes a wide typology of services: early childhood care and education, emergency childcare, drop-in part-time babysitting services, care services for sick children, multi-purpose childcare facilities, out-of-hours childcare or out-of-school care. This is not only essential for the healthy development of the child, but also to allow parents, especially women, to sustain or find employment. It is also a social inclusion measure that reduces the risk of poverty and social exclusion. The United Kingdom has a high overall education expenditure, but this includes the largest percentage of private expenditure of any European country. While similar levels are spent on education overall in the UK and Sweden, 20% of the total is private expenditure in the UK compared with 3% in Sweden. In the EUROSTAT "child wellbeing index", the Netherlands scores best, while the UK receives the lowest rankings. Fairly similar rankings emerge from the OECD Doing Better for Children (OECD 2009), with the Nordic countries showing excellent results for child well-being, and the UK performing weakly. The average childcare costs for families with two children, in OECD countries, amounted to 13% of overall family net income. However, there are wide variations, ranging from 4% in Belgium to 33% in the United Kingdom. Payments for the cost of services for a two-year-old are lowest in Spain and highest in the UK (OECD 2009, p. 68). All EU countries have some period of leave for parents of young children: half the countries (14) offer six months or less, with the UK having the shortest period at six weeks, while Spain offers 16 full-paid weeks.

Admission to formal compulsory schooling occurs at age five in England. There is no consideration of a full-time entitlement to early childhood services for all children under compulsory school age. Most forms of care are provided by the private sector. Another common form of childcare is that provided by friends, neighbours and family members. From her research on forms of ECEC provision, Lloyd (2015) stated that the UK's early-childhood education and care system remains deficient in accessibility, affordability and quality. Young children's rights and interests appeared to have been subjugated to the perceived interest of the economy and the government's deficit-reduction. According to Lloyd (2015), the absence of any consideration given to children's rights to quality early-years provision and of early childhood as a legitimate phase of life, more than as preparation for later educational outcomes, raises serious concerns about the future direction of early-years policymaking under the Conservative Government. In keeping with this, one participant in this study, Ellen, calls for public policies of work-life balance, and of early-childhood education. She is 35 years old, from Dublin but living in London for the past ten years. She was treated in a private clinic and gave birth in a London public hospital nine months ago to a boy, the result of her ovum and a UK sperm donor. She works in patient safety management in the NHS and has a salary of GBP 63,000 per year.

> I think there should be significantly more support for childcare placements, and particularly for women in Britain. Governments make a big deal about equal pay, and wanting to support women in the workplace, and everyone knows that the biggest reason is around women going on maternity leave, and then childcare. If it was childcare vouchers, or support that is a tax relief on getting your child in, that just feels much more equal and fair. I also think there is social judgement: "You decided to have a child on your own, and now you can't do it, then you shouldn't have decided to do it". Children's centres should be free. I am paying for them with my taxes too . . . you'd avoid any sort of judgement because you've

> not been given it, you've just being allowed to access childcare the same way that everyone else is, so that you can get back to work, and earn money, and pay taxes.

At the national level, there is a need to develop a co-ordinated approach to address the issue of affordability, so that family income does not determine which children may benefit from quality early-childhood services. The limited access to services for pre-school children, the variability in service provision across boroughs and regions, and the inequities in access to appropriate services for children in need of special support should be addressed. Ellen perceives that there are widespread negative attitudes towards solo mothers in the media and among the public, which can only further erode solo mothers' confidence and make them less likely to seek help. There is perhaps a role for government in challenging these negative perceptions, to help tackle the stigma of solo motherhood and improve the wellbeing of solo mothers and their children. Boris Johnson, the British prime minister, was strongly criticised on a radio show on the 29th of November, 2019, for an article he wrote in 1995 in the Spectator stating that the children of single mothers were "ill-raised, ignorant, aggressive and illegitimate" children. In that radio show he refused to apologise. The journalist asked the prime minister, who has seven children, two from extra-marital affairs, how many children he had fathered, but he refused to discuss his own family. A caller explained that her children "suffered the stigma", demanding to know, "Why are you (Boris Johnson) happy to criticise people like me when you refuse to discuss your family?" (Merrick 2019). Debbie and Grace explain, from their experiences, the lack of work-life balance policies and the socio-cultural expectations that women be the family caregivers. Debbie, whom I mentioned earlier—a 60-year-old Jewish white South African and British citizen and a head midwife at a public hospital in London, earning GBP 40,000 per year—described how she experienced having a full-time job and being a full-time mother:

> I was awake every two hours, because the baby's screaming his head off and you've got to go to work the next day, and there's no-one else to take that baby. There are days when I crawled in here (the hospital), thinking "I don't know how I'm going to get through the day, and I've got to go and deliver babies and be safe?" I think childcare is a major issue in the UK. I got admitted to the hospital nursery, but it was still 8:00 a.m. till 6:00 p.m., and I worked 8:00 a.m. to 8:00 p.m. It didn't reflect any midwife's working hours. Childcare is so expensive! I used to pay £1000 per week to have a nanny between 8am to 7pm. Childcare in this country is so badly recognised and organised and so unsafe.

Cory and Stirling (2015) and Harknett et al. (2020) suggest that work and family policies need to adapt in order to keep up with these changing family structures, and ensure that all families are supported to balance work and care, by closing the gender pay gap, improving flexible working arrangements better to enable parents to respond to their family's needs, and by ensuring greater availability of affordable and high-quality childcare. Grace, a 51-year-old white British IT analyst who had her son 13 years ago with her own egg and non-anonymous sperm donor at a private clinic in the UK, explains the denigration that she perceives women, motherhood and caregiving receive:

> I've never understood the degree to which motherhood seems to be denigrated to second best. Investing in the people of the future. I watch here in two central boroughs of London for 30 years, working in the community, and I look at the services for mothers and children and the amount of money that keeps disappearing. How much money has been wasted on Brexit to the detriment of everything else! How can you go out and get a job and get some self-worth if you can't afford childcare? Safe childcare, not leaving kids with your neighbours or playing downstairs. All I asked for my child was safe, affordable childcare.

Participants in this study have described the ways that they became invisible, that is, they perceived they lost their identity as a person of value the minute they left paid work

or negotiated becoming part-time workers to take care of their children. It is this devaluing of and discrimination against caregiving that provides the common thread linking the experiences of women at the top and at the bottom. Claire is white British, 42 years old. She gave birth in a public hospital 19 months ago to her daughter who was conceived with her own egg and a sperm donor from the US at a private London clinic. She explains the difficulty of balancing her job and her family life. She works as a senior manager at an American IT company that has 20,000 workers:

> I worried about can I afford to do this generally and will I cope with having a child 24/7 never being able to give it to anybody else? It was the whole how can I manage it all? Because I have a senior job, it's in an industry which generally requires long hours and commitment to your work. I need to earn a certain amount of money, particularly in London, to sustain a lifestyle to pay a mortgage, to pay for childcare. Then the pressures of being a solo parent where you have to do the pickup and the drop off and what that means to your working hours and your perceived commitment to the job. How am I going to do a job which involves 70 h a week?

Claire reveals her constant worry about her work, the hours they demand she invest, travel and be absent from her home for days. However, she has a baby she breastfeeds and whom she cannot leave with a childminder all day long, but she is fortunate in having a sister who lives nearby and who can take care of her baby when the childminder's day ends. She mentions the male environment of her company, where most of the men are fathers, but whose wives are the ones who take care of the children, schooling, feeding and caregiving, or the management of it all, generally employing other women to take charge of these tasks. In fact, she does not know if she is going to be made redundant because she had informed her employers that she could not do all the tasks required of her:

> I'd be asked to go to Paris four days a week for the next four months, and I can't do that. The company I work for, it's run by white middle-class American men, it has huge challenges with diversity and inclusion. There's very few women, around 22%, the gender pay gap is terrible. They're not really geared up to women with families and flexible working. Whereas in a smaller organisation they don't have the resources to focus on decent policies for working families.

Thus, her life has changed. She cannot go off anywhere just like that, she cannot work at weekends without having to calculate who will look after her daughter, how many hours, whether the childminder is available or not, if she has family members or a social network that can take care of her child, whether she can trust the person who does so, whether the baby will be happy with that person. There are many decisions and worries that need to be dealt with before accepting the task that her company sets her or not. It is clear which set of choices are more valued today. Workers who put their careers first are typically rewarded; workers who choose their families are overlooked, and overworked. Ellen, mentioned earlier, faces similar problems:

> I've extended my maternity leave. I'm going back part time and using annual leave. My mum will hopefully come over from Dublin once a month to do the extra days because the nursery is so expensive, I can't really afford it. I get no support because they've changed the rules and it disproportionately affects single parents. It used to be household income, and now it's individual income, so a couple could both be earning £49,999 each, so they earn almost £100,000, and have two people, so they can share childcare, they would still qualify for child benefit. I'm one person, but because I earn more than £50,000, I don't get anything.

Her mother has to help her, flying in from Ireland, and she makes clear the discrimination faced by single parents, mostly mothers, from the measures of the British government. According to Garnham (2018), the chief executive of Child Poverty Action Group, when the bill introducing Universal Credit (UC) was published in 2011, it was criticised on how

the policy was flawed. Women are disadvantaged in Universal Credit in a number of ways. Firstly, it resembles a return to the 1950s family wage model. Secondly, it entrenches traditional divisions of labour. The insistence of UC on dividing a couple with children into a "main earner" and a "main carer" (or second earner) is problematic. Thirdly, the benefit cap disproportionately affects women: of households subject to the benefit cap, 93% have children, 72% are lone parents (76% with children under five and 31% with a child under two). The vast majority of these will be women. These claimants have young children so they face barriers to work, and cannot find affordable housing. Those with babies and toddlers are not required to look for work in the benefits system, yet they are still hit by the cap. Single parents, mostly mothers, are twice as likely to receive less money than to gain financially when moving from the old benefits system to UC, according to new research which criticises the "harsh treatment" of the claimants (Talbot 2021).

Katya is a case in point. She is 47, a Russian Jew who lived in Israel before migrating to London twenty years ago. She holds a Master's degree and works as a mental health nurse at an NHS hospital, being considered a key worker. It took her 3 years to take the decision to become a solo mother by choice. Then she travelled to a private clinic in Spain and got an embryo adoption from a double anonymous donation. She had the embryo implanted and flew back to London on the same day. She had given birth just five weeks earlier when I went to her shared flat for the interview. Her baby was asleep and she was very distressed. She told me that the council wanted to evict her from the two-bedroom flat that she shared with another tenant. They wanted to remove her on the premise that, because she had had a baby, she was no longer just one person. According to the council, she and her baby "were overcrowding the flat". Her eyes filled with tears: she only earned GBP 30,000 a year and the rent for a small flat near the hospital where she worked would cost her GBP 1300 a month.

She could not afford it: it would consume three-quarters of her salary. Despite this situation, the council was pressuring her with threatening letters. They had shown her social housing where there were too many people, many with problems of addiction or mental illness. She did not feel "safe" with her baby in this type of housing. She said: "the council does not care about single mothers". During the first hour of the interview, her account was constantly interspersed with "it's my choice": "I chose to have a baby". According to her, the state should not be made responsible for her and her baby: "you make your bed you lie in it", she would repeat. She did not criticise the council for: (a) wanting to remove her from the flat with her five-weeks-old baby; (b) not providing affordable housing for key workers; or (c) not paying key workers enough money, thus forcing her to live through this pitiful situation. Nevertheless, in the second hour of the interview, Katya asserted that there should be affordable housing, quality education and care for children aged 0–5 available to everyone.

Sandher (2019) describes the UK's key workers as foreign-born, working dangerously, and earning less: "More than one in five Health and Social Care workers were born abroad and they have seen their hourly earnings fall by 7.5% since 2010". The OECD (2020) states that in today's COVID-19 pandemic, we are all relying on immigrants who are over-represented in key worker categories. Stringent conditions for receiving welfare benefits are increasingly common in high-income countries. Katikireddi et al. (2018) argue that requiring lone parents with school-age children to seek work as a condition of receiving welfare benefits adversely affects their mental health. Research already shows low-paid female workers are five times more likely to experience depression. Pickavance (2020) argues that now is the time to "reset" our cultures by placing worker wellbeing centre stage, and to think about employment practices and rates of pay that make saving more likely. Childcare must become an urgent strategic imperative. Another example is Susan, 54, a white British Londoner, who works as a freelance criminal solicitor. She is the mother to a 10-year-old boy who was conceived with the help of a double anonymous donation (egg and sperm) at a private clinic in Spain, and gave birth at a public hospital in London. She speaks about her efforts to balance family and work:

> I do legal-aid criminal work and there's no money, terrible hours and no flexibility. This is the problem with the job I got in the summer, they said to me: "We want you to work in the city," and I was like, "Okay, that's fine," "You've got to be there at nine o'clock," I said, "I can't be there at nine o'clock because I've got a child that I had to drop at school at 8:55, I can be there at 9:30 and I can do a half an hour lunch, if you want me to." Not even prepared to discuss it! Why do I have to physically be there? I've got a mobile phone, if you need to speak to me, you just call me. The reality is I'll probably be at court, so why do you need me to physically be in the office? Very, very old-fashioned ways of seeing things.

When law firms and corporations haemorrhage talented women who reject lockstep career paths and question promotion systems that elevate quantity of hours worked over the quality of work itself, the problem is not with the women (Slaughter 2015, p. 15). Plenty of women are juggling paid work and childcare but still they run up against obstacles created by the combination of life circumstances and the rigid inflexibilities of their workplaces and the lack of public infrastructure of care. The workplace is discriminating in favour of workers who can outsource caregiving to someone else. Governments and employers assume that care work is not work that really matters, even though it is essential to the very brain formation and growth of the young. Care work is work. It is not self-indulgent; it is radical and necessary (Federici 2012; Ahmed 2014). Systematically marginalizing care "furthers the myth that our successes are achieved as autonomous individuals and, as such, we have no responsibility to share the fruits of our success with others" (Lawson 2007, p. 5).

Susan does not opt out of her job, she is shut out by the refusal of her bosses to make it possible for her to fit her family life and her work life together. These women need reliable work at a decent wage that allows them the following: to save for a rainy day; access to affordable, high-quality day-care and early-education programmes; paid days off and family leave for the inevitable times that their children or other loved ones who depend on them are sick or in need; and recognition and respect for the care they do (Slaughter 2015, p. 24). Yet today the UK does not provide affordable day-care, early-education and afterschool programmes that take up the caregiving slack. They do not provide sufficient paid leave that any worker can use when a child is sick. The result is that the mother with dependent children must patch together an unstable and unreliable network of caregivers in ways that sharply hinder her ability to succeed at her job. For middle-class women, the struggle to balance caregiving and breadwinning is a daily grind and often the tipping point that may drive them into poverty. When I asked Susan: "Why do you think there is no change in policies?" she replied:

> I don't think this government is particularly interested. They say they want parents to go back to work but it seems to be more of a stick than a carrot, most of the time. So, "We'll take your benefits away, unless you work". I think mostly women make it work and they're the ones who are going home. It is not only a matter of gender. The way it's organised, the people who run the business make the money and the people who do the job get paid very little. So, I have encountered women who have got nannies like a Queen's Counsel, who are partners and say: "Well, I can manage it, why can't you?" Yes, even though they're paying their staff £35,000 per year and they're probably earning £90,000 and they've got husbands who are earning if not the same then certainly enough to pay for a nanny. So, of course she can make it work and when I raised it, she said, "Well, you can't do this job unless you work full-time," and that was basically her view. So, even the women who are running it don't see it. The fact that the majority of people who are in Parliament have come from such a privileged background. It goes back to Norman Tebbit "getting on your bike". It's not actually having any real sense of how people who are not them are living. The other thing I find very hard, because I've been to lots of these meetings is that I'm sitting in a room full of men most of the time. The only other woman

> might be the person taking the notes. I can sit there and tell them all my ideas for hours but they've got no vested interest in there.

In 1981, at a time when the British Conservative Government of Margaret Thatcher was being blamed for high unemployment, a member of her cabinet, Norman Tebbit, gave a speech to the Conservative Party Conference and said: "I grew up in the '30s with an unemployed father. He didn't riot; he got on his bike and looked for work and he kept looking till he found it" (Daily Telegraph 1981). The implication being that he thought people who were long-term unemployed were simply too lazy to find jobs. The Queen's Counsel is not accommodating of work-family conflicts, she has absorbed the values and practices of the system where she has succeeded, and perpetuates it in demanding that others make it the same way, discounting social class, ethnicity and solo motherhood as factors that obstruct equality. Only 34% of all members of parliament (MP) are women, only 10% of all MPs are from minority ethnic backgrounds (Audickas and Cracknell 2020). Increasing the supply of affordable, good-quality childcare would help solo parents, the majority mothers, to move into work. The literature has demonstrated the importance of arranging childcare as a key element of lone-parent employability services, and the impact of affordable and readily-available childcare can be seen in international comparisons (Graham and McQuaid 2014).

In the case of the participants living in London they, in general, have interiorized the discourses of successive governments and part of the media that grumble about a "nanny state" (a term of British origin that conveys a view that a government or its policies are overprotective or interfering unduly with personal choice. The term "nanny state" likens government to the role that a nanny has in child rearing). Thus, most of the London participants follow the principle of "you made your bed, now lie in it"—I've chosen to be a solo mother by choice, so I'll take on paying for the ART because I'm around 35 or older, I'll take on paying for the education and care of my child until the age of five because there are no state policies of education and care for this age group, at the same time as needing to work for a salary that will pay the mortgage or the rent in the most expensive capital in Europe (Statista 2021).

The London participants have, in general, also interiorized the discourses of British governments regardless of their educational level, all of them having had the benefit of a university education, some with Masters and doctorates, and some have even transgressed the rules of their religious community and the opinions of their families against their having children on their own with the aid of ART, and have gone ahead with their decision. In that part of their lives, they were brave and transgressive with respect to their families of origin, their social networks, their religious community or their milieu. However, in other parts of their lives, such as demanding from the state access to public assisted reproduction for women aged 35 or older, work-life balance policies or fair education and care policies, they were not so outwardly brave. They have taken in the discourse that demonizes the "nanny state", one that blames solo mothers, the poor or the unemployed who have no choice but to seek aid from the state, and socially stigmatizes them. They find it humiliating to need state support, something which for them goes hand in hand with the idea of personal failure.

The British author Owen Jones states that the more unequal the society, the greater the need to demonize in order to justify it. According to Jones, the case of the UK is key because, particularly since Thatcherism, the change occurred whereby poverty and inequality were no longer presented as social problems but as failures of the individual (Jones 2015). Tebbit's phrase, "get on your bike", became a national cliché. The huge inequalities and the shift from the need for a collective response to governmental individualism are especially notable in the UK, where, in general, the media maintain and support this discourse.

This may explain how the London participants have internalized the public discourses on what is success and failure, and applying for state benefits is represented as begging from the state. Because these women have chosen something individually as a personal option—having a family outside of the heterosexual nuclear family norm—means that they

have to pay a price that must come out of their own pocket: private ART treatment, the private clinic, the importation of semen or travel to other countries to attain egg donors or double donation because in the UK this type of treatment is not provided due to a lack of egg donors (Turkmendag Ilke and Murphy 2008), or psychological treatment to treat their genetic bereavement for the many times that, despite the ART, they have not been able to get pregnant or have had miscarriages (García-Lumbreras 2019).

They also have to pay the price for the fact that their employers (private or public, such as the NHS) have not established work-life balance measures. It is they who, preparing the way for years, have saved money or changed their place of residence to where they could have easier access to good preschools to care for and educate their children, or who have to work part-time and draw on their savings because their employers will not consider a balance between family and work. Lastly, the UK participants perceive that the successive governments view the raising and care of children as a private, individual matter, not a collective one: "look after yourselves", abandoning any co-responsibility of the state or employers with regard to work-life balance policies or of implementing public education and care policies for the preschool population.

This lack of public policies in the reproductive, labour and education spheres translates into an obstacle course in which the women have to fend for themselves in order to be mothers and balance their motherhood with their career. Due to the pandemic, they have also become their children's teachers in a home-schooling context. Yet despite the worst conditions that the London participants suffered with regard to the lack of educational or care policies for their preschool children, despite the fact that only a minority of them could count on the sporadic help of their family and social networks, despite the fact that some of them were forced to become part-time workers, they did not, in general, demand access to public reproductive treatment, or work-life balance policies, or public policies of care and education for children aged 0–5 that would enable and guarantee that they and future generations might have and raise their children and work for a decent wage. They did not demand them, even though if women do not have the financial means, the option of being mothers on their own is impossible.

6. Second and Third Obstacles Intertwined: Work-Life Balance Policies and Early Education and Care Policies in Spain

Guillén and León (2011) argue that the countries of southern Europe—Portugal, Spain, Italy and Greece—form a welfare model with a different tradition and characteristics. These countries share certain political and institutional peculiarities: precarious labour markets with high unemployment rates; income transfer programmes characterized by high protection in certain cases (pensions) and large areas of exiguous protection or total lack of protection (dependence; housing); a strong private sector presence in many areas of service provision; a peculiar mix between public and private sector; and a familialism that does not only involve the nuclear family but also the extended family (Naldini 2006). It is precisely family solidarity that has traditionally substituted for the lack of, or little flexibility in, public and private care services.

The relation of women with employment has been characterized—unlike what has taken place in Anglo-Saxon and Continental countries—by continuity and full-time work. However, Mediterranean familialism has been undergoing a spectacular transformation in recent years (León and Mauro 2013; Calazada and Brooks 2013). This is shown in the transformation of the attitudes towards the family and lifestyles, in the high employment rates of women between the ages of 25 and 49 in Spain and Portugal—these rates are similar to Sweden and Denmark—and in the growing development of early-childhood education services and attention to dependence. Nonetheless, the feminization of part-time work is a reflection of the forced choice of this type of contract that women take in order to be able to care for their children or family members in a situation of dependence, or to take care of other family or personal responsibilities.

According to data from the Spanish National Institute for Statistics (INE 2019), of the 18,535,900 households that were registered in the 2018 Ongoing Household Survey in

Spain, 10.1% (1,878,500) are one-parent families. Of these, 81.9% (1,538,200) are headed by a woman. Irene, a 39-year-old Spanish architect from Madrid, who has lived in London for six years, has an eight-months-old baby conceived through anonymous sperm donation and was treated at a private clinic in Madrid. She works in a construction company in London with a salary of GBP 65,000 a year, but now she has to ask to become part-time to be able to look after her baby, as she complains that the creches in London are very expensive. In our interview at her home in Madrid, she compares Madrid and London with regard to bringing up a child, work-life balance policies and early education and care policies.

> When I went to the UK, I was surprised by how sexist it is, much more than Spain. A crèche costs 1500 quid a month. What family can pay that? The woman stops working and in a few years has several children in a row and her professional career vanishes, her husband's flourishes. If you have two children under three, preschool rises to £3000 a month. In the end women give up their professional career. In Spain it is looked down upon if the state does nothing when someone needs help. There are many public creches and you don't pay more than 190 € a month. In the UK they are very individualist, there is a negative conscience about state protection of the individual, it is frowned upon to request help from the state. I've paid taxes all my life and I believe that the state should be there to provide education and care from the age of 0, that's why I pay taxes.

She expects and demands her rights to early-childhood education and care once maternity leave has ended. She wants and needs to continue working. This demand is heightened in the case of a solo-mother family, since it is not founded upon the premise of the hetero-patriarchal middle class nuclear family in which the woman stays at home to look after the children and do the housework without any social or monetary recognition, or she must make a "forced choice": work part-time and work in the home caring for the children, thus reflecting the ideology of the male breadwinner and the female caregiver. Irene continues:

> I see English society as still very conservative, the men very chauvinist in many cases, paternalist and condescending. My project manager, a 60-plus-year-old man, calls me "cutie pie" at work. The fact that he calls me "cutie pie" already devalues me. You have to demonstrate a thousand times over your worth because you are a woman and a foreigner. For the mere fact of having an accent it seems that you are worth less as a person.

Irene debunks her idea of the UK as one of the most advanced countries and suffers in person the degrading treatment of her boss for being a woman and unequal treatment for being a foreigner with a particular accent. She also compares public early-childhood education in Spain with the necessarily private equivalent in the UK. Many children start in preschools straight after Spain's four-month statutory maternity leave. New mothers are entitled to 16 weeks fully paid leave, and as of 2021, fathers have the same right. Even though compulsory education does not begin until the age of six, the OECD reports that Spain has had nearly full enrolment in early childhood education and care. In 2018, 98% of 3–5 year-olds were enrolled in early childhood education and care programmes in Spain, compared to 88% on average across OECD countries (OECD 2021). Preschools run by the state usually provide childcare for the whole day and include lunch.

The costs are subsidized by the state and vary depending on income. For example, in Madrid, for the academic year 2020–2021, families whose per-capita income is equal to or less than EUR 5644 a year pay a monthly school fee of EUR 58, while families whose per capita income is higher than EUR 25,725 a year pay EUR 188 a month. There is a reasonable amount of flexibility in terms of hours of attendance and parents can choose mornings, afternoons, full days or just a few days per week. State education is free of charge in Spain from preschool to 18 years of age, although in some regions parents may be asked to pay for books, other materials and extra-curricular activities. In the case of the Spanish participants

of this study who live in Spain, they all stressed the importance of their own families in the raising of their children, when their maternity leave ended and they could access public preschools. For example, in the case of Nerea, a sociologist who had her daughter with sperm donation at the age of 35, her mother offered to look after her daughter while Nerea worked:

> In order to make the decision to be a solo mother by choice, I counted on my mother, and she told me that she was retiring around that date, and that she would help me for as long as needed. Having my mother's help was very important. Also having a public preschool where I took my daughter from when she was a baby.

Vera, a 47-year-old from Barcelona, had her daughter through double donation at a private clinic nine months ago. She is a self-employed IT designer, and her father said to her:

> We love you, we see that becoming a mother is very important to you and as you catch us in old age and we can't help you much, logistically speaking, we have decided to give you this money so that you can use it for the private clinic or for nannies or for whatever you need.

Her parents and siblings live nearby and if she needs to leave her baby for a while, her parents look after her. María, a 46-year-old from Seville who had her two children, now four and six years old, through sperm donation from different donors at a private clinic, is a civil servant and lives close to her mother and siblings. She underlines the importance of living close to a preschool that is connected to a primary school that charges very little.

> I'm the oldest and I have a sister and a brother who are married with children and they have had to help me daily. I also help them. I chose the school that was close to my mother's house and mine, because if I go to work and it's my mother who has to pick them up at a given time because they get sick, I wanted to make that task easy for her, as she's helping me.

However, employers do not make balancing work and family easy. Lia, aged 38, the daughter of Argentinian exiles, who lives in Madrid and is a lecturer at a public university, is the mother of a three-year-old boy, conceived through sperm donation at a private clinic, and a seven-year-old girl, from her last relationship. She complains of the unequal treatment by the law toward solo-mother-by-choice families:

> In the case of solo mothers by choice, they should add the paternity leave to the maternity leave so as not to discriminate against the child in comparison to heterosexual nuclear families who can benefit from adding the maternity and paternity leaves together. I requested it in writing from my university. The law does not see it that way. Moreover, I gave classes until 9 p.m. with my six-month-old baby. I had to pay a childminder. Neither the department, nor the university equality unit that the university boasts about, helped me in anything.

Rosa is a 54-year-old from Madrid, is the founder of a solo mothers by choice association, a journalist and the mother of a 14-year-old adopted daughter and a ten-year-old girl conceived though sperm donation at a private clinic. She explains:

> We (solo mothers by choice) only have the resources of one adult person to maintain the household: half that of a two-parent family. One single source of income, a more limited support network, half the leave in terms of personal days, holidays, even due to birth, fostering/adoption and breastfeeding. We also only have two hands and one mind to run the ship. Mental health is fundamental for maintaining and accompanying the little ones.

Thus, investment is needed in work-life balance, which is understood as social co-responsibility. The measures should address family diversity and be adapted to the needs of all types of families. Treating what is different equally created inequality and discrimination, according to Lola, founder of the Federation of Single Mother Associations (FAMS):

> We already began the state of emergency of the pandemic at a disadvantage, which we have been making known to the administrations and social agents for some time now, because of a system that revolves around the traditional family and that penalizes us in different areas, both financially and in terms of balance. Through FAMS we have launched the campaign #ConciliarDificilEquilibrio (Work-life: difficult balance) to show the juggling acts we have to perform, the difficulty of balancing all the factors: work, education, health, care, self-care, in a context without social co-responsibility from the public sphere, creating greater inequalities and gaps in our families. The fundamental role of caregiving in this society needs to be recognized and valued, in economic terms too. This crisis is making it all clear in all its rawness. Society needs a work-life balance plan in the short term with urgent measures so that the consequences do not fall on the shoulders of women and children harming families like our own who started the COVID-19 game several squares behind the starting square.

A few days ago, the European Parliament (2021) passed two resolutions: one to apply gender perspective in the COVID-19 crisis, and the other with the EU strategy for gender equality. These are non-binding resolutions that do not compel the European Commission to modify its proposals or the member states to apply particular measures. Instead, they fix priorities. One of these priorities is the creation of a European Pact for Caregiving, because the current Work-Life Balance Directive—that must be transposed into member states' national law by August 2022—"proves insufficient". The parliament asks its member states for measures for "the promotion of men's equal role as carers, thereby tackling gender stereotypes in take-up of either paternity, maternity, or both, leave (Wayne et al. 2016) the recognition of the role of informal carers by ensuring their access to social security and their right to pension entitlements". There are mentions of single-parenthood in the main design mechanisms and strategies, planning, evaluation and monitoring of public policies that address child and family protection. However, these policies have the two-parent family model as their starting point, despite recognizing the protective needs of single-parent families due to their particular vulnerability. These references have not mobilized administrations to look for regulation at the state level that recognizes the condition of single-parenthood as a family model; rather it has served as a reminder that another type of family exists when situations of particular vulnerability to poverty and risk of social exclusion occur. In short, social policies do not take this group specifically into account as a family model that should be protected as such; instead, intervention is structured as a form of relief through complements in benefits, tax relief, grants and income guarantees.

All the Spanish participants living in Spain spoke of how to improve the lives of solo-mothers-by-choice families with political demands. In the interview I conducted with an ex-president of the "Solo-mothers by Choice" association, she explained:

> One of the achievements of this association is reaching a greater number of women, letting them know that we exist and that they are not alone. Another is legal recognition. The administrations cannot make laws on something that is not recognized as such. If it does not exist, it does not have rights. For example, the children of two-parent families have, from the beginning of 2021, 32 weeks of leave (maternity and paternity), and our children only have 16. The approach is twofold: the right of women to choose their family model, and the right of the child to have the same rights as other children regardless of the filiation from their mother or father. This is not being met. Somehow they state that our children can have the same rights, but until now nobody has bothered to legislate on the matter. And we also want a solo-parent family law that would see us as just another family model. This includes families that are solo-parent due to the death of one parent, due to circumstance, due to divorce where the father does not take care of the children, and so on. A law that generations will benefit from. What we want is the raising of children in diversity with equal rights: making visible, forming a network and protesting are our pillars.

One of the most well-known spheres in which violence is wielded against women is the economic. Whether in couple relationships, the labour market or the division of housework and care work, women undergo a great deal of hardship. The economist Carmen Castro (2020) explains that the Istanbul Convention—the most important international treaty on the human rights of women—states that all these types of economic violence form a part of gender-based violence, alongside physical or psychological violence. As such, they are a serious assault on the human rights of women and girls. Castro adds: "Caregiving has to be part of that economic and social change and to do so through an agreement on a different distribution of times, divisions and incomes" (Castro 2020, p. 58).

7. Discussion and Conclusions

In this article, I have analysed, firstly, how these women address the need to turn to the private provision of a fundamental human right: the creation of a family. One of the long-standing ethical challenges surrounding assisted reproduction is the unequal access to treatments and whether high costs hinder procreative rights that include access to ART. Secondly, I have examined how "solo" motherhood is a complex reality of social typology, in which different forces from different institutions, social agents and powers converge, interact and affect the women in this sample and broader groups.

In neither of the two countries that I focused on in this article is there a framework of integrated public policies and measures at state level that regulate and recognize solo-parenthood as part of family diversity on an equal playing field with other family models. The absence of a national law hinders there being any homogeneous legal, social, educational, economic and labour treatment of the rights of solo-parent families. This fact does not mean that they can all be put in the same boat without differentiating between, and attending to, the needs of each of them. The inclusion of single parenthood in public policies and in social solutions requires the breaking of the monocular approach that identifies it with poverty. The aim is to provide an analysis capable of observing, capturing and confronting how situations of discrimination affect women-mothers-workers by themselves–and their children.

This is done not only from a multidimensional gender perspective, but also through the intersection of the inequalities faced by the members of these families due to economics, national origin, gender, functional capacities, education, culture, and so on. The solo-parent family is made completely invisible when it comes to designing public policies and establishing measures for equality and protection. Therefore, tackling this question requires taking on approaches that can reveal the multidimensionality of the problem in order to guide public policies and have a bearing on the quality of the lives of these families. Family and personal networks should not be the ones responsible for solving daily difficulties, and the state should not intervene only in a subsidiary fashion when all else fails.

The consequence of this legal framework and public policies is that they perpetuate both the two-parent family model and the barriers that prevent women from freely choosing what personal and affective life they wish to have. This system worsens female poverty and, in particular, the poverty of single-parent households, because it leaves them without protection. A true policy of equality must be able to attend to women who are caregivers and breadwinners, as well as domestic workers, child-minders and early-education teachers, and all those who care for the people other women, in general, have to stop caring for in order to balance their work and their personal life.

Solo-mother families must not be an exception; they must be part of the norm, of the normality of family situations that public policies need to address. Only in this way can solo-motherhood cease to be associated with poverty and risk of exclusion and to articulate integrated policies. By recognizing solo-motherhood as part of family diversity, it will be shown: (a) that all forms of family have common needs related to supporting life (emotionally and materially); and (b) that certain family realities (e.g., solo-parent, immigrant, large, same-sex, blended families, families at risk of or in a situation of exclusion) present particular needs that must be addressed attending to the needs of each of them.

Early education and work-life balance policies should be key tools for attaining a wider outlook, a truly co-responsible approach that engages and commits institutions and businesses, men and society as a whole, to overcoming the view of early education and work-life balance as a "matter for working women". Faced with the challenge of social exclusion, effective early education and work-life balance policies are also an antidote to poverty, as they enable more people from working and middle-class families to balance and maintain their jobs, instead of being forced to reduce their working day or to abandon their job in order to give care, thereby creating a network of protection for all families.

Governments need to consider well-remunerated leave, early education policies and flexible work agreements as a right of "co-responsibility with caregiving" that should be compatible with a socially responsible labour market (Campillo Poza 2019). These policies do not only benefit families. It is a right for all women and men at different moments of the life cycle, which meets the needs of all generations and improves employment conditions, early-education policies and labour well-being, and the productivity of all businesses and institutions that have measures to guarantee work-life balance. The aging of the population and gender inequality are pressing challenges in European societies that require a combination of ambitious policies, including (a) equitable assisted reproduction, (b) work-life balance and (c) early-childhood education and childcare. These would guarantee the co-responsibility of society as a whole in the face of these challenges, and commit institutions to social cohesion as a fundamental pillar of national projects. There is a need for governments to take a lead in providing integrated solutions that harmonize the actions of different states facing these challenges in order to achieve a more just and sustainable society, as well as economic growth.

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