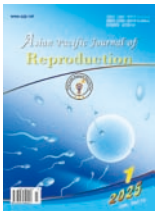

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Decreased desire to have children: A qualitative study

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ABSTRACT

Objective: To explain barriers to childbearing among working women from the perspective of working women and midwives.

Methods: In this study, a qualitative study of content analysis method was employed. The study was conducted from December 2021 to July 2022. The population consisted of working women and midwives. Data collection was conducted using semi-structured interviews and continued until data saturation was achieved. Through purposeful sampling, 10 women and 11 midwives were selected as the sample. The data were analyzed by Graneheim and Lundman content analysis approach. For more rigorous, Nvivo 14 software was also used for data management, analysis, coding and organization of data.

Results: This study included 21 women (10 women employees and 11 midwives) aged 25-43 years (for women employees) and 27-56 years (for midwives) with 1 to 34 years of job experience. In examination of participant' views about the barriers to childbearing, 1 124 codes were identified, of which we managed to extract six subthemes and two themes. Two themes emerged: "lack of social support and lack of family support". Subthemes of "lack of social support" were "inadequate leave, long distance from workplace, and insufficient wages". Subthemes of "lack of family support" were "lack of spouse support, lack of spouse's family support, and lack of their family support".

Conclusions: Different socioeconomic factors influence childbearing tendency in working women. Social and family supports play an important role in this regard. It is important to take these factors into account at the time of policymaking in the field of midwifery.

KEYWORDS: Content analysis; Employee women; Childbearing; Midwives; Qualitative study

1. Introduction

In the aftermath of family planning implemented in Iran, there was a rapid decline in fertility. In other words, the number of births per woman dropped from six in the early 1980s to about two today[1]. According to the results of last Census of Demography and Health in Iran, 73.3% of married women over 15 years of age used a contraceptive method. The prevalence of using contraceptive in urban and rural areas was 77.4% and 67.2%, respectively[2], while the rate of contraceptive use in the world, developed and developing countries was 60.9%, 68.5% and 59.4%, respectively[3]. Population

Key Points:

Question: What are the barriers to childbearing?

Findings: From participants' views, two themes emerged (lack of social support and lack of family support). Six subthemes included inadequate leave, long distance from workplace, insufficient wages, lack of spouse support, lack of spouse's family support, and lack of their family support.

Meaning: Social and family supports play an important role in childbearing. These factors should be taken into account when conduct policymaking.

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growth declined from 3.9% in 1986 to 1.5% in 1996 and finally to 1.1% in 2021[4].

According to last Iranian Population and Housing Census, the rate of Iranian population growth has reached 1.29%[5]. According to the United Nation report, if Iran continues to replace its population at the current rate without any planning to strike a balance, in the next 80 years its population would drop to 31 million, of which 47% would be above the age of 60[5]. Iran is currently one of 10 top countries that are rapidly aging, ranking sixth in the world[5].

According to demographic studies, if the current trend of population growth persists, it is expected to reach zero in approximately 2036-2041, with the prospect of a negative population growth and population structure shift towards aging in the next 20 years[6]. The International Conference on Population and Development (ICPD) highlights the need[7] to ensure couples' empowerment in family planning, especially empowering women as a prerequisite for promoting reproductive health and family planning. Women should be allowed to make decisions regarding their childbearing so that they can exercise their role in family planning[7].

The physical access to family planning services in the health system is not sufficient to realize family planning goals[7]. Some of factors affecting family planning are beyond the health system and hence social and cultural environment must be also taken into account[7]. To improve women's health and increase access to family planning services, cultural and social characteristics and barriers that wield influence on access to these services must be identified as the basis for future planning[7].

In Iran, fertility decisions are mainly informed by relationships and power structure governing the life of couples in the family, though the huge effect of social and cultural factors in this regard cannot be overlooked[8]. Therefore, women play a key role in making this decision and it acts as a determining factor in their behaviors, reproductive attitudes and family planning, given that women often shoulder the bulk of responsibility of family planning[8]. The empowerment of women in family planning is seen as the cornerstone of population and development programs in Iran[9]. Dealing with maternal duty is a matter of issue for highly educated or working women mainly in the societies where women have a vital role in the care for children and household tasks. In the occurrence of challenging jobs and lack of supportive family policies, couples are reluctant to have children because of the further responsibility of having children[10]. Moving toward nuclear and child-centered families as well as paying more attention to the quality of the childcare in educated couples and working women induces them to have a smaller family[11]. Total fertility rate among Iranian women is 1.8, compared to 1.2 in highly educated and working women[12].

Therefore, it is necessary to investigate the type of barriers and their significance in any society from the perspective of women employees at the reproductive age, as the people who are the main target of family planning services. Since qualitative research based on the naturalistic paradigm gives deeper insights into human phenomena and this approach is less frequently used in studies on parenting barriers, the present study was designed to explore barriers to childbearing.

2. Participants and methods

2.1. Study design

This study was a conventional content qualitative study, descriptive interviews with midwives and working women to examine their perspective on the meaning of childbearing. The study design allowed a profound exploration of the issue when there was scant information available.

The participants consisted of 10 women referred to family planning clinics and 11 midwives. They were invited orally with a letter that explained the goals of study as well as confidentiality and anonymity considerations in reporting and secure data management. They were informed that they could withdraw from the study at any moment during data collection without any penalties. An informed consent form was signed by participants prior to the start of study.

2.2. Data collection

The interviews were conducted by M.GH, a midwife who was familiar with patient's background and interview process. She collected data through face-to-face individual interviews. This study was conducted from December 2021 to July 2022. A semi-structured interview was developed, which contained questions like, "Would you like to describe childbearing to me? Or "Which factors may affect your childbearing?" (Table 1). We also used probe questions during interviews, "Can you elaborate further on this?" or "Can you give me an example for this issue?" All participants were interviewed at the clinic in a separate room to ensure privacy. Each interview lasted between 30 and 45 minutes. Participants were selected with maximum variation in demographic characteristics. Data collection continued until saturation was reached. Data saturation means that no additional data are being found whereby the researcher can develop properties of the category and additional data do not lead to any new emergent themes. Saturation of the data was achieved by interviewing eight women and nine midwives, and two other women and two midwives were also interviewed for more certainty. The recorded interviews were transcribed by M.GH at the end of each interview. The text was then read line by line to extract semantic units.

All data was anonymous and securely stored in the university database, which was password protected and only accessible to researchers. Participants were told that study results could be sent for them upon their demand.

Table 1. Questions of semi-structured interview.

Questions
1. Would you like to describe childbearing to me?
2. Which factors may affect your childbearing?
3. What factors increase your desire to have children?
4. What obstacles reduce your desire to have children?

2.3. Data analysis

Data collection and analysis were conducted concurrently. We used conventional content analysis to analyze data according to Graneheim and Lundman's content analysis approach. These stages included meaning unit, condensed meaning unit, description close to the text, interpretation of the underlying meaning, sub-themes and themes[13]. The interviews were re-listened and reviewed to gain deeper insights into the data, and by Nvivo 14 software, data management, analysis, coding and organization were also done.

Emerging themes were identified and examined to determine their relevance to extracted data. Initial themes were refined and divided into subthemes based on original data to establish clear patterns. Quotes that illustrated the themes were assigned a code. In the end, 1 124 codes were identified, of which we managed to extract six subthemes and two themes. Due to the length of the interview, two midwives and one woman were interviewed twice.

2.4. Trustworthiness

In this study, several approaches were used to guarantee methodological rigor. All interviewers were experienced qualitative researchers and had expertise in the fields of midwifery and family planning. Field notes were extracted from each interview (data triangulation). Throughout the study, we reflected on the analytic process (investigator triangulation). Research team held meetings to discuss the scientific and organizational aspects of the study (peer debriefing). The article was written in accordance with the consolidated criteria for reporting qualitative research (COREQ).

2.5. Ethical approval

All procedures performed in the study involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the ethics committee of Kerman University of Medical Sciences (research project code: 1395.502; ethics approval date 4 December 2021).

3. Results

In this study, participants consisted of 21 women (10 women employees and 11 midwives) in the age range of 25–43 years for women employees and 27-56 years for midwives with 1 to 34 years of job experience. The participants' characteristics are outlined in Table 2. Participants' quotes are italicized. Labels M and W are used to identify midwives and women, respectively.

Table 2. Characteristics of participants.

Characteristics	Value, *n* (%)
Women employees, *n*=10	
Parity	
Primiparous	5 (50.0)
Multiparous	5 (50.0)
Level of education	
Diploma	2 (20.0)
BA* degree	6 (60.0)
MA** degree	2 (20.0)
Job experiences, years	
>10	4 (40.0)
≤10	6 (60.0)
Midwives, *n*=11	
Age, years	
27-36	4 (36.4)
37-46	4 (36.4)
47-56	3 (27.2)
Level of education	
BA* degree	6 (54.5)
MA** degree	5 (45.5)
Hospitals	
Government hospitals	6 (54.5)
Private hospitals	5 (45.5)
Job experiences, years	
>10	7 (63.6)
≤10	4 (36.4)

*Bachelor of science; **Master of sciences.

In examination of students' views about the barriers to childbearing, two themes emerged: "lack of social support and lack of family support". Subthemes of "lack of social support" were "inadequate leave, long distance from workplace, and insufficient wages". Subthemes of "lack of family support" were "lack of spouse support, lack of spouse's family support, and lack of their family support".

3.1. Lack of social support

The women and midwives in this study asserted that one of the main factors affecting childbearing is social support. Factors such as sufficient wages and appropriate work enhance motivation for parenting. This theme comprised three subthemes, as describe below.

3.1.1. Inadequate leave

Postpartum leave in Iran is 9 months, which is a short time for women and babies. Given the inadequacy of this leave period, women may develop an aversion to childbearing, as they believe this time is not sufficient for child development. This is a point raised by one of women (W3, 31 years old, primiparous), "*After delivery, we are with our baby for only nine months but this time is very short and the baby needs to be with her mother for a longer time. That's why I don't like to have children*".

3.1.2. Long distance from the workplace

According to most participant statements, one barrier to childbearing is long distance home from the workplace. As a result, it is difficult for the mother to return home immediately after work and provide the necessary childcare. More importantly, in case of any emergency and trouble for the child, the mother will not be able to protect her child on time. In this regard, a midwife (M2, 37 years old, 12 years of experiences) notes "*…many mothers whose workplace is out of the city are reluctant to bear a child on this account. This long distance separates the mother from her child*".

3.1.3. Insufficient wages

Inadequate wages and benefits awarded to women employees pose another obstacle to childbearing. There is no doubt that nurturing a child is costly and their wage is not enough to pay these expenses. As noted by one of the mothers (W5, 43 years old, multiparous), "*Nurturing a child is costly and with my payment, I can't afford it. That's why I don't want to have children*".

3.2. Lack of family support

In Iran, family support for female employees is important and in the absence of such support, it is difficult for women to continue working, especially co-parenting. With this support, the responsibility of working mothers is reduced. In participants' experiences, lack of family support of working mothers is a major reason for their aversion to childbearing.

3.2.1. Lack of spouse support

Spouse support is crucial to the child care and support. Besides, it is difficult for a mother to take care of a child alone. The following statement lends credit to this concept, (M3, 46 years old, 11 years of experiences) "*Unfortunately, in some cases there is no assistance or co-operation from the spouse in childcare and this factor is an obstacle to childbearing*".

3.2.2. Lack of spouse's family support

The support by the spouse family is an important factor that facilitates childbearing for women. The experience of our participants showed that lack of support is a barrier to childbearing. In this regard, a mother stated: (W1, 41 years old, primiparous): "*If my spouse's family had helped us with the costs and problems of nurturing a child, I would have given birth to a second baby*".

3.2.3. Lack of their family support

As stated by many participants, the lack of family support is the last barrier to childbearing. The wife's family also plays a main role in the support of mother. Assistance with care and raising of child can be considered as a facilitating factor in childbearing. This is a point echoed in the words of one of participants (W2, 36 years old, multiparous), "*If it was not for my family support, I would not be able to have a second child*".

4. Discussion

Based on the results of interviews with 21 women and midwives, we found that the lack of social and family support are main barriers to childbearing. Participants stressed that they were more likely to have children if they had access to necessary facilities. Insufficient leave period, long distance from workplace, and insufficient wages are subcategories of "lack of social support" that have a bearing on the childbearing tendency in working women. On the other hand, in the absence of essential social support, working mothers' tendency for childbearing is reduced. These findings are consistent with those reported in previous studies. Dougall *et al* in qualitative retrospective interviews on 61 self-selected women referring to one of the two fertility clinics in the USA reported that establishing careers and financial security were the major factors affecting childbearing tendency[14]. In the same vein, Lappegard reported that gender inequality is evident in the lack of support for women who attempt to handle work and childrearing[15].

Behboudi *et al* in their qualitative study that involved private semi-structured interviews with 23 women aged ≥30 years, who were either childless or pregnant for the first time, revealed that lack of social support is the main factor for delayed childbearing[16]. In our study, we observed that lack of family support is a key barrier to childbearing. Brehem and Engelhardt, drawing on data from 21 OECD (the Organization for Economic Cooperation and Development) countries, painted a more exhaustive and systematic picture of the association of fertility, cultural values, economic structure and social policy, while addressing some of the theoretical and methodological issues that arise in explaining the reversal of this magnitude. This study suggests that the supply of childcare facilities to children under the age of 3 years is vital to stimulate childbearing[17]. González and Trommlerová also suggested that incentive policies such as direct cash payments improved work-family compatibility, and inadvertent policies facilitate early childbearing[18].

Cook *et al* in a qualitative study in Canada found that a stable relationship with spouse has a huge bearing on a women's decision for childbearing[19]. Safari *et al* reported that supports received from others are a key factor in amplifying the childbearing tendency of parents[20]. Luppi demonstrated that undesirable welfare status of parents after the birth of the first child would probably influence the decision for having the second child[21]. Sofolahan-Oladeinde *et al* in a qualitative study on women with HIV/AIDS in southwest Nigeria exhibited that spouse support has an impact on childbearing. In this group of women, family support, especially

spouse support, influences the childbearing tendency of women[22]. Eka *et al* highlights the dynamic and complex nature of childbearing decisions, which are deeply rooted in personal beliefs and support offered by significant others[23]. Madiba reported that partner support has a nurturing effect on childbearing decision making[24].

This study had a number of limitations. The participants were selected from among women employees and midwives, whose experiences and perspectives may be different from housewives. Therefore, future studies can explore the attitudes of housewives on this subject. The authors believe that the findings of this study could be extended to other transitional and developing countries with socioeconomic status comparable to Iran. Exploring the experiences of working women and midwives is important to better understand and develop effective reproductive interventions and policies. As such, it is suggested to conduct large-scale studies across the country. Also, we only studied a small sub-group of women employees and midwives. Exploring the viewpoints of other sub-groups such as obstetricians can also be helpful.

In conclusion, according of the finding of this study, two main factors are likely to influence childbearing tendency of women: lack of social support and lack of family support. It is crucial to take these obstacles into account at the time of formulating childbearing policies. Understanding barriers to childbearing in this population is vital to formulate appropriate policies. Hence, more quantitative and qualitative studies about the motives and barriers of childbearing tendency are required.

Conflict of interest statement

There is no conflict of interest to declare.

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Data availability

The data that support the findings of this study are available from the corresponding author on special request.

Authors' contributions

All authors contributed to this article equally. The final manuscript was also approved by all authors.

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