

Chapter 6

Fertility and Having a Child

Title Page Image 6.1

<https://unsplash.com/photos/oOnJWBMib5A>



Learning Objectives

After reading this chapter, you should be able to:

1. Distinguish between the levels of analysis used in the study of fertility.
2. Understand the difference between actual and desired fertility.
3. Analyze the consequences of 30 years of low fertility in Canada.

4. Understand the transition to parenthood and its effects on marriage.
5. Analyze the many ways in which parental roles are “gendered” and non-egalitarian.

<*vignette*>

“Mr. Li, your wife is going to need your help having this baby!” the obstetrics nurse said. “The reason you are here at this prenatal class is that childbirth involves both parents and the father or partner is coach and helper in the process. In a few minutes we will take a look at a birth video but, first, are there any questions?”

William Li raised his hand hesitantly. “When my parents were having their children, the dads never went into the delivery room. That was something for women. How did we get to the point that men rather than nurses are in there?”

The nurse drew a long breath and replied, “Nurses are needed to help with many of the technical medical parts of childbirth, including checking for dilation of the cervix. You, as husband, will be responsible for helping your wife stay comfortable with back rubs and positioning and emotional support. You will be needed to ensure that your birth plan and medical wishes regarding anesthetics are followed. And, finally, you will have the great privilege of being present at the moment your child comes into the world.”

Another expectant father joined in: “Have any of the fathers ever fainted during their wife’s labour?”

The nurse sighed before replying, “That is why we show you the video of birthing, so you can get that out of your system.” (See www.medicalvideos.us/videos/1294/ for an example of a birthing video.)

<*end of vignette*>

When you are in your teens and twenties, you focus on contraception, but many couples in their late twenties and early thirties switch to a focus on getting pregnant rather than preventing pregnancy. They switch from not wanting a child to wanting one. Although the path for later fertility has many obstacles, such as higher rates of miscarriage and even more difficulty conceiving, one of the most interesting phenomena is the transition to wanting a child and the process of becoming a family.

Transitions

The birth of a child to either a couple or a single person represents one of the major life course transitions for many of us. This transition is significant because we add the **parental role**. We add this role—the very complex and age-graded role of parent—to our existing family roles such

as son or daughter, sibling, and husband or wife. This in itself is interesting because most of the social roles we assume are age-graded for us. For example, when we are 16, we can drive; when we are 65, we can retire. The parent role is dictated by the age of one's child and the experiences that child brings to the parent, such as daycare, primary school, secondary school, dating, and soccer practices. This transition to the parent role is also significant because the child, whether adopted or genetically related, is treated as a consanguine (with blood) relative, and these relationships are "durable" in both cultural and legal ways. While one may separate or divorce a spouse, to leave one's child is considered abandonment and negligence by both society and the courts.

Besides the transition to the parent role, the birth of a child signifies dramatic changes in the relationship of many couples. It is estimated that about 75 percent of couples experience a decline in their feelings of love and less motivation to work on the couple relationship with the birth of the first child (Belsky & Rovine, 1990). This finding has been corroborated in several other studies (e.g., Cowan & Cowan, 1999; Feeney, Hohaus, Noller, & Alexander, 2001). This leads many researchers to ask: What is there about the birth of the first child that brings such declines in couple relationships? Just as interesting is the fact that some couple relationships actually improve with the birth of the first child. We may ask: What leads some couple relationships to decline and others to improve with the birth of the first child?

The actual day and time of birth is obviously the **transition point**, but the transition to the parent role is a process that involves deciding to have a baby, conception, gestation, birth, and adaptation to having the child at home. These are all complex experiences and this chapter addresses them in chronological order. In addition, these changes are clearly developmental. There are complex age- and duration-graded **timing norms** about relationships. For example, it may be an expectation of "good" parenting to breastfeed a child when he or she is an infant but not when the child is an adolescent. The norms about parenting are very much tied to the maturation of the child and the family relationships. Therefore, it is most appropriate that we examine this transition chronologically.

Box 6.1

The Anticipation Effect

[This video](#) discusses the anticipation effect: a drop in health and wellbeing before separation from partner and advent into single parenthood.

Why Do Couples Want A Child?

Over the years, many texts have enumerated some of the reasons why couples want children. It must be stressed, however, that if we really knew why couples wanted children, we could then predict and control fertility. The history of world fertility is full of surprises (e.g., the baby boom) and has proven difficult to predict. Furthermore, it is very likely that the "reasons" for fertility are

not constant across time, culture, and place. Indeed, the study of fertility leads us to have more humility than hubris about our knowledge in this area.

Most explanations of fertility can be grouped as ones that rely on macro-structural causes such as the environment, social norms, and economic constraints. We commonly expect fertility to decline in tough economic times or during periods of social upheaval. On the other hand, some explanations of fertility focus on the micro-individual level, with cause most often being related to “choices” that individuals and couples make (Mitchell & Gray, 2007). These individual choices are often based on experiences that relate to macro-level phenomena, such as having a stable job or owning a home, and may lead couples to think that it is a good time to have child. Having a stable job and owning a home also may be related to other macro-level phenomena, such as a buoyant economy. We examine some of the macro-structural explanations of fertility later in this chapter, but for now we focus on the choices that individuals and couples make.

Typical Reasons

In this section, we address some of the most common reasons cited by couples for wanting at least one child.

Conformity is perhaps the most frequently cited reason why people have children. In other words, having children is simply what adults are supposed to do. This should not necessarily be viewed as a simple form of conforming to a pattern of behaviour. Scholars such as Aldous (1999) have argued that many people believe that one is not truly recognized as an adult until the parent role is in place. In other words, the social status of being a “mature adult” is tied to the social role of parent. Thus, one is motivated to have a child to achieve adult status in the eyes of one’s parents, relatives, and even the larger society.

A second often-cited reason for having children is that people do not want to miss out on such a major *life experience*. The idea that giving birth and being a parent are experiences that are important to the richness of life is deeply ingrained. People argue that not to have a child is to miss out on life. This reasoning is found even among some feminist scholars, such as Betty Friedan (1981), who argues in her book *The Second Stage* that women should not have to sacrifice the experience of having children and a family in exchange for an occupational career.

A third reason cited for having children, closely linked to the two above, is that a couple’s desire for children is really a desire for social capital (Schoen, Astone, Kim, Nathanson, & Fields, 1999; Schoen, Kim, Nathanson, Fields, & Astone, 1997). **Social capital** is defined as the network of relationships to which the individual has access. The basic idea is that social capital is necessary to the flow of social support and information from others. Schoen and his colleagues argue that in the developed world, many social organizations and networks are reserved for those who have children. For example, coaching soccer is tied to being a mom or dad. Most school and community organizations view having a child as the price of entry into those networks. Certainly, those who have no children would be looked at with suspicion if they wanted to coach children’s soccer or attend student presentations at a school. Furthermore,

relatives reawaken long-dormant relationships upon the birth of a first child. Certainly, there are social networks for single adults but consider the density and complexity of social organizations dealing with children and families, from ballet to baseball. Having a child is a way to enter these complex and rich networks.

Another very common reason often cited for wanting to have a child is *old age* security. In developing nations where there are no old-age security systems, having a child is viewed by many as assuring that someone will take care of you in your old age. In many of these countries, having multiple children has served the same purpose as an old age security system. The fact is that as countries invest in forms of old age security, their birth rates drop. Whether this is a cause-and-effect relationship or part of a larger process of development remains a question. Overall, we can say that having children for old age security is not as viable a reason for having a child in most of the developed world (Sleeboos, 2003).

Image 6.2

<https://unsplash.com/photos/I0ltPtIsVEE>



Other reasons are cited for having children, such as *entertainment*, but most of these can be grouped into one of the reasons discussed above. There are also vague proposals about biological imperatives to have children. Such biological reasons fail to explain differential fertility across time since we would not expect biological imperatives to fluctuate but certainly fertility has fluctuated, as has desired fertility. Thus, biological imperative explanations for fertility do not

stand up to serious scrutiny and face the problem of trying to explain variability with a biological constant.

Actual and Desired Fertility

One of the first points we need to make about “wanting a child” is the distinction between **desired or intended fertility** and **actual fertility**. Desired or intended fertility is usually measured by asking men and women: How many children would you like to have? or How many children do you intend to have? Since these questions are usually asked before a couple or individual has any children, the answers may range from no children to five or more. It is interesting that indicators of desired or intended fertility are not good predictors of actual fertility. For example, in the Organisation for Economic Co-operation and Development (OECD) report on fertility, the authors found in their sample of developed nations that intended fertility tends to be higher for women than is their actual fertility (d’Addio & d’Ercole, 2005). In 2001, the average response among Canadian women was 2.47 desired children; however, the actual fertility at that time was approximately 1.5 children (Proudfoot, 2010). Because of this poor correlation between actual and desired fertility, it is best to consider these as two independent dimensions of fertility.

When examining fertility intentions in Canada over the last few decades, we find that most women, if they are going to have a child, prefer two children (2.4 in Canada and 2.5 in the United States, according to a 1997 Gallup poll; www.gallup.com/poll/9871/1997-Global-Study-Family-Values.aspx). Although this is the average response to desired or intended fertility, it clearly does not predict actual Canadian fertility, which has been consistently below two children per woman. Clearly, desired fertility is higher than actual fertility. In fact, an OECD study reports that the gap between desired and actual fertility is greatest in countries with low fertility rates (OECD, 2007).

To figure out what is happening regarding wanting children and actually having them, we need to separate the two processes. Wanting a child or children and deciding to have a child are quite different processes. Wanting a child is clearly attitudinal and more malleable than the actual process of having a child. For example, in young adulthood people are slightly more likely to say that they don’t want any children, but as they age, they often change their minds. This means that the attitudinal measure of desired number of children is not stable. Furthermore, this brings up the awkward problem of whether those wanting no children are in the same category as those wanting one or more. Indeed, in the 1960s there were several social movements to support voluntary childlessness. In addition, there is a significant grey area between those who do not want a child (**voluntary childlessness**) and those who cannot have a child (**involuntary childlessness**). Many people find that after trying to conceive for 12 months or more, they change their desired fertility to “no children.” As a result, it is very difficult to know the real reason for wanting no children.

There is reason to believe that the “no children” group should be studied separately from those who desire a child or children. People who do not want children often cite overpopulation,

lowering of our ecological footprint, and having time for the conjugal relationship. Indeed, the reasons traditionally cited by scholars for desiring a child simply do not make a lot of sense when applied to those not having children.

On the other hand, it is difficult to assume that *desired family size* represents much of a predictor of actual fertility. On the surface, it may seem that desired family size is the same as what people would do with their fertility if they were unconstrained by economic and social facts (McClelland, 1983). We can chart social and economic shifts, but they fail to act as mediators between desired family size and actual fertility. In other words, desired family size is a relatively poor predictor of actual family size.

When we review the various reasons that people cite for having children, it is not immediately clear why we have a disparity between the number of children people want (higher) and the number of children they actually have (lower). Mitchell and Gray (2007, p. 30) address this question in their research and conclude the following:

In terms of labour market issues, we find that, of the measures of employment or material security, having a secure job and having a job with opportunities for advancement are far more important to those who expect to have a child in the future. Almost 95 percent of those who expect to have a child in the future say that having a secure job is important or very important, compared with less than 85 percent of those who do not expect to have a child in the future.

Although Mitchell and Gray consider this 10 percent difference to be meaningful, one could argue that the great majority of people (85 to 95 percent) want a secure job regardless of their fertility plans!

If we follow the logic of Mitchell and Gray's argument, the prevalence of contract positions rather than secure jobs with benefits for young people may result in curtailed desired fertility. A closer look at this requires that we examine actual fertility in Canada.

Recent History of Fertility in Canada

When we turn to an examination of actual fertility, we first need to clarify how fertility is measured. First, fertility is always measured only among women, not couples. At a simple level, we could count the number of live births to women in a year. This method is called the **crude birth rate (CBR)** and it has several drawbacks. The major drawback is that the CBR does not take into account whether the greatest bulk of women are in the early years of their fertility or are in the later years and have largely completed their fertility. For example, if Maggie is 22 years old, wants three children, and so far has one, she may well achieve a convergence between her desired and actual fertility. However, if Maggie is 45 years old, it is much more likely that she will not achieve her desired fertility simply because fewer years remain before menopause.

A better picture of a country's fertility is afforded by a measure called the **total fertility rate (TFR)**. The total fertility rate is an estimate of fertility per woman based on the assumptions that (1) she will maintain the cohort rate of fertility for the past year, and (2) she will live to the end of her fertility (usually 45 to 50 years of age). Note that the TFR is an average and is usually reported as the number of children per woman that we expect in Canada. TFR is calculated yearly and is often used for comparisons with other countries. Another useful measure of fertility is age-specific fertility. **Age-specific fertility rates** are simply the number of children born to women in a given year for each age group. We often see ages grouped in five-year increments, such as 20 to 24 and 25 to 29.

We really would like to understand why people decide to remain childless, or have trouble conceiving, or wait so long to decide to have a child. To explain what is happening today, we often need to get a broader historical perspective. Figure 6.1 shows the TFR in Canada for more than 100 years.

Figure 6.1 shows that the TFR in Canada began to decline in 1961 after the postwar baby boom. It should be pointed out that if the baby boom (1941 to 1961) were eliminated, the decline in fertility would be consistent over the entire graph. Indeed, this downward trend is usually seen as part of the **demographic transition** from an agrarian economy favouring large families to an urban-industrial economy favouring small families. Goode (1963) argued that as the world industrializes and urbanizes, children become an economic liability, and therefore the number of children will decrease. As the number of children decreases, couples will spend increasing amounts of time in marital roles rather than parental roles. This change to an emphasis on conjugal roles is further buttressed by ideas of romantic love and individual mate selection. Goode called this new family form the **conjugal family**.

Figure 6.1 Total Fertility Rate, Canada, 1871 to 1996

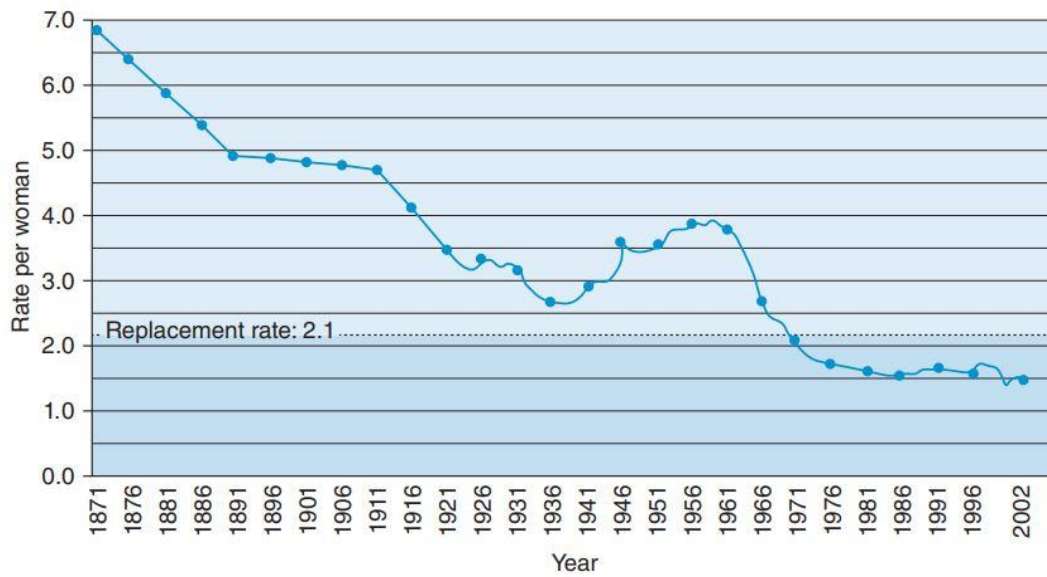


Figure 6.1 Total Fertility Rate, Canada, 1871 to 1996

Source: Health Canada. (2005). Changing fertility patterns: Trends and implications. *Health Policy Research*, 10 (May). Reproduced with the permission of the Minister of Health, 2011.

Figure 6.1 also shows that around 1970, the TFR in Canada slipped below replacement level. **Replacement level fertility** is simply the fertility needed to replace each parent with a reproduction-age offspring. Clearly, there are two parents, so the assumption is that we need two children as replacements. The problem is that not all babies will survive to reproduction age. As a result, the TFR we need in Canada is slightly higher than two children (2.13). Each country computes its own replacement level based on child mortality statistics. Dropping below replacement level means that each parent is not replaced. Even though that may be the case, bulges in the population such as the baby boom will ensure that the population does not go into decline. Population decline is the point at which more people in a country die than are born (assuming that emigration and immigration are equal). **Population decline** has some obvious economic consequences since the labour force will shrink and the number of consumers will also shrink. As Career Box 6.1 illustrates, such demographic changes have consequences for your future career choices.

Fertility Timing

Fertility timing influences our measures of intended fertility and actual fertility. As you might guess, it is sometimes very difficult to assess the fertility of an age group (e.g., 20- to 45-year-old cohort) while its members are still in their fertile years. If women in a particular age group decide to delay fertility until 35 years of age, even our estimates of their fertility based on current behaviour would be inaccurate.

Career Box 6.1

Demography and Your Decisions

As you think about declaring a major in university or your career direction, it may be useful to consult the demographic projections for your region, province, and country. Clearly, if fewer children are being born each year and this shortage is not being addressed by immigration, you might want to carefully consider the demand for teachers and child-care workers. Of course, this always must be balanced with other social trends such as mothers' timing for returning to work affecting demand for child care. Demographic trends also tell us about growth sectors. For example, the service sector serving the elderly will grow as the baby boomers enter their retirement years. This provides opportunities for new businesses and services to develop for this particular population bulge. You can access much of this demographic information through publicly available Canadian census data (Statistics Canada).

Furthermore, if women delay their fertility, they may not have sufficient time left in which to conceive in the manner they anticipated or expected. For example, if young women are taking more time to finish their education and then want to get a solid job with benefits before thinking of marriage and having a child, these institutional timing considerations could delay both marriage and fertility (Ranson, 1998). The fact that they wait so long may leave few years for child-bearing. These few years may be further eroded by increasing difficulties with conception among women over age 30 and increasing infertility of male partners due to low sperm counts. This, in turn, could explain some of the difference between the high number for desired fertility and the low number for actual fertility. Obviously, the way we time events such as education and work in our life course has important effects on the timing and even the ability to have children.

We need to take a closer look at the fertility rate in each age group (commonly referred to as age-specific fertility). Figure 6.2 shows that the traditionally most fertile age group (20- to 24-year olds) now has lower fertility than even the 30- to 34-year-old age group. This rather drastic change in fertility patterns since World War II is mainly due to both delay of fertility and increase in childlessness. The "good news" from these data is that teen births are declining, but this is part of an overall trend in fertility decline. Only the older age groups (30- to 34-year-olds and 35- to 39-year-olds) are showing some increase in fertility, but that has to be understood in the context that in most previous historical periods a couple would have completed their fertility by these ages.

Figure 6.2 Age-Specific Fertility Rates, Selected Age Groups, Canada, 1941 to 2002

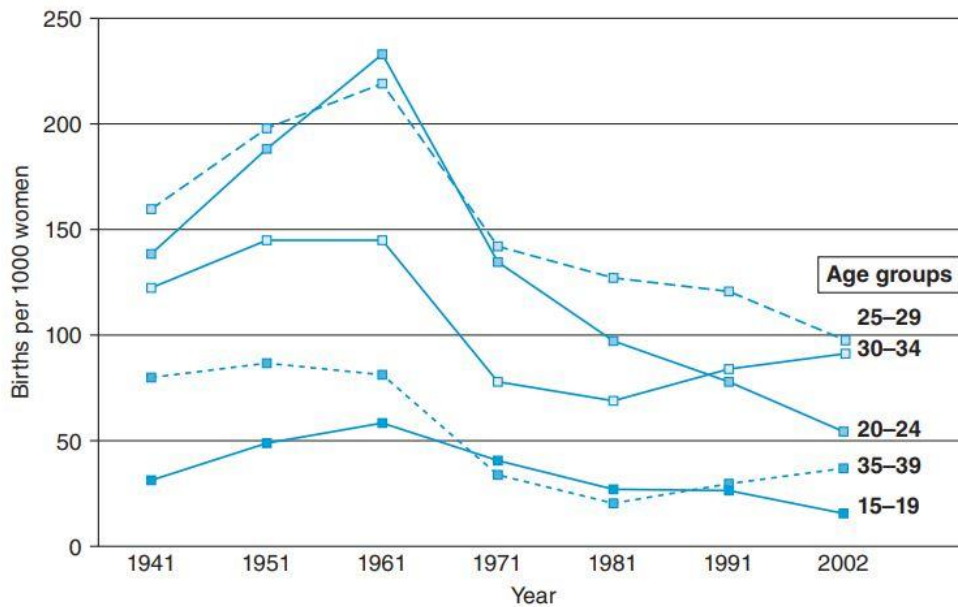


Figure 6.2 Age-Specific Fertility Rates, Selected Age Groups, Canada, 1941 to 2002

Source: Health Canada. (2005). Changing fertility patterns: Trends and implications. *Health Policy Research*, 10 (May). Reproduced with the permission of the Minister of Health, 2011.

Figure 6.3 Distribution of First Births, by Age of Mother, Canada, 1976 and 1996

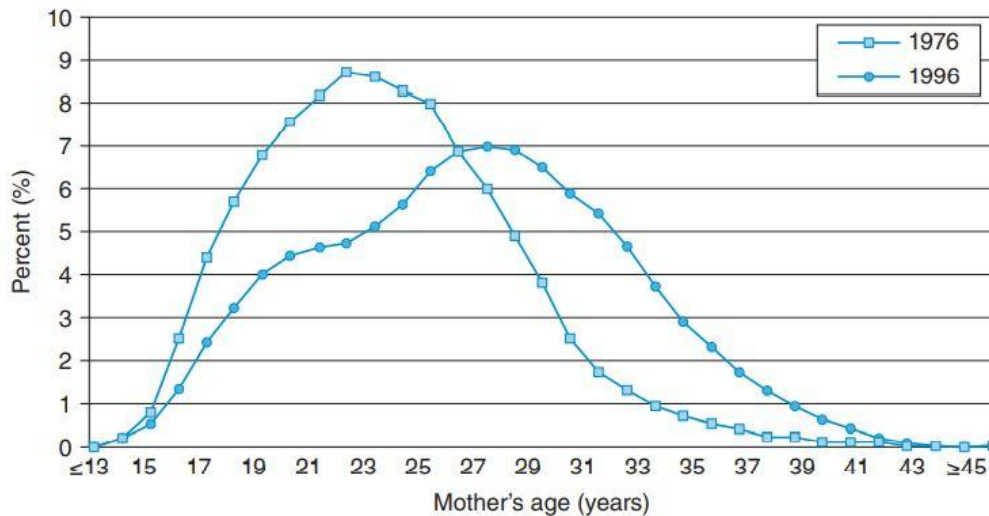


Figure 6.3 Distribution of First Births, by Age of Mother, Canada, 1976 and 1996

Source: Health Canada. (2005). Changing fertility patterns: Trends and implications. *Health Policy Research*, 10 (May). Reproduced with the permission of the Minister of Health, 2011.

Figure 6.4 Distribution of First-Time Mothers, by Age and Education, Canada, 1996

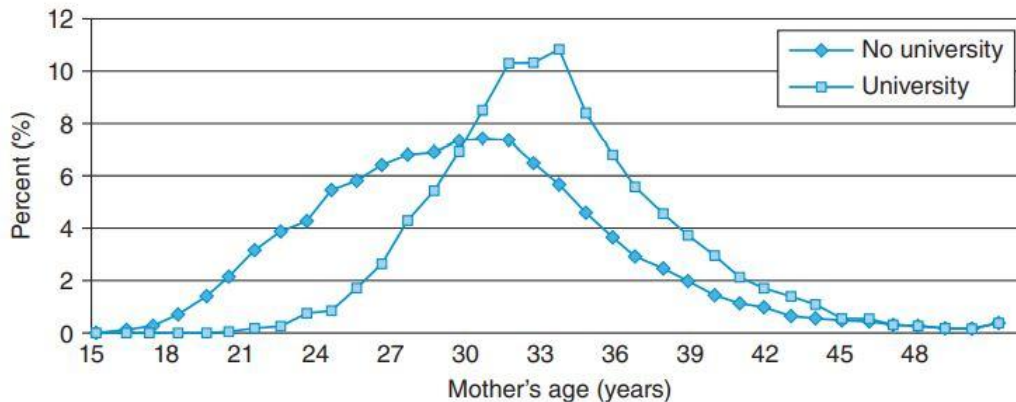


Figure 6.4 Distribution of First-Time Mothers, by Age and Education, Canada, 1996

Source: Health Canada. (2005). Changing fertility patterns: Trends and implications. *Health Policy Research*, 10 (May). Reproduced with the permission of the Minister of Health, 2011.

Figure 6.3 graphically represents the delay of fertility in Canada. This figure compares fertility by age of the mothers for two years: 1976 and 1996. It is obvious that mothers in 1996 were having children at significantly older ages. What is perhaps less obvious but just as important is the “spread” of the 1996 distribution. The 1996 curve is more spread out (platykurtic) than the more peaked distribution for 1976. Although these data are only limited to two time periods, such changes in distribution might suggest an overall weakening of social norms favouring having children. In general, when we have strong life course norms about the appropriate time to have children, we expect a very peaked distribution (leptokurtic). As timing norms weaken, the curve becomes more spread out (platykurtic). As the classical theorist Emile Durkheim pointed out in his work on suicide, anomie or “normlessness” can indicate social disorganization within an institutional sector of life.

Any attempt to explain why women are delaying fertility would certainly focus on the changing timing norms. Women’s participation in the labour force doubled from 1970 to 2000. Previous age cohorts of women often did not enter the labour force until their children were teenagers or older. In 1970, the big switch was that women started to get more education and started their first major jobs after completing their education. Because of these timing changes, marriage and fertility were delayed. Figure 6.4 shows that mothers with post-secondary education are delaying their fertility longer than mothers with no university education. Clearly, extended periods of education are implicated in timing changes.

Education alone does not account for the changes in fertility. Another major factor is economic well-being. Interestingly, Mitchell and Gray (2007, p. 38) report that their sample of Australian couples reveals the following:

. . those who expect to have children, attach more emphasis to job security, career advancement and home ownership. Hence, those who want children express greater desire to set up an environment that is suitable to have children.

Figure 6.5 Difference between Average and Median Two-Parent Family Incomes, by Mother’s Age at First Birth, Canada, 1971 and 1996

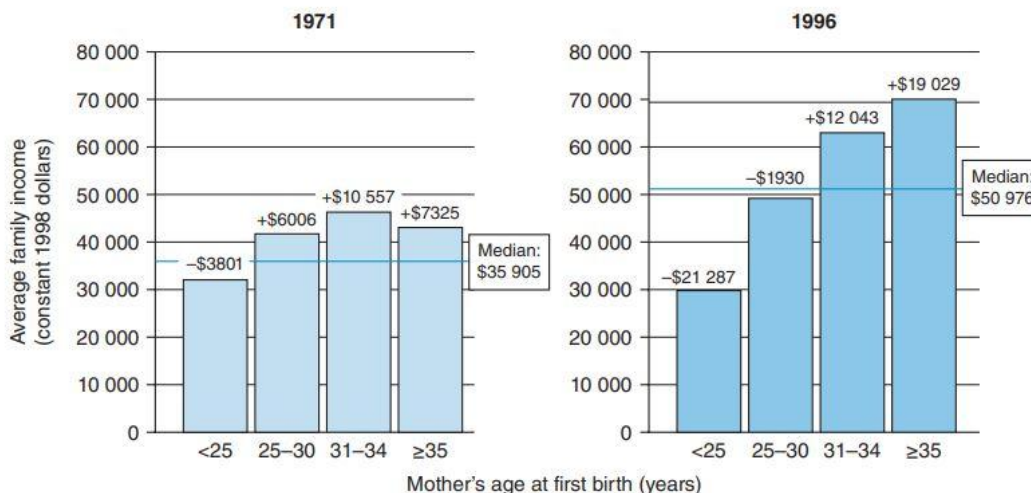


Figure 6.5 Difference between Average and Median Two-Parent Family Incomes, by Mother’s Age at First Birth, Canada, 1971 and 1996*

*Data are based on two-parent families with the oldest child being 0–5 years of age. Average and median two-family incomes are measured in constant 1998 dollars.

Source: Health Canada. (2005). Changing fertility patterns: Trends and implications. *Health Policy Research*, 10 (May). Reproduced with the permission of the Minister of Health, 2011.

It is relatively easy to compare the median family incomes for two-parent families by age group of the mothers when they had their first child. Figure 6.5 clearly indicates that couples in 1996 did not achieve the median family income for Canada until the women were age 30 or older and then had their first birth. In contrast, couples in 1971 achieved this level of well-being when the women were about 25 years of age. This suggests that the findings in Mitchell and Gray’s Australian sample may have a bearing on Canadian fertility patterns. It seems to suggest that couples who want children might delay fertility in part so that they can achieve a level of economic well-being previously achieved by much younger couples. The fact that achieving this economic well-being now requires two salaries rather than one would seem to be even more of a deterrent to fertility.

Figure 6.6 Fertility and Miscarriage Rates as a Function of the Mother’s Age

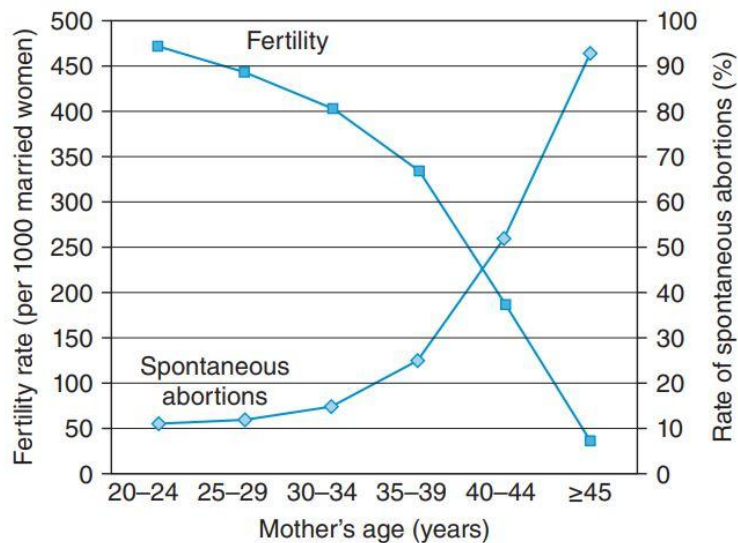


Figure 6.6 Fertility and Miscarriage Rates as a Function of the Mother's Age

Source: Health Canada. (2005). Changing fertility patterns: Trends and implications. *Health Policy Research*, 10 (May). Reproduced with the permission of the Minister of Health, 2011.

It may seem that the timing of fertility is largely irrelevant to Canada's TFR. After all, if a couple plans to have two children, what difference does it make whether the mother intends her fertility to occur between ages 25 and 30 or ages 30 and 35? This does make a difference, however. Certainly, male infertility and, more particularly, female infertility increase with age (Fox, 2000). In addition to infertility problems, problems of conception and miscarriage are associated with the mother's age. Figure 6.6 shows that the rate of miscarriage (spontaneous abortion) is 50 per 1000 married women in their early twenties but increases exponentially to more than 450 per 1000 after age 45. A woman in her late thirties has almost triple the risk of miscarriage as a 20-year-old woman. In 2007, Canada's average age of first-time mothers was 29.3 years, meaning that roughly half were above that age. As a result, some of Canada's lowered TFR is due to biological problems of infertility and miscarriage associated with delays in child-bearing.

Current Fertility in Canada

The analysis of Canada's recent history of fertility is useful for developing a context in which we can understand current changes in Canadian fertility. The most recent data suggest that fertility in Canada is increasing somewhat. Table 6.1 seems to indicate that Canada is enjoying somewhat of an upward trend in births, although this is not an incipient baby boom. This seeming mini-boom levelled off in 2008 to 377 886 births (see Table 6.1). If we compare this 2008 number with Canada's highest number of births in the 1950s, Canada is producing only about two thirds of that earlier number even though the country's population was only 17 million in 1959 and was 33.5 million in 2008. In other words, Canada is producing many fewer children despite a much larger population base. Indeed, we have seen only a modest increase in the

TFR, to about 1.7 children per woman. The replacement level is about 2.13, so Canada is still very far from even maintaining its population through reproduction (or natural increase).

Table 6.1 Number of Births, Canada, 2003–2008					
2003	2004	2005	2006	2007	2008
335 202	337 072	342 176	354 617	367 864	377 886

Source: Statistics Canada, Births, 84F0210XWE, September 2009; <http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?lang=eng&catno=84F0210X>

Data Box 6.1
Aboriginal People Surpass One-Million Mark
<p>New data from the 2006 Census show that the number of people who identified themselves as an Aboriginal person has surpassed the one million mark.</p> <p>A total of 1,172,790 people reported Aboriginal identity, that is, North American Indian (hereafter referred to as First Nations people), Métis or Inuit. The census enumerated 976,305 Aboriginal people in 2001 and 799,010 in 1996.</p> <p>In 2006, Aboriginal people accounted for 3.8% of the total population of Canada, an increase from 3.3% in 2001 and 2.8% in 1996.</p> <p>The Aboriginal population has grown faster than the non-Aboriginal population. Between 1996 and 2006, it increased 45%, nearly six times faster than the 8% rate of growth for the non-Aboriginal population over the same period.</p> <p>Of the three Aboriginal groups, the fastest gain in population between 1996 and 2006 occurred among those who identified themselves as Métis. Their numbers almost doubled (+91%) to an estimated 389,785. This growth rate was nearly three times as fast as the 29% increase in First Nations people, whose numbers reached 698,025. The number of people who identified themselves as Inuit increased 26% to 50,485.</p> <p>Source: Statistics Canada (2008)</p>

The type of relationship into which children are born has also changed dramatically over the last few decades. Increasingly, Canadian children are born to couples in cohabiting relationships or to single, never-married females rather than to married couples. It is interesting to note that, in Canada, 26.2 percent of births are to single, never-married females versus 61.6 percent of births to legally married couples. The most surprising fact about this is the rather incredible

variation across different provinces. While only 11.6 percent of births in Ontario are to single, never-married women, British Columbia has a rate of 18 percent, Quebec has a rate of 59.9 percent, and Nunavut has a rate of more than 75 percent. Part of this variation results from the popularity of cohabitation in certain regions and the fact that cohabiting females are classified as single, never married. Regardless of classification, it is clear that births to single, never-married, and cohabiting women are increasing (Statistics Canada, 2006b).

In a monograph titled *Families Count*, the Vanier Institute of the Family (2010) concludes that given the current rate of decline in fertility, with the exception of the Aboriginal population (see Data Box 6.1), Canada cannot expect to maintain its population relative to death past 2030. At that point, the country would slip into population decline. Furthermore, they state that “International immigration is now the primary population growth engine, accounting for two-thirds of growth in 2006” (Vanier Institute of the Family, 2010, p. 4). They continue with the implication that after Canada reaches zero population growth in 2030, any population growth after that must be tied to immigration.

Figure 6.7 Total Fertility Rate over Time in High- and Low-Development Countries, Weighted by Population Size

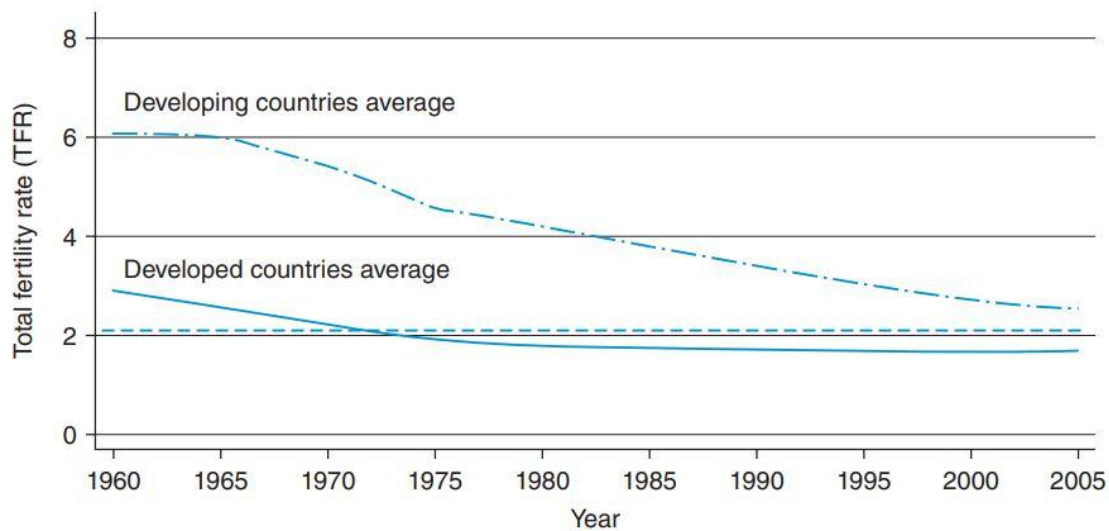


Figure 6.7 Total Fertility Rate over Time in High- and Low-Development Countries, Weighted by Population Size

Note: The population weights are based on 2000 population estimates. The dashed line represents replacement fertility (TFR = 2.1).

The implications of zero population growth can be seen as salutary from an ecological perspective and devastating from an economic perspective. From an ecological perspective, declining population could mean a smaller ecological footprint. Economically, however, we can sell our goods and services to our national population and see economic growth only if either the population is growing or we can convince consumers to buy increasing amounts of goods. Both of these scenarios are unlikely in a declining population with fewer children, teachers,

schools, and houses needed. On the other hand, we can sell our goods and services to other countries if they represent consumer markets for us. This leads us to take a quick look at what is happening in other countries

Worldwide, fertility is clearly declining. There is considerable variation as to the explanation for the decline, including human development indices that track education and health and women's labour force participation. Perhaps the clearest statement in this regard has been made by one of the leading demographers studying fertility, S. Philip Morgan. Morgan and Rackin (2010) present data showing that the average and country-specific TFRs have declined (see Figure 6.7). You can examine this for yourself by using the following tool:

<http://homepage3.nifty.com/sociology/motion.html>. Clearly, developed countries have been below replacement level since the early 1970s but developing countries are approaching the replacement level as well.

Like many other developed nations, Canada is approaching a point of population decline where there are more deaths than births. Population for any year is defined by the following formula.

$$\text{Population (January 2010)} = \text{Population (January 2009)} + (\text{Births} + \text{Immigration}) \\ - (\text{Deaths} + \text{Emigration})$$

Canada will be competing with many other countries for immigrants to maintain its population. The country is currently on track to begin population decline in 2030, so actions must be taken to redress this outcome, either by increasing the natural birth rate or by increasing immigration.

The assumption that immigration could solve both short-term labour shortages and longer-term fertility problems may be too optimistic. Indeed, Caron Malenfant and Belanger (2006) have demonstrated that visible minority women's fertility in Canada mainly falls below replacement level. Only in South Asian, Arab, and West African groups was fertility above replacement level, and that was probably due to these being more recent immigrant groups. Indeed, further analysis of data from the Ethnic Diversity Survey (Statistics Canada, 2003a) found that being in the first immigrant generation explains much of the variation in fertility among visible minority groups.

Many countries, such as France, have tried pro-natalist policies and some countries, such as Germany (via Chancellor Angela Merkel), have gone on record as saying that the policy of multiculturalism, which is tied to large-scale immigration, does not work. The perceived failure of multiculturalism in Europe has not yet surfaced in Canada. What is in doubt is whether immigration can address the shortfall in fertility. Indeed, Canada would have to increase its immigration rate considerably to keep from falling into population decline. It is perhaps even more important to maintain a labour force that can support the aging population. Therefore, even though immigration may not address fertility, it does address labour shortages. The only real alternative for countries eschewing immigration and multiculturalism is to pursue some form of pro-natalist policy to address fertility. Much of Europe has already made this investment, with varying degrees of success. Some of these policies include universal daycare, extensive paid

parental leave, and payments or tax credits for births. In North America (with the exception of Quebec), we have not yet squarely addressed fertility as a problem. We can expect to see continuing debates throughout the world as countries try to address both labour and fertility shortages.

The Transition to Parenthood

Although the actual fertility rates in developed nations are below the replacement level of about 2.13, it is useful to recall that people continue to desire more children. As we have seen, some of the difference between desired and actual fertility results from delaying marriage and fertility to acquire post-secondary education and cement one's workforce participation and experience. We also noted that couples delay first birth until they feel financially stable and are living in an environment conducive to having a child. Now we turn our attention to the transition to parenthood.

The transition to parenthood is of great interest to family scholars for two reasons. First, this transition represents the assumption of the most responsible roles in a family, those of mother and father. These roles are well defined by both informal and formal social norms. While the roles are informally defined by expectations that parents will nurture their children, they are also formally and legally defined by laws governing parent abandonment, child neglect, and abuse. Even such areas as child discipline are surrounded by both formal and informal norms, which at times may be contradictory. The next chapter on parenting will develop some of these topics more fully.

The other major reason that the study of the transition to parenthood is important to family scholars is more practical. For several decades, we have known that the transition to parenthood is usually accompanied by significant declines in most areas of the marriage. Even though marriages with a child are more stable than marriages without a child at the same duration of time, these marriages may contain greater conflict and less love than was the case before the child joined the family. From a practical standpoint, we study this transition to solve the mystery about the decline in marriage.

Getting Pregnant and Pregnancy

Although most of us assume that the transition to parenthood begins with pregnancy, there is some evidence to suggest that the course of the marriage and indeed some child outcomes are tied to the "style" the couple adopts toward pregnancy. Cowan and Cowan (1999) argue that those who plan to initiate sex with the idea of having a child are in many ways better prepared throughout other phases of the transition to parenthood. On the other hand, some couples just stop using birth control and adopt a "whatever happens" attitude. Like the "sliders" discussed in the cohabitation studies, these couples are generally less prepared throughout the transition to parenthood.

Image 6.3

<https://www.pexels.com/photo/man-woman-technology-white-9574506/>



We have already discussed involuntary infertility, but it should be clear that problems in conceiving a child are more noticeable to those who carefully plan intercourse during ovulation. We do not know all of the causes of involuntary infertility, but several have been speculated on in the popular press. One of these is the significant lower live sperm counts among males. The reasons for these lower live sperm counts are not clear but speculation has pointed to a host of environmental causes such as tight-fitting briefs and plastic bottles containing synthetic estrogens. Female infertility is most commonly attributed to ovulation disorders, fallopian tube blockages, or pelvic inflammatory disease. Although estimates in Canada are difficult to come by, one preliminary estimate is that 7 percent were unsuccessful when measured over two years of attempting to get pregnant while 8.5 percent were unsuccessful when measured over one year (Norris, 2001).

Pregnancy is usually divided into three phases or trimesters. Although gestation to term is usually slightly longer than nine months, each trimester is roughly three months in duration. Although many discussions of pregnancy focus on the development of the fetus, our interest is in the developing couple. Each trimester has certain events that define it as unique for the couple and make it a developmental stage for them as well as for the baby.

In the first trimester, the couple discovers that they are going to have a child. Usually, suspicions of pregnancy are confirmed by a visit to a doctor. At that time, a series of appointments are scheduled to check on the development of the fetus. For planners, there is usually little

ambiguity about the positive nature of the news, whereas for “sliders” the news may contain some ambiguity about the timing and whether a child is really wanted. For **primiparous** (first-time) mothers, the first trimester also is a source of anxiety since this is the most probable time for a miscarriage. Of course, if there is ambivalence about having the child and then there is a miscarriage, this usually results in feelings of guilt despite the fact that there is no evidence that ambivalence is related to miscarriages. The first trimester is also usually identified by “morning sickness” or nausea, although this may extend into other trimesters.

The second trimester is often reported by women as the most enjoyable trimester. Weight and balance are usually not yet a problem and many adjustments to being pregnant have already been made. In the second trimester, several diagnostic interventions such as amniocentesis may be suggested. Perhaps the least intrusive of these is ultrasound. Although these were routine at an earlier time in many areas, most provinces no longer fund this for all pregnancies. Many of these diagnostic interventions are routine for women over age 35 or with pre-existing risk factors.

The third trimester is important because the child will be born at the end of it. As a result, it usually involves preparations such as booking a hospital room, readying the child’s room, and, perhaps most important, attending prenatal classes. Prenatal classes are essential for both partners to attend because as the couple draws up a birthing plan, the partner will know under what conditions the woman may want an epidural or other pain remediation. The experience of meeting other expectant parents who are at the same stage of pregnancy can be reassuring. Some prenatal classes also discuss post-birth issues such as diapers and bathing. After the prenatal classes, the couple usually packs a bag that will be ready to go to the hospital with them.

The First Birth and the Decline of Marriage

For the great majority of couples, the birth of a first child is a major life course transition. For some, this will be a home birth but for most, the birth will occur in a hospital. There is no doubt that hospitals socialize the new parents about many facets of early child care. Most hospitals offer assistance with and endorsement of breastfeeding the baby because of the protective maternal antibodies contained in breast milk and the overall nutritional value of breast milk. Another area addressed is how to hold and bathe the baby. Usually, the new parents take their child home within a few days of the birth. Some have equipped themselves with a list of things to check when the baby cries, such as wet diaper, last feeding, and so on. Unlike in some previous generations, first-time parents today are unlikely to have had infant brothers or sisters under their care or to have had much experience with infants.

Feeney et al. (2001) asked first-time parents what they disliked most about being first-time parents. As you may have guessed, most parents said that lack of sleep was unpleasant (48 percent), followed by not knowing what to do (35 percent). Certainly, these two factors could be related, though no examination of that was conducted by Feeney et al. At the beginning of the previous century, larger families afforded siblings experience in dealing with younger children as

part of anticipatory socialization for parenthood. In addition, adult siblings may have experienced some anticipatory socialization when caring for a new nephew or niece. With increasingly smaller family size, these opportunities to learn are less available. Indeed, while preparation for birth is supported by prenatal classes, preparation for parenthood has yet to receive much support or attention. We will return to this issue later in this section. For now, note that it is not surprising that new parents report not knowing what to do as a problem.

Feeney et al. (2001) also report the “best” things that new parents list. The baby smiling (45 percent) and simply having the baby (31 percent) are mentioned at a relatively high rate compared to “being closer to my spouse” (10 percent). Many of the joys of having a first child are tied to either the increasing developmental and interactional ability of the infant or the notion of being a family. The early growth and development of the child as witnessed by increasingly complex parent and child interactions is an early source of joy. As well, by adding a child and becoming a family with the fully adult roles of mother and father, the couple attains a socially and legally recognized status.

Regardless of the joys, or even the hardships, of having a first child, most scholars have noted that this transition event is tied to changes in the course of the marriage. This was first noted by Blood and Wolfe (1960) in their landmark study of married couples in Detroit. They observed that the majority of wives were very satisfied with their marriages in the first few years of marriage, but that after 20 years only 6 percent were very satisfied. This research supplied impetus for scholars to examine marital satisfaction and marital quality throughout the life course of the family. The findings in this area have been very consistent. Starting with the life satisfaction research of Campbell, Converse, and Rogers (1976) and followed by that of Rollins and Feldman (1980), there has been a consistent finding that marital satisfaction follows a U-shaped curve (see Chapter 5, Figure 5.6) across stages of the family life course. This finding has been replicated by many other researchers in the United States (Anderson, Russell, & Schumm, 1983) and Canada (Lupri & Frideres, 1981; Rhyne, 1981). Only the U.S. study by Valiant and Valiant (1993) has failed to show strong support for this curvilinear relationship.

In the present context, we are only interested in the first two stages of this curve: the decline of marital satisfaction from the wedding day to the birth of the first child. Of course, it could be argued that this decline is simply the result of newly married couples moving from the romantic idealization of their partners to a more realistic viewpoint. This perspective would focus on a continuous decline as newly married couples find out increasingly accurate information about each other. Although some of this general decline may be due to removing the “rose-coloured glasses” of romantic love, researchers have discovered a much more abrupt process in the decline of marital satisfaction.

The decline in marital variables was first noted by Rossi (1968), although she focused mainly on the role of mother. She believed that the difficulties experienced in the transition to parenthood for mothers were due to four factors: the lack of support for a lifestyle other than motherhood, the shift in emphasis from the marital role to the mother role, the abruptness of this transition, and the lack of guidelines and support for parenthood. While all four of these factors may still

make some sense today, we have come a very long way from the “lock-step” conformity of the 1960s about the automatic assumption of the mother role and the lack of lifestyle alternatives to motherhood. Rossi’s (1968) study sparked decades of scholarly research on the transition to parenthood. Her work was followed by that of many scholars, including Russell (1974), LaRossa and LaRossa (1981), and Belsky, Spanier, and Rovine (1983).

Belsky et al. (1983) made a particularly instructive contribution to the study of the transition to parenthood because they followed a panel of married couples across three time points in the transition: pregnancy, three months postpartum, and six months postpartum. They concluded that statistically significant declines in many of their measures of marriage were evident for both husbands and wives with the first birth. This was followed by further analysis by Belsky, Lang, and Rovine (1985).

The most definitive statement about the changes in marriage associated with the first birth results from the three-year longitudinal study by Belsky and Rovine (1990). In this study, Belsky and Rovine followed married couples from pregnancy to three years postpartum. Their findings are unequivocal. Both husbands and wives showed significant declines on measures of marriage. The authors found that wives declined on all four measures, reporting decreased love, increased amount of perceived conflict, less effort on relationship maintenance, and more ambivalence about the marriage. Husbands reported declines in all areas except perceived conflict (see Table 6.2). Belsky and Rovine also tested for whether this was a linear or curvilinear (getting worse and then better) decline. They found that all trends were linear, with no support for measures improving after three years postpartum. Perhaps the only good news in their study was that while 75 percent of new parents declined, 25 percent of couples in their sample either stayed the same or improved on measures. This leads to an obvious question: Why and how do couples improve their relationships in the transition to parenthood?

Table 6.2 Mean Husband and Wife Marriage Scores

Table 6.2 Mean Husband and Wife Marriage Scores

Scale	Time of Measurement				F	Trend	
	Prenatal	3 Months	9 Months	36 Months		Linear	Quadratic
Wife (n = 128)							
df					3,381	1,127	1,127
Love	80.63	77.78	75.30	74.00	22.80***	51.02***	ns
Conflict	20.52	21.10	22.22	22.65	8.39***	18.35***	ns
Ambivalence	10.11	10.59	12.39	13.04	14.34***	28.46***	ns
Maintenance	31.77	29.80	28.64	28.27	20.91***	49.74***	5.46*
Husband (n = 117)							
df					3,348	1,116	1,116
Love	75.54	74.33	73.54	71.02	10.36***	23.51***	ns
Conflict	20.11	20.07	20.82	20.40	ns	ns	ns
Ambivalence	13.31	13.98	14.41	14.84	2.88*	5.43*	ns
Maintenance	29.92	28.89	28.53	27.09	12.25***	28.54***	ns

* $p < .05$. *** $p < .001$.

Source: Belsky and Rovine (1990).

Although we do not have a complete understanding of all factors that contribute to the decline of marriage during the transition to parenthood, Canadian researchers Cowan and Cowan (1999) shed considerable light on some of the major factors. They studied married couples over a 10-year period. During this time, many couples had a child and some opted to remain childless. The couples that had a pregnancy were followed throughout the duration of the study. Cowan and Cowan used both quantitative measures and interviews in this study. Because of the richness of the data, they were able to address the question of why and how couples prosper or flounder in the transition to parenthood. The answers are complex, of course, but overall a picture emerged about the expectations couples have regarding this new stage of the life course (being a family) and how these expectations could end up being disappointed.

For many couples, the most egalitarian roles in intimate relationships are found in cohabitation. Certainly, with the addition of the marital roles of husband and wife, the relationship becomes slightly less egalitarian. For the most part, however, marital roles before children are also egalitarian. Each partner negotiates and takes on part of the household labour and each is likely to maintain full-time employment in the workforce. When the woman becomes pregnant, the couple usually decides who will take parental leave, based on who is earning the higher salary, the need for rest after the labour of childbirth, and breastfeeding. Considering all this, it often appears to be “rational” that the woman should stay at home. Women tend to earn on average 80 to 90 percent of what men at the same level earn, and women of course give birth and breastfeed. Even though breast milk can be expressed and stored, this practice requires an understanding employer and on-site refrigeration. So, for many couples, the decision that the woman rather than the man will take parental leave seems “rational.” This seemingly “rational”

decision, however, begins to change the egalitarian marital roles and division of labour to much more gendered and non-egalitarian traditional roles.

With the birth of the baby, the mother is suddenly placed in a role in which she is expected to know more about the infant's care than the father. Cowan and Cowan document that this expectation is not only held by the couple but is also invoked and reinforced by the father's parents. Not only does the woman's role as mother intensify in ways she may not have anticipated, but the man also takes on his primary socially defined role as "breadwinner," often investing more hours and energy in work because of his new family responsibilities. As this role intensifies for the new father, work is seen from a family perspective as making legitimate "demands" on his time and energy, pulling him even farther from any egalitarian distribution of household labour. The father may come home in the evening tired from work only to find that the mother wants time away from the constant demands of the infant. The father may further expect that since his wife is home all day, she should naturally take care of the cleaning, cooking, and domestic chores. What transpires is that the couple that envisaged "being in this together" and "sharing the workload" of the baby suddenly finds themselves in the traditional roles they witnessed in their parents' and grandparents' relationships. The disappointment of these violated expectations of egalitarianism and the reality of the unexpected traditional roles create conflict between the couple regarding household labour, the value of each person's work, and the denial of help when both partners are exhausted from lack of sleep.

Certainly, the role of mother is increasingly intensified in our society. One example of this intensification is breastfeeding the baby. Most new mothers return to work somewhere between six months and one year postpartum (Statistics Canada, 2006f). Based on 2003 estimates, about 28.6 percent of infants aged six months to one year are in alternative care and 56.1 percent are in alternative care after one year of age (Statistics Canada, 2006e). The worldwide campaign by UNICEF and the World Health Organization (see Box 6.1) to have all mothers breastfeed their babies has placed some pressure on new mothers to make significant adaptations to achieve the breastfeeding goals. Many new mothers may wish to place their child in the care of a relative or in infant daycare when they return to work. However, if they are to continue feeding their infant breast milk once they return to work, they must express the milk using a breast pump and have refrigeration available. Of course, many offices are not equipped for these activities. The preferred situation would be work site infant care facilities, but such facilities are few. It is difficult for relatives and fathers to participate in infant feeding without the woman expressing and bottling her milk. Thus, the general expectation that mothers will breastfeed intensifies the gender specialization and reinforces traditional roles that move many couples further from an egalitarian division of labour.

Box 6.1
Baby-Friendly Hospital Initiative (BFHI)

In Canada the BFHI is overseen by the Breastfeeding Committee for Canada.

The BFHI is a global program initiated in 1991 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in response to the Innocenti Declaration (1990). This program encourages and recognizes hospitals and maternity facilities that offer an optimal level of care for mothers and infants. A Baby-Friendly™ hospital/ maternity facility focuses on the needs of the newborns and empowers mothers and families to give their infant the best possible start in life. In practical terms, a Baby-Friendly™ hospital/ maternity facility encourages and helps women to successfully initiate and continue to breastfeed their babies, and will receive special recognition for having done so. Since the inception of the program, over 15,000 hospitals worldwide have received the Baby-Friendly designation.

The BFHI protects, promotes and supports breastfeeding through the Ten Steps to Successful Breast-feeding developed by UNICEF and the World Health Organization. In order to achieve Baby-Friendly™ designation, every hospital and maternity facility must:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers to initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in, allow mothers and infants to remain together—24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

A Baby-Friendly™ hospital/ maternity facility also adheres to the International Code of Marketing of Breast-milk Substitutes (1981). The Code seeks to protect breastfeeding by ensuring the ethical marketing of breastmilk substitutes by industry. The Code includes these ten important provisions:

1. No advertising of products under the scope of the Code to the public.
2. No free samples to mothers.
3. No promotion of products in health care facilities, including the distribution of free or low-cost supplies.
4. No company representatives to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealizing artificial feeding, including pictures of infants on products.
7. Information to health workers should be scientific and factual.
8. All information on artificial feeding, including the labels should explain the benefits of breastfeeding and all costs and hazards associated with artificial feeding.
9. Unsuitable products such as sweetened condensed milk should not be promoted for babies.

10. Products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.

For more information about the Baby-Friendly Hospital Initiative, and the new Baby-Friendly Initiative in Community Health Services, please visit the Breastfeeding Committee for Canada.

Source: <http://www.bcbabyfriendly.ca/BFHI.html>

The intensification of the gendered division of labour, the move away from egalitarianism, and the assumption of more traditional roles may all provide difficulties to marital relationships. However, recall that a few couples actually improve their relationships with the birth of the first child. This information led Cowan and Cowan (1999) to investigate ways to improve marital relationships for new parents. During the course of their 10-year study, Cowan and Cowan identified an intervention strategy. The strategy was simply to assist the couple during the pregnancy stage to talk realistically about the expectation each had for the postpartum division of labour as well as the social values and expectations of family and friends surrounding them. Although this could not be called an experimental test of the intervention strategy, the resulting difference in divorce rates certainly provides grounds for optimism. Cowan and Cowan (1999) report that six years after the beginning of their study, 20 percent of the new parents divorced compared with 50 percent of the childless couples, but only 4 percent of the couples in the intervention group divorced. Even though we may not have complete understanding of the factors contributing to marital declines during the transition to parenthood, there is certainly every reason to encourage prenatal discussions of accurate and realistic expectations for husbands and wives after the birth. Though not an argument in favour of traditionalism, it is likely that couples who adjust best to some of the postpartum realities are those who were most traditional even before pregnancy.

Conclusion

This chapter has traversed diverse areas of academic and scholarly research. The macroscopic discussion of worldwide declines in fertility is in bold relief to the microscopic declines of marital happiness with the birth of the first child. Yet both of these pictures of child-bearing are consistent with one another. At the macroscopic level, fertility is declining in most of the world and many developed nations will soon be entering population decline with all of its attendant economic and social implications. At the microscopic level, the first birth provides more challenges to egalitarian couples than it did to their parents or grandparents who had more traditional role expectations. These perspectives may seem overwhelming except that Cowan and Cowan (1999) point out that couples can talk about and renegotiate roles. Certainly, when we move to Chapter 7 on parenting, some of these themes will surface once again.

What are the ramifications for you of below replacement level fertility in Canada? Are you more likely to start a business selling walkers for the elderly than toys for children? During your lifetime, will schools and playgrounds become increasingly deserted? Will all countries in the developed world seek major increases in immigration to deal with workforce shortages? Undoubtedly there will be serious repercussions, but these will be spread over decades rather than a few years.

The transition to parenthood is changing dramatically. In the middle of the last century, almost all couples that had a child were married. Even those who had premarital pregnancies were soon married. Today, children are increasingly born to single, nevermarried, and cohabiting women. We know that the cohabiting relationship is the most egalitarian of family stages, so the dramatic changes in division of labour that accompany being parents may be even more uncomfortable for cohabiting couples. This discomfort with the demands of the parental role could spark a revolution in parenting, with fathers taking on more responsibilities for child care. However, it is also possible that these changes could simply further dampen fertility in Canada.

Summary of Key Points

- The major reasons people often state for wanting a child are cited by social scientists as the following:
 - Conformity to others
 - Having the life experience
 - Increasing social integration (social capital)
 - Old age security
 - Entertainment
- Desired fertility is higher than actual fertility in most developed nations.
- While reports of voluntary childlessness may be confused with involuntary childlessness, it is clear that involuntary childlessness is increasing in North America.
- Mitchell and Gray (2007) argue that fertility timing is specifically linked to having a secure job
- Canada's total fertility rate (TFR) has been below replacement level since 1971.
- Demographic transition theory argues that urbanization and industrialization (modernization) are related to lower fertility.
- The only age groups of women with slight increases in fertility are those 30 to 34 and 35 to 39 years of age.

- Post-secondary education is associated with women being older at the birth of their first child.
- Economic security measured by median family income is reached on average five years later today than in the 1970s.
- As women age past 21 years, fertility declines and the risk of miscarriage increases.
- Fertility is declining in both developed and developing nations of the world (see Figure 6.7).
- Many measures of marital happiness decline between the first birth and three years postpartum.
- Many aspects of the division of labour with infants are gendered, such as who takes parental leave and breastfeeding.
- Egalitarian expectations for the marriage after the birth of the first child may be unrealistic and should be discussed before the birth.

Glossary

actual fertility Recorded live births collected as vital statistics.

age-specific fertility rates The number of children born to women in a given year for each age group. Often ages are grouped in five-year increments, such as 20 to 24 and 25 to 29.

conjugal family Goode's (1963) name for the small nuclear family form that emphasizes the conjugal or marital roles over the parental roles, in part because small family size means that less of one's lifetime will be spent in the parental role and more will be spent in the marital role with children having left home.

crude birth rate (CBR) The number of live births in a country in a given year.

demographic transition The change in fertility associated with changing from an agrarian economy that favours large families to an urban-industrial economy that favours small families.

desired (intended) fertility The number of children women say they would like to have by the time they complete their fertility.

involuntary childlessness The inability to conceive and birth a child after 12 months of unprotected sex.

parental role This role is composed of both formal norms (laws) and informal norms about the level of care, economic and social support, nurturance, discipline, and protection adults are responsible for regarding their children.

population decline The point at which more people die than are born (assuming that emigration and immigration are equal).

primiparous First-time mothers or couples.

replacement level fertility The fertility needed to replace each parent with a reproduction-age offspring

social capital The network of relationships to which an individual has access.

timing norms Refer to age- and duration-graded relationships.

total fertility rate (TFR) An estimate of fertility per woman based on the assumption that (1) she will maintain the cohort rate of fertility for the past year, and (2) she will live to the end of her fertility (usually 45 to 50 years of age).

transition point An instantaneous point in time at which we demarcate one stage from another (e.g., the past stage from the new, current stage). For example, no matter how much preparation and anticipatory socialization a couple experiences, they do not become parents until the moment of their child's birth.

voluntary childlessness The decision and practice of birth control techniques to avoid having children.

Connections

<https://www.bbc.co.uk/news/uk-england-cambridgeshire-13335037>

<https://medicalvideos.com/videos/1294/> (Unviewable link)

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