

The Influence of Gender Role and Women's Empowerment on Couples' Fertility Experiences in Urban Society of Mashhad, Iran

Talat Khadivzadeh (PhD)¹, Robab Latifnejad Roudsari (PhD)^{2*}, Masoud Bahrami (PhD)³

¹ Assistant Professor, Department of Midwifery, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran

² Associate Professor, Evidence-Based Care Research Centre, Department of Midwifery, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran

³ Assistant Professor, Nursing and Midwifery Research Center, School of Nursing and Midwifery, Isfahan University of Medical Sciences, Isfahan, Iran

ARTICLE INFO	ABSTRACT
<i>Article type:</i> Original article	Background & aim: Iran has experienced a great variation in women's status in recent years. There is a little knowledge on how and why advancing gender equality and equity and the empowerment of women play a role in recent fertility reduction in the country. This study was conducted to gain insight into the role of gender beliefs and women's empowerment in the couples' experiences of fertility in Mashhad, Iran in 2011-2012. Methods: In this exploratory qualitative study in-depth interviews were conducted with 54 purposefully selected eligible male and female participants and some key informants who lived in urban society of Mashhad. Data was collected until saturation was happened and analyzed adopting conventional content analysis approach through giving analytical codes and identification of categories using MAXqda software. Study rigor verified via prolonged engagement, thick description and validation of analysis through member check. Results: Findings from data analysis demonstrated three major categories about the influence of women's empowerment and gender role on fertility experiences including: 1) The couple's understanding of gender roles 2) Women's empowerment and changing gender roles 3) Couple's interactions in complementary or parallel roles and 4) Fulfillment of fertility goals based on role division. Some aspects of couples' interaction including equal roles in fertility decisions, choosing and using best fit family planning method and participative child care influenced couples' fertility behavior. Women's empowerment together with balanced gender role in the family resulted in success in attaining couple's fertility desire. Conclusion: Managing fertility behaviors needs to understand the roles of spouses in their mutual interaction in fertility decision making and related behaviors. Imbalanced gender role in family acts as an obstacle to reach the fertility goals and leads to lower than desired fertility. Reproductive health policy makers and family planning counselors could apply the findings of this study in order to publicize proper fertility behaviors through making the couples aware of the risks of gender role imbalance.
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Introduction

Iran has experienced one of the most dramatic declines in fertility rate over the last years. No other countries have experienced a 50% decrease in fertility rate in only one decade

(1). Total fertility rate has lowered from 7.7% in 1966 to the replacement level in 1998-2000 (2, 3). Based on the national census, conducted in 2001 in Iran, total fertility rate has lowered to 1.9% in Iran (4).

* Corresponding author: Robab Latifnejad Roudsari, Department of Midwifery, School of Nursing and Midwifery, Mashhad, Iran. Email: LatifnejadR@mums.ac.ir

Sociologists, psychologists, and economists have conducted several studies worldwide to explain changes in fertility rate and the related factors (5). Socio-cultural theories indicate that fertility is influenced by various factors such as gender roles, sense of satisfaction, hedonism, religion, and particular social norms (6). Women's empowerment and gender equality were emphasized as global priorities in the Program of Action by the 4th International Conference on Population and Development in Cairo in 1994 (7, 8).

In recent decades, given the changes in women's capabilities, different areas of life such as employment, child bearing, and leisure time have undergone socio-cultural changes. Nowadays, women seek equal opportunities in all gender roles. Gender roles are defined based on a combination of social and behavioral norms, which are considered as proper social and interpersonal behaviors for women or men (9). Gender-based differences in roles are consequences of human experiences in the process of socialization. In fact, in many cultures, most women are expected to play maternal roles and experience motherhood (10).

In Kohan's qualitative study (2009), the participants' descriptions of empowerment in family planning included four main categories of control over fertility plan, participative family planning, maintaining health during reproductive years, and access to optimal family planning services (11). These categories are influenced by socio-cultural beliefs about gender roles in family and society.

According to a study by Droese Vase (2010) in Uganda (with a high fertility rate), men fully controlled sexual relations and were the main decision-makers for child bearing (12). In a study by Khadivzadeh (2013), an important reason for delayed child bearing was being unprepared for playing maternal or paternal roles in spite of motivation. Also, one of the most important reasons for this delay was multiple roles of women (13). In addition, Papadimitriov (2008) in Australia showed that the more women were involved in female roles, the more they were motivated for child bearing. The main reason for delayed child bearing or lack of motivation among women was the consequent lack of freedom or limited time for leisure

activities or professional tasks. This study showed that women with higher masculinity scores less valued children or child bearing (14). However, Khadivzadeh et al. (2013) found no relationship between masculine characteristics and negative or positive motivation for fertility (15) or women's attitude toward fertility (16).

Unfortunately, no studies in Iran have investigated the effect of gender roles on fertility. Therefore, considering the recent economic and socio-cultural changes in Iran and with the purpose to understand future population changes, we conducted this study to gain insight into the role of gender beliefs and women's empowerment in the couples' experiences of fertility in Mashhad, Iran in 2011-2012.

Materials and Methods

In this qualitative study, which is part of a large exploratory qualitative study on couples' fertility behavior in urban society of Mashhad, Iran, a qualitative content analysis was conducted.

The study population consisted of married women, aged 15-49 years, who lived in Mashhad, Iran; also, men, whose wives met the inclusion criteria, were included in this study. Finally, 40 participants including 27 married women of reproductive age (15-49 years old) and 13 men, whose wives were in reproductive years, were enrolled in the study. The couples had lived in Mashhad for at least three years prior to the study, and planned to stay in this city in the coming years. The inclusion criteria were as follows: 1) fluency in Farsi language; 2) consent to participate in the study; and 3) previous experience of fertility decision-making. Exclusion criteria were as follows: 1) residing in Mashhad for only educational or occupational reasons; 2) infertility due to genetic or medical problems; and 3) woman's infertility or menopause.

Ethical considerations were observed throughout the study and the approval of the university ethics committee was obtained. Data were collected using purposeful sampling with maximum variation. Participants were selected from healthcare centers, houses, governmental offices, private companies, and other places (where participants were accessible) in

Table 1- Participants' demographic characteristics (40 subjects including 27 females and 13 males)

Variables	Frequency (%)
Education level (n=40)	
Higher education	16(0.40)
Middle school and high school diplomas	13(32.5)
Elementary and middle school education	11(27.5)
Age distribution (n=40)	
<25 years	4(0.10)
25.1-35 years	12(0.30)
35.1-45 years	13(32.5)
≥45 years	11(27.5)
Residence history (n=40)	
Native of Mashhad	22(0.55)
Migrant from other cities in the state	11(27.5)
Migrant from other states in the country	(17.5)
Women's employment status (n=27)	
Housewife	13(48.2)
Employee (working at home or outside the house)	14(51.8)
Number of children (n=40)	
1-2	22(0.55)
3-4	12(0.30)
5-6	4(0.10)
7-8	2(0.05)

different regions of Mashhad. Healthcare centers were selected since they were easily accessible and provided a wide range of healthcare services for women during fertility period.

Participants were selected purposefully, and were thoroughly informed about the aims and methods of the study. After obtaining the subjects' consents, the time and location of the interview were determined. In addition, individuals with previous experience of fertility were introduced by the staff of healthcare centers or other participants. Also, the variety in age, career, place of residence, education level, and number of children was ensured in the selection process.

Sampling with maximum variation is usually preferred for qualitative studies (17). In the current study, sampling was continued until the point of data saturation was reached. Semi-structured face-to-face interviews were conducted (separately or in company of their partners). The subjects were assured about the privacy of the setting and they could openly talk about their experiences; the interviews were not recorded without participants' knowledge. The subjects were assured about the confidentiality of the data, and informed consents were obtained from all participants.

Firstly, the subjects were asked to describe the fertility decision-making process and characterize their own participation and their partners' roles in child bearing decision; also,

the reasons for their decision were investigated. The next questions were asked based on the given answers, and more important issues were discussed. In some cases, notes were taken in the setting.

After the interviews, participants completed a demographic questionnaire, which included personal questions about age, level of education, career, and their children's birthdays. Finally, they were informed about possible future interviews and further contacts for determining the time and place of the interviews.

Afterwards, the recorded interviews were transcribed, and primary analysis of interviews and field notes was carried out for planning the next interviews. In order to confirm the quality of the research, four criteria of credibility, dependability, confirmability, and transferability, proposed by Lincoln and Guba (1985), were evaluated (18). Measures to ensure the trustworthiness and generalization of study findings included prolonged engagement, prolonged and sometimes repeated interviews, prolonged data collection and analysis, repeated reading of the manuscripts, member check, audit trail, and using multiple data sources for a rich presentation of study conditions and participants.

Data were analyzed by conventional qualitative content analysis, using MAXqda software. For data immersion and a thorough analysis of the interviews, the researchers listened to the

recorded interviews repeatedly, and the manuscripts were read and coded. Then, various categories were derived using an inductive approach by reducing the data into themes and condensing the codes. Table 1 demonstrates some representative characteristics.

Results

After data analysis, four categories were derived regarding the impact of women's empowerment and gender roles on fertility rate. These categories are as follows: 1) the couple's understanding of gender roles; 2) women's empowerment and change of roles; 3) couple's interactions in complementary or parallel roles; and 4) fulfillment of couple's fertility goals.

The couple's understanding of gender roles

Based on the research data, individuals' decisions and behaviors were influenced by their attitude toward gender roles and behaviors in family and society. Most participants believed that raising children and housekeeping were the main responsibilities of women. Participant no. 34, a 35-year-old man with 2 children, said:

"If both husband and wife are busy with activities outside the house, it will be difficult to raise the children."

In his opinion, children's welfare is guaranteed if women are capable of housekeeping and taking care of children. As he stated:

"In the past, men had to work and make money, and women had to raise the children. These days, women work; so, who is responsible for children's needs? They might get emotionally hurt."

Most participants believed that family responsibilities remain a top priority for women, even for employed mothers. On the other hand, some interviewees believed that couples should share family responsibilities. Although most women considered child rearing as their first priority, they were eager to control their lives, especially fertility decisions and other social activities.

Participants had different ideas about feminine and masculine qualities. Some women believed that despite the differences in masculine and feminine traits, these differences

cannot account for variations in male and female roles. However, some participants believed that mothers' responsibilities in family and society should be different from those of men, since they differ in certain characteristics. Even if home responsibilities are shared between the partners, mothers are expected to take the primary responsibility for raising children.

Many of the participants believed that fathers could not completely take over the maternal role. Participant no. 1, a 43-year-old female employee, believed that only mothers have the innate ability to fulfill children's needs:

"God empowers mothers. A mother should breastfeed her baby, the same as she carries the baby during 9 months of pregnancy. God only gives such feelings to a mother."

Participant no. 3, a 32-year-old female employee, focused on mothers' childrearing abilities. Despite sharing some responsibilities with her husband, she could not share her own responsibilities with him. However, as she stated, it is possible to share some responsibilities with others (especially the husband) under mother's supervision. As she said:

"It would be good if my husband helped me, but I never let him. I think fathers can help carry the baby and stuff, but they cannot help with everything."

Carrying children, especially during infancy, was mentioned by many participants. Some participants believed that only mothers are fully qualified to provide care for children during this period. According to some employed women, the aim of working is welfare of children, and sharing childcare responsibilities during infancy is contradictory to this goal.

Participant no. 22, a 34-year-old woman with 4 children, said the main aim of working is promoting family welfare, especially children. As she stated:

"I go to work for my children, for a better life for myself and my family. But when my children need me, I should be by their side."

Some participants believed that traditional gender-specific tasks are in accordance with physical and mental characteristics of men and women, and distorting this balance would have a negative impact on the family. As participant no. 29, a 37-year-old woman with 2 children, said:

"Men are made for working outside the house, because they are more tolerant. Why should he spend his time at home for things he cannot do? Why should I work? If I do, I won't work properly; I won't be a good mother to my children, either."

Overall, although most participants agreed with the idea of women working and participating in social activities, they considered house chores and child rearing as mothers' first responsibility.

Women's empowerment and changing gender roles

Participants mentioned the following points as the basics of women's empowerment and gender equality for fertility decision-making: "acquiring health-related literacy", "desire for improving life quality and social class", and "promoting social skills and decision-making capacities", which are mainly related to high education level and social interactions.

Younger and highly educated women had more health-related information. They paid more attention to their health and welfare, compared to others. An increase in women's empowerment, due to increased health-related literacy and understanding of social rights, improves women's abilities and skills in child rearing.

Most participants were familiar with the risks of short inter-pregnancy intervals and older maternal age for both mother and child. Younger and especially highly educated women were eager to take on equal roles as men and work outside the house. Findings showed that level of education and social interactions are directly associated with maternal abilities and motivation to improve quality of life and social status.

The majority of participants believed that women of the younger generation are more familiar with their rights, compared to the past, since they have higher education and social interactions. These women consider their preferences when they are involved in fertility decision-making. In fact, women's understanding of the discrepancy between child bearing and their personal preferences has resulted in decreased fertility rate and longer intervals between pregnancies.

Most participants believed that women today play major roles in fertility decision-making (decisions about the number of children and time of child bearing). Most participants shared similar opinions about the reasons for reduced fertility rate. As participant no. 44, a 51-year-old woman with 2 children, remarked:

"Today, women do not accept poor marriage or living conditions. First, they wait to see if they can continue their marriage or not, then, they decide to give birth. Women, themselves, decide when to have a baby."

The most important factors, contributing to delayed pregnancy, were improvement of life quality and child rearing, as well as family and personal development.

In this regard, participant no. 3, a 32-year-old woman with one child, said:

"I want to enjoy my life and plan for my personal development. A woman with 4 children should make sacrifices."

Employed women tend to control their personal lives. Some of the participants said they could live independently under unexpected conditions (such as death or divorce). They wanted to overcome financial problems and manage their own lives. As participant no. 15 (a 31-year-old woman) said:

"It is important to earn money. In small families, one can control her life in difficult situations."

Some participants believed that women should work outside the house due to poor economic conditions and financial needs of the family. Indeed, in these situations, women decided to help their families. Participant no. 4, a 43-year-old woman with one child, believed in equal rights of men and women in family and society. As she stated:

"Qualified women decide to earn money because of poor economic conditions. So, both men and women should work to meet their needs."

Highly educated women are more involved in social activities, and spent more time on their occupational tasks. A few participants mentioned lack of spirituality in life as a reason for change in roles of men and women. As participant no. 29, a 35-year old woman with 2 children (a theology lecturer at university), said:

"Lack of spirituality is an important factor. Women do not know their roles in society; male and female roles have been reversed. This is a sign of apocalypse."

One of the employed women, who had 4 children, expressed her concern about the decreased tendency toward child bearing. In fact, she considered it a reason for change in women's role in society, and said:

"They prefer to be a man, not a woman."

Based on the obtained data, increased women's empowerment for performing traditional male roles is related to women's inclination to work outside the house. Some participants believed that most people only value earning money and have no regard for maternal or female roles at home. They believed that this viewpoint is the main reason for women's tendency toward male roles in the society.

As a university teacher with two children remarked:

"Once a woman told me that I'm so lucky to be working! She said what I do is useful for the society. She felt like raising decent children and helping them is not useful for the society."

Some participants believed that Western culture and lifestyle, shown in the media, affect people's perceptions about gender roles and reduce the tendency toward child bearing. Participant no. 26, a 46-year-old university lecturer with two children, said:

"Media often portrays women as active individuals in the society. Such women always have small families. So, people lose their motivation for having children."

Overall, acquiring information about physical status and reproduction, tendency to improve quality of life and social status, and development of necessary skills were associated with higher empowerment of both partners and changed their roles (especially female roles) in family and society.

Couple's interactions in complementary or parallel roles

The most important aspects of fertility for couples were "participation in fertility decision-making", "fertility control", and "cooperative childcare".

Most participants believed that fertility decisions should be mutually made by the

couple. The subjects made a decision about child bearing by evaluating the conditions, available resources, and their preparedness.

Data showed that highly educated and employed women had more control over fertility decisions; in fact, they actively participated in fertility decision-making. Some men stated that their opinions about fertility are always welcomed by their wives. Some women believed that it is necessary to consider men's viewpoints about fertility; however, some women believed that their opinions about fertility were not valued in the family.

Most participants (both men and women) considered using contraceptive methods for themselves and their spouses. Most participants used condoms during their fertility period, which indicates the effective participation of men and their responsibility in fertility control. According to the data, although men and women had equal responsibilities for making fertility decisions, the major responsibility of child rearing was assigned to women.

There were different patterns for sharing responsibilities between men and women in the present study. Some participants mentioned the traditional division in which women stayed at home and raised children and men worked outside the house. In some cases, both partners were working and participated in social activities. Despite the increased participation of women in male roles, men played no major role in raising children or homemaking. In this regard, participant no. 3, a 32-year-old woman with one child, said:

"Today, women work like men; however, men's roles have not changed. This is why women cannot handle more than 1 child or 2."

As most female participants stated, men's lack of cooperation in child rearing was related to their heavy workload and their lack of understanding of the necessity of helping their partners at home. Some participants believed that if mothers are forced to work outside the house and take care of the family, they have no option but to have fewer children. Participant no. 15, a 31-year-old woman with 2 children, said:

"In some families, both husband and wife work two shifts. Fathers cannot help at home and

mothers cannot work outside with a little baby. So, most people prefer to have small families."

Women, participating in educational, professional, and social activities, besides homemaking, have less time for child bearing and raising, even if they are willing to have more children. Employed and educated women mainly tend to have fewer children. However, religious women (who are educated or employed) are exceptions, as they mentioned homemaking and child bearing as the main responsibilities of women. On the other hand, some participants preferred to have small families since they wanted to maintain their freedom and achieve their personal goals.

Fulfillment of fertility goals based on role division

In the present study, higher fertility rate was observed in families with traditional division of male and female roles, i.e., most participants with more than 4 children were mainly housewives or men whose wives were housekeepers.

Women's increased responsibilities and interactions in society and their tendency to have equal roles and social activities as men were related to low-to-medium (1-4 children) fertility rate. Desirable number of children and proper intervals between pregnancies among employed women were achieved by men's participation in house chores and child rearing. In fact, sharing responsibilities between partners balances their workload in the family and society.

Two full-time employed women, with 4 children, stated that their husbands and others participated in child rearing. In this regard, participant no. 7, a 47-year-old woman with 4 children, said:

"When men help at home, house chores are shared. If my husband did not support me, I could not bear four children."

Fertility level of women, who work full time and are not supported by their husbands, was lower than others. Imbalanced task division between men and women, which led to heavy workload of women, was an effective factor for decreasing fertility. Based on the results, when women get involved in traditional male roles and men's participation in housekeeping or child rearing does not change, women's

workload at home and society increases; therefore, these women become uninterested in having more children.

In this regard, employed women's viewpoints indicated that social facilities with reasonable prices and good quality can modify gender roles and facilitate the achievement of desired fertility goals.

Even when husbands relatively participated in child rearing, lack of social facilities at the workplace was a barrier to fertility. Women, who were daily paid or experienced unstable work conditions, did not receive their full salary after delivery and were unable to use breastfeeding or postpartum leave and; these conditions were barriers to achieving the desired fertility rate.

Postpartum leave was a great advantage for employed mothers and helped them fit their maternal roles. Nursing mothers, who worked under contract, were granted 2-month leave and two thirds of their salary. Some participants mentioned the advantages of breastfeeding breaks during working hours and paternal leave. They believed that via these measures, they could perform different tasks and meet their fertility goals. Most employed women complained about lack of nursery care centers at work. They also mentioned the high expenses of these centers (and other related expenses).

Some employed mothers stated that the main obstacle to bearing more children was their partners' lack of cooperation in child rearing and homemaking. On the other hand, other participants said they could bear as many children as they desired, since they were supported by their mothers and other relatives, who were skilled in childcare.

According to the gathered data, highly empowered women with social activities preferred to have smaller families since they were not supported by the authorities, even when they were willing to have more children,

As the statements indicated, women avoid further pregnancies due to their occupational tasks and work conditions. Pregnancy at higher ages and longer intervals between pregnancies (due to education and work conditions), were obstacles to attaining the desired number of children. Although most of the subjects preferred to have 2-4 children, they sufficed to

1-2 children (the fertility rate was not desirable). However, in some cases, couples preferred small families since they wanted to maintain their freedom and attain their personal goals.

Discussion

The findings of this study showed that women's empowerment and gender roles are the most important factors in shaping fertility behaviors. Couples' understanding of the concept of gender role varied among the participants. Some believed in differences in male and female characteristics and some assumed no difference between the two genders.

Increased women's empowerment leads to increased level of education and social interactions, increased health-related literacy, more understanding of social rights, changes in gender roles, and increased quality of life and child rearing; in fact, women's empowerment increases women's capacity for fertility decision-making. These women also have the ability to weigh up their involvement in social and professional activities against fewer opportunities for child bearing/rearing.

In several cases, despite the women's decision and tendency toward child bearing, their professional and social activities were a barrier to attaining fertility goals. According to the data, highly empowered women with social activities preferred to have smaller families (even if they were willing to have more children) since they were not supported by the authorities.

Previous studies showed that empowered women marry at older ages, have better access to healthcare services, insist on women's rights, delay their pregnancy, and have fewer children; therefore, they enjoy better reproductive health and family planning (19).

In the present study, the couple's viewpoints on gender roles were summarized in three aspects of "participation in fertility decision-making", "fertility control", and "cooperative childcare". In the study by Kohan et al. (2009), which aimed to explore women's experiences of empowerment in family planning, four main categories of control over fertility plan, participative family planning, maintaining

health, and having access to optimal family planning services were introduced (11).

In the study by Al-riami (2004) in Oman, 50% of men made fertility decisions by themselves (20). Also, the study by Bedar et al. (2007) in Pakistan showed that women were less interested in child bearing, compared to men; however, they were not involved in fertility decision-making. They found a significant positive relationship between women's empowerment and using family planning methods (21).

The findings of the current study indicate different actions and interactions in the process of forming fertility behaviors in participants with traditional or modern views about gender roles. The results were in agreement with the quantitative findings of Papadimitriov (2008) and Hanin (1987), who reported a significant direct relationship between women's motivation for being a mother and playing female roles (14, 22). The qualitative study by Papadimitriov showed that beliefs of men and women about gender roles had no effect on their fertility. In her study, male and female roles were defined as being a breadwinner and a housekeeper/child bearer, respectively (14).

Our findings showed that although women participated in roles which were traditionally known as masculine, no evident changes were observed in men's participation in household tasks or child rearing. Based on the findings, when mothers work outside the house, besides caring for children, they try to maintain their work/life balance by bearing fewer children. Therefore, women cannot attain the desired number of children.

Employed women, who had more children, could take on different responsibilities if their partners, mothers, or relatives participated in household chores, or if they used nursery day care for children. Based on the findings, traditional role division between men and women was associated with higher fertility rates. Balanced workload division between men and women was associated with attaining the desired fertility rate.

Involvement of women in money making and lack of their partners' participation in household chores inhibit achieving desirable fertility rates. Studies conducted in Western countries showed

that workload division (either outside or inside the house) influences the fertility rate. In fact, women who work inside and outside the house face many challenges (23, 24). However, Torr (2004) in the United States showed that higher fertility rate was associated with both equal and unequal workload division at home and in society (25).

De Laat (2004) showed that in a society with high fertility and employment of women, workload is divided equally between men and women, and women are less involved in household chores (26). In the study by Henz (2008) in Western Germany, couples with equal workload had less desire for child bearing (27).

In Europe, Italy is reported to have the lowest fertility rate, since workload is traditionally divided between men and women. In this country, a large discrepancy between the desired and actual number of children is observed (28, 29). According to the conducted studies, women's heavy workload (without having enough facilities or support at workplace) was directly associated with fertility decline. Empowered women had more authority over fertility decisions when fertility goals were incompatible with their life goals. In fact, they had more power to resist social constraints regarding child bearing, as demonstrated in the qualitative study by Khadivzadeh et al. (2013) (30).

Conclusion

This study showed that increased level of education, women's working and empowerment in recent decades, and changing gender roles lead to increased participation of women in fertility decision-making and their tendency toward having smaller families. Furthermore, increased tendency of women toward male roles in society is not accompanied by men's change of role or participation in household chores; therefore, women deal with increased workload and responsibilities both at home and at workplace. Since working women are more involved in social activities (without enough support at the workplace), the desired number of children decreases among these women.

According to the data, the real fertility rate in most employed women is less than the desired rate, although most of these women (either at

the start of their career or not) prefer to have more children. However, given their understanding of time limitation for fertility, knowledge about proper physical and mental conditions for fertility, limited facilities, and the necessity to play multiple roles, they could not attain the desired number of children. The findings could provide more information about partners' roles and interactions regarding fertility, and the effects they have on fertility decisions and behaviors.

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Conflict of Interest

The authors declare no conflicts of interest.

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