

Fertility intentions and the way they change following birth—a prospective longitudinal study

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Abstract

Introduction: Women's fertility intentions, their desired number of children and desired inter-pregnancy interval (IPI) are related to micro (personal) and macro (socio-cultural) level factors. We investigated factors that contribute to changes in women's fertility intentions in Israel, a developed country with high birth rates.

Methods: Pregnant women (N=1163), recruited from prenatal clinics and hospitals in two major metropolitan areas, completed self-report questionnaires prenatally (≥ 24 weeks gestation) and postpartum (two months after childbirth). Women reported their socio-demographic background and obstetric history prenatally, their desired number of children and IPI at both time-points, and their objective and subjective birth experiences postpartum.

Results: Findings indicated that background characteristics were related to prenatal fertility intentions. The strongest contributor to prenatal fertility intentions was degree of religiosity- the more religious women were, the more children they desired and the shorter their desired IPI. Women's postpartum fertility intentions were mostly consistent with their prenatal reports. In univariate analyses, emergency modes of delivery were associated with a decrease in the desired number of children and less satisfaction with birth was associated with desiring fewer children and increasing desired IPI. In multivariate analyses, only being very-religious, more educated, and previously giving birth decreased the likelihood of desiring fewer children. Greater birth satisfaction and giving birth for the first time decreased the likelihood of changing desired IPI.

Conclusion: Having a negative birth experience could adversely affect women's fertility intentions, but in a pronatalist and medicalized birth culture, social pressures may decrease the effects of birth experiences on family planning.

Introduction

Fertility intentions, the desire to have a certain number of children and the spacing between them, are related to micro and macro level factors- the individual's characteristics, personal unconscious motivations, and socio-cultural environment [1-4]. Less is known regarding the way experiences, especially the lived birth experience, relate to changes in fertility intentions. Quantitative and qualitative studies suggest that fertility intentions and fertility rates are related to women's mode of delivery [5-7] and to the subjective experience of birth [8-10]. Yet, robust prospective studies documenting changes in fertility intentions following birth are rare [11]. The current study aims to investigate the contribution of the birth experiences and personal-cultural characteristics on changes in fertility intentions among women in Israel, a country with a unique reproductive context [12].

Sociodemographic, Cultural Context and Fertility Intentions

Fertility intentions refer to reproductive decision-making both in terms of tempo intentions, the spacing between children or intra-pregnancy interval (IPI), and quantum intentions, the desired number of children [1]. Fertility intentions were found to predict actual birth rates together with demographic and socioeconomic factors and cultural norms [13]. A comprehensive evaluation of changes in fertility intentions should account for these various socio-cultural factors.

Micro-level factors such as education, income, age, employment, sense of empowerment and household roles influence the decision to have additional children and the IPI [14-17]. Younger age has been found to be associated with longer IPI [18] and the relationship of older maternal age (35 or older) with a shorter IPI was interpreted as a means to achieving the planned family size in a short amount of time. Lien [14] & Wang [16] indicated that women who got married at an older age waited less, only for their first pregnancy, and had a similar IPI as women who got married younger in their subsequent pregnancies.

Macro level factors such as the normative expectations, religion and policies affect fertility intentions and rates [2, 13, 19]. The current study was conducted in Israel, which is considered to be a traditional and familial society. Israel has the highest fertility rates in the Western industrialized world, with an average of 3.16 children per woman [20-22]. Despite declining fertility rates in the developed world in the last few decades, Israeli fertility rates remain high. Correspondingly, voluntary childlessness is rare and not a socially legitimate decision [23]. Women's fertility intentions in Israel are formed vastly through tradition and gender roles, in addition to the predominant nationalistic and religious sentiments [12, 24]. Judaism, the dominant religion in Israel (74.3% of the population [25]), emphasizes motherhood and fertility as an important role for women: The religious commandment states that one should "be fruitful and multiply and replenish the earth" (Genesis 1:28) and fertility itself is considered a blessing (Deuteronomy 7: 13-14). The Muslim population in Israel is also characterized by high birth rates [26], but since the current research was conducted among mostly Jewish women, we will not elaborate on that here.

The Jewish population in Israel is made of several religious sects, which differ in their cultural beliefs, practices, and social norms. They could be broadly defined based on levels of observance of the Jewish traditions in their everyday life, with the very-religious (Ultra-Orthodox) being most observant, followed by religious (Orthodox/Modern-Orthodox), traditional (slightly observant) and secular (non-religious). The very-religious are the smallest religiosity group (approximately 10% of Jewish women 20 years of age and older), similar to the religious (11%), the traditional group (35%) is larger and the largest group are the secular (non-religious), making up 44% [27]. As with other religions [28], in Judaism, fertility rates are influenced by religiosity [20, 24, 29]. Israeli very-religious women have high fertility rates, nearing 6.5 children per women. Fertility rates are lower among religious (4.5 children per woman), traditional (2.5 children per woman) or secular families (2.1 children per woman) [26]. Very-religious women often do not 'plan' the number of children they will have, adhering to the religious commandment that is interpreted as having as many children as God wills. Fertility issues (i.e. pregnancies, miscarriages, infertility, family planning) are considered a private matter [30] and thus it is likely that very-religious women would not disclose specific fertility intentions (i.e., answering "do not know" or "whatever God chooses").

Nonetheless, research has shown that women who do not answer regarding fertility intentions in surveys are typically like most of their socio-cultural group [31].

The high fertility rates in the Israeli population make it an ideal context to study changes in fertility intentions following childbirth. The higher rates eliminate floor and ceiling effects, allowing more room for change in fertility intentions. Having a heterogeneous sample in terms of religiosity, will allow for a more sensitive investigation since religiosity plays such an important role in women's fertility intentions.

Reproductive History, Birth Experience and Fertility Intentions

Reproductive history such as parity, going through fertility treatments and perinatal experiences might affect women's childbirth intentions [15]. The birth experience can be described in two different ways: the objective birth experience, referring to physical factors (e.g. cesarean delivery, vaginal assisted delivery, use of analgesia, home delivery); and the subjective birth experience, including personal emotions and attributions regarding the birth process (e.g. satisfaction with birth). Together and separately, these birth experiences are postulated to influence women's intentions regarding future reproduction.

Mode of delivery is one of the most studied physiological factors in relation to subsequent childbirth. Operative deliveries, either cesarean delivery or instrumental vaginal delivery (such as vacuum extraction) may result in longer IPI compared to unassisted vaginal delivery [6, 7]. Subsequent deliveries have been found to decrease after a cesarean delivery compared to vaginal delivery [5, 18, 32, 33]. In addition, a decrease in the number of subsequent pregnancies was observed with respect to instrumental vaginal delivery, compared to unassisted vaginal delivery [7, 34]. One of the explanations of the effects of mode of delivery on subsequent childbirth is physiological and relates to the increased infertility risk following cesarean delivery [18, 35]. An alternative explanation focuses on the subjective experience of having a more traumatic birth. This is corroborated by findings from a qualitative study in which women conveyed their lack of interest for future pregnancies following an operative delivery, in spite of their previous large family plans [6]. An emergency operative delivery (whether vaginal instrumental or cesarean) could be perceived as a traumatic event, which increases childbirth-related fears and thus women may become more reluctant to have another child, sooner or later [9, 36].

The subjective birth experience is related to perinatal physiological and medical occurrences and to cognitive, emotional and intra-personal factors such as, lack of control, fear or anxiety during birth, incongruence between expectation and reality in childbirth, spouse or caregiver support [37, 38]. In a recent review [39], the detrimental effects of a negative birth experience were documented, but it was noticeable that there is a lack of rigorous empirical research on the subject. Studies indicate that negative birth experiences decreased the chances of subsequent pregnancies and prolonged the IPI [9, 37]. Negative birth experiences and postpartum mental health difficulties were found to be related to a decrease in the number of subsequent pregnancies and increase in the IPI, regardless of the initial plan for family size [8, 40]. In contrast, satisfactory birth experiences, caregiver support, and positive emotions felt when seeing their baby for the first time, were among the factors that motivated women to give birth again [41, 42]. Concurrently, other studies did not find an indication that a negative birth experience

affects women's fertility intentions [39]. Therefore, there is a need for additional research that assesses the unique contributions of both the objective and subjective birth experiences and the socio-cultural context to changes in fertility intentions.

Aims and Hypotheses

There is a gap in knowledge on the way socio-cultural and reproductive factors simultaneously and distinctly influence fertility. The current study aimed to fill this gap by examining correlates of women's fertility intentions (desired number of children and desired IPI) during pregnancy and following birth among a heterogeneous cohort of Jewish Israeli women. In the current study, we hypothesized that:

1. Greater religiosity, lower education, higher income, conceiving spontaneously (as opposed to having had fertility treatments) and giving birth for the first time will be related to a greater number of desired children and shorter IPI.
2. A more negative subjective birth experience and an emergency operative mode of delivery (instrumental vaginal delivery or emergency cesarean delivery) will be related to a change in fertility intentions in the postpartum period (desiring fewer children and/or increasing IPI).

Methods

Sample characteristics

The current study included 1163 participants who were 31.49 ± 4.64 years of age with 23.6% ($n = 274$) who were 35 or older. A little over half of the sample identified as secular (53.4%, $n = 619$), 19.0% identified as traditional ($n = 220$), 15.9% as religious/orthodox ($n = 184$) and 11.7% identified as very-religious/ultra-orthodox ($n = 136$). Most participants were married or cohabiting (98.0%, $n = 1138$) and they were relatively educated with 75.0% ($n = 866$) who pursued higher, post-secondary education. Half of the women reported having an average income level (51.6%, $n = 584$) ($M = 3.25 \pm 0.72$, range 1-5). Over a third of the women (40.7%, $n = 473$) were about to have their first child and the rest had previously given birth and were going to have their second to tenth child. The average number of children participants would have following the upcoming birth would be 2.08 ± 1.31 . A tenth of the women in the study used fertility treatments to achieve the current pregnancy (10.7%, $n = 123$).

Study design

The current investigation focuses on 1163 women who participated in two time-points of a large birth cohort study. Eligibility criteria included a singleton pregnancy ≥ 24 weeks gestation, with vaginal delivery medically possible. Exclusion criteria were being in pain or having a medical emergency and non-Hebrew speaking. Participants completed questionnaires prenatally (T1 $M = 32.38 \pm 5.18$ weeks gestation) and at two months postpartum (T2 $M = 9.74 \pm 2.37$ weeks postpartum).

The study was approved by the Research Ethics Committees of all participating institutions. Recruitment took place between January 2016 and April 2018 at four Women's Health Centers in the community and a hospital in the center of Israel (88.6% of participants), and another Hospital in Jerusalem (11.4% of participants). These locations service women from a variety of religious and non-religious communities.

Recruitment was done by a study team that included trained research assistants, social work graduate students and midwives. Women received an explanation about the study from a member of the study team and were asked for their written consent. Thereafter, they completed the first questionnaire (T1). Participation rates were 69.8%.

Follow-up was conducted by the study team approximately two months after the women's due-date (T2). Women who provided their email address were sent a unique link to the questionnaire using Qualtrics software. Women who did not use email were mailed a paper questionnaire with a return envelope. The return rates for the second questionnaire was 71.8% (1163 out of 1619 women who were recruited into the study).

Measures

Socio-demographics and obstetric history were assessed at T1 and included basic socio-demographic questions such as age (in years), religion and religiosity level (secular, traditional, religious/orthodox and very-religious/ultra-orthodox), educational level (up to and including secondary education/ higher education), income level, whether they had previously given birth, if they had fertility treatments and how many children they have.

Desired number of children were assessed at T1 and T2. Women were asked to indicate how many children they desire to have with the following options: 1 = One child, 2 = two children, 3 = three children, 4 = four children, 5 = five or more children, 6 = I do not know.

Decrease in the desired number of children was calculated by subtracting T2 values of desired number of children from T1. Women who desired the same or a greater number of children between pregnancy and postpartum received a score of 0. Women who desired fewer children in the postpartum period compared to pregnancy were coded 1 (had a calculated T1-T2 value greater than 0).

Desired IPI was assessed at T1 and T2. Women were asked "how many years after the upcoming/recent birth would you like to have another child?". Besides a space to specify the number of years, women could choose the options "I will not want additional children" or "I do not know".

Increase in desired IPI was calculated by subtracting T1 IPI values from T2 values after excluding anyone who at T1 stated that they will not want additional children or those who answered "I do not know" at either timepoint. Women who reported a desired IPI of 6 months longer, the same IPI, or shorter in the postpartum measure compared to the measurement during pregnancy, received the score 0 indicating no increase in IPI. Women who reported a desired IPI of more than 6 months of the

IPI reported during pregnancy, or changed their desire to not wanting additional children received a score of 1, indicating an increase in desired IPI.

Emergency mode of delivery was assessed at T2 by asking where and how women gave birth, with the following options: Emergency cesarean delivery; planned cesarean delivery; instrumental vaginal delivery; vaginal delivery with epidural analgesia; vaginal delivery without epidural analgesia; vaginal delivery in a natural birth center; home birth. Women who gave birth either via emergency cesarean delivery or instrumental vaginal delivery received an emergency mode of delivery score of 1. The rest of the women received a 0, indicating not having an emergency delivery procedure.

Birth satisfaction was assessed at T2 using the Childbirth Satisfaction Scale [43]. The scale includes 8 items assessing subjective general satisfaction with the birth experience. Women were asked to rate their agreement with the statements on a 1-5 scale. The scale was unidimensional and internally reliable ($\alpha = 0.93$). Scores were computed as the average item response.

Analysis

Analyses were performed using SPSS 24 [44]. At the first stage of the analysis, we describe the overall demographic, obstetric and prenatal fertility intentions using descriptive statistics. In the second stage we examined our first hypothesis by conducting univariate and multivariate analyses between background variables and prenatal fertility intentions using χ^2 , independent sample t tests, Spearman's Rho, One-Way Analysis of Variance (ANOVA) and Multivariate Analysis of Covariance (MANCOVA). In the final stage, we assessed the extent of changes in fertility intentions between the prenatal and postpartum measurement using paired t tests and χ^2 . Thereafter, to test our second hypothesis, we examined if change in fertility intentions were related to background variables and to the birth experience using χ^2 and independent samples t tests for univariate associations and binominal logistic regression for multivariate analyses. Results were interpreted as significant at $p < 0.05$.

Missing value analyses indicated that there were very few missing variables (ranging 0.1%-4.5%). Due to the small number of missing values, no data imputation was conducted; pairwise deletion was employed when possible and listwise deletion was used when pairwise was not possible. In the analyses of changes to desired number of children, very-religious women who answered "I do not know" about their desired number of children were regarded as desiring five or more children (since they are most likely similar to their peers [31]). Women who were not very-religious that answered "I do not know" were excluded from those analyses.

There were differences between women who dropped-out of the study and those who were retained in the main study variables: Women who dropped out were more often very-religious, younger, less educated, had a lower income, had previously given birth, and desired to have more children, compared to women who did not drop-out.

Results

Fertility Intentions During Pregnancy

As can be seen in Table 1, most of the women had their minds set prenatally on their desired number of children (88.3%, $n = 1002$) and reported a median of 3 desired children. Most of the women (91.7%, $n = 1044$) desired to have additional children after the upcoming birth. Of these women, 77.1% ($n = 805$) reported their desired IPI, which was on average 2.28 ± 0.85 years.

There were differences in the prenatal fertility intentions reported during pregnancy between women of different religiosity groups. As can be seen in Table 1, rates of not reporting fertility intentions, especially, desired number of children (answered "do not know") grew with increasing religiosity. It is also noticeable that there was little variance in the desired number of children for very-religious women. Almost all (94.2%, $n = 65$) of those who reported, chose the option of "five or more children". These findings support the assumption that women who did not report their desired number of children, would have also answered desiring five or more children, and thus, these women ($n = 53$) had their scores imputed for further analyses.

Fertility intentions were related to all the socio-demographic and obstetric variables in univariate analyses as hypothesized (Table 2): One-way ANOVA of desired number of children indicated that the number increased linearly between the religiosity groups, with secular women desiring the least number of children, followed by traditional women, religious women and very-religious women who desired having the highest number of children. Post-hoc Scheffe tests revealed that each group significantly differed from the other. Regarding differences in desired IPI, ANOVA indicated that there were significant differences between the groups in their desired IPI. Yet, post-hoc Scheffe testing revealed that the only significant differences were between secular women, who desired a longer IPI, and the very-religious women, who desired the shortest IPI. Women with a higher education desired having fewer children and longer IPI compared to women who did not have more than secondary education. Women with higher income desired fewer children ($r = -0.22$, $p < 0.001$) but income was unrelated to IPI ($r = 0.05$, $p = 0.16$). Women who had previously given birth desired more children and longer IPI compared to women who had not previously given birth. Having fertility treatment to achieve current pregnancy was related to fewer desired number of children and to a shorter desired IPI.

One-way MANCOVA (Table 3) indicated that religiosity, parity and older age were uniquely related to both fertility intentions and in addition fertility treatments and education were related to IPI. The fully adjusted model explained 54.6% of the variance in the desired number of children with religiosity explaining most (45%) of this variance. Post-hoc comparisons indicated that each religiosity group differed from the other groups in their desired number of children (all $ps < 0.001$), with secular women desiring the least number of children. Regarding IPI, the adjusted model explained 14.0% of the variance in IPI with religiosity explaining 3% of this variance and parity and age explaining 8% and 5% respectively. Post-hoc comparisons indicated that secular women desired a longer IPI compared to all the other groups (all $ps < 0.01$), which were not significantly different from one another.

The Lived Birth Experience and Changes in Fertility Intentions

The most prevalent mode of delivery among the study participants was vaginal delivery with epidural analgesia (46.6%, $n = 541$), followed by vaginal delivery without using analgesia (26.9%, $n = 312$), instrumental vaginal delivery (9.7%, $n = 113$), emergency cesarean delivery (9.1%, $n = 106$) and planned cesarean delivery (7.7%, $n = 89$). In other words, there were 219 women (18.8%) who had an emergency delivery (i.e. instrumental vaginal delivery or emergency cesarean delivery). Average satisfaction with childbirth was 3.89 ± 1.03 . Having an emergency delivery was associated with lower levels of birth satisfaction (2.89 ± 1.05) compared to women who did not have an emergency delivery (4.12 ± 0.87) ($t(288) = 15.96, p < 0.001$).

Women were mostly consistent in their fertility intentions when comparing prenatal and postpartum responses: the desired number of children and desired IPI reported at T1 were highly correlated with the T2 reports ($r = 0.88$ and $r = 0.63, ps < 0.001$ respectively). Paired sample t -test, indicated a slight decrease in women's desired number of children between T1 (3.48 ± 0.99) and T2 (3.44 ± 1.01) ($t(1006) = 2.22, p = 0.03$). There was also a slight overall decrease in desired IPI between T1 (2.27 ± 0.85) and T2 (2.18 ± 0.92) ($t(730) = 3.40, p = 0.001$). There were 98 (9.7%) women who reported desiring fewer children at T2 than they did at T1 (decreased their desired number of children). There were 111 (14.8%) women who reported desiring a longer IPI at T2 compared to T1 (increased their desired IPI) or changed their minds from desiring additional children to not desiring additional children. Women who decreased their desired number of children were twice as likely to also increase their desired IPI compared to women who did not decrease their number of desired children ($\chi^2(1) = 9.01, p = 0.003$).

Changes in fertility intentions were related to some of the background characteristics and birth experiences in univariate analyses. Being very-religious was associated with less decrease in desired number of children ($\chi^2(1) = 8.00, p = 0.005$). Parity was related to changes in both types of fertility intentions: Women who had previously given birth were less likely to report a decrease in desired number of children and more likely to report an increase in desired IPI ($\chi^2(1) = 12.810, p < 0.001$ and $\chi^2(1) = 4.71, p = 0.03$, respectively). Education, income levels, maternal age and having fertility treatments were unrelated to changes in fertility intentions.

The objective and subjective birth experiences were related to changes in the desired number of children. Having an emergency delivery was related to a decrease in desired number of children ($\chi^2(1) = 6.33, p = 0.01$). Birth satisfaction was related to changes in desired number of children: Lower rates of birth satisfaction were reported by women who decreased their desired number of children (3.67 ± 1.10) compared to women who did not decrease their desired number of children (3.95 ± 0.99) ($t(996) = 2.61, p = 0.009$). There were no differences between women who had an emergency delivery and those who did not in the desired IPI ($\chi^2(1) = 0.08, p = 0.78$). Women who increased their desired IPI had lower reported birth satisfaction (3.53 ± 1.15) compared to those who did not increase their IPI (3.95 ± 0.98) ($t(138.92) = 3.62, p < 0.001$).

Binary logistic regressions of changes in fertility intentions are presented in Table 4. These multivariate analyses indicated that being very-religious, having a higher education and having previously given birth

were all uniquely associated with a lower likelihood of decrease in the desired number of children. The birth experiences (having an emergency delivery, birth satisfaction), age, fertility treatments, and income were unrelated to changes in the desired number of children. In the model predicting change in IPI, lower birth satisfaction and having previously given birth were the only predictors uniquely associated with a greater likelihood of increasing desired IPI.

In order to assess moderating effect of religiosity on changes in fertility intentions, we also ran the regression models separately for very-religious women and for the rest of the women and the significant predictors stayed the same in all the models, suggesting no interaction.

Discussion

Findings of this in-depth investigation of prenatal and postpartum fertility intentions confirmed the hypothesis regarding the importance of socio-demographics (especially religiosity) and obstetric history for quantum and tempo fertility intentions. These factors explained more of the variance in desired number of children than they did in the desired IPI. The hypothesis regarding the impact of childbirth experiences on fertility intentions was only partially confirmed. Compared to the prenatal assessment, a less satisfactory birth experience was related to a decrease in desired number of children and to a longer IPI. Yet, in multivariate analyses, satisfaction was only related to an increase in IPI and having an emergency mode of delivery was unrelated to fertility intention changes.

The social norms regarding the importance of motherhood in the Jewish Israeli society [12, 23] were also reflected in our findings. Almost all the women in our study (99.5%) desired to have more than one child and of the women who desired additional children, two-thirds (64.8%) desired a relatively short IPI of 2.5 years or less. Religiosity was the main predictor of prenatal fertility intentions. This is similar to findings from other national studies, which indicate that very-religious women have the highest fertility rates, followed by religious women, traditional women and secular women [24, 26, 29]. It is not surprising that almost all the very-religious women in our study reported desiring five children or more. This was strengthened by the finding that among the very-religious women, there was hardly any change to the postpartum desired number of children. Motherhood is the fulfillment of womanhood in the religious society and is a central life goal for religious women [30]. Raising a large family is held in high esteem and contributes to the woman's happiness and self-fulfillment, while not having children, causes great distress [45].

Contrary to our hypothesis, the effect of the objective birth experience on changes in fertility intentions was no longer significant after introducing socio-demographic factors. This is similar to other studies that did not find an association between mode of delivery and fewer subsequent pregnancies [34, 46]. Since in Israel, as in most of the Western world, birth is medicalized, it is possible that having an emergency mode of delivery is not viewed as outside of the norm [47]. The physical experience of having a medicalized birth is acceptable and what matters more is the subjective experience, which might be overwhelming, and consequently affects women's future fertility [48].

Indeed, in univariate analyses having a dissatisfying birth was related to changes in both types of fertility intentions. This is in line with other studies that also indicated the importance of the subjective birth experience on future pregnancies and their timing [9, 37, 39]. In our study, when we examined the unique contribution of birth satisfaction using regression models, it was only related to the increase in desired IPI and not to the desired number of children. It is possible that the timing of the next pregnancy is more flexible, and it is likely that women who have had a dissatisfying birth might want to delay having another child until they felt more emotionally ready. On the other hand, the desired number of children is a more rigid fertility intention, particularly in a pronatalist culture, where even having only one child is unacceptable and stressful for women [49]. Social pressures on reproduction are particularly strong in the religious population, which is reflected in the strong associations of religiosity and fertility intentions in our sample. In this socio-cultural context, it is unlikely that a personal experience such as a negative subjective birth experience is enough to change such a fundamental planned course of life as the number of children, though as seen here, it could extend the IPI. In a small Israeli study, postpartum post-traumatic stress was related to not wanting to have additional children when women were questioned shortly after giving birth [40]. Conceivably, in a pronatalist culture, only in extreme cases where the birth experience creates lasting or severe mood disturbances, a major fertility intention such as the desired number of children is affected.

Parity was a strong predictor of fertility intentions and their change postpartum, but in different ways. First-time mothers were more likely to decrease their desired number of children but less likely to change their desired IPI. It is possible that for first-time mothers, the transition to motherhood is more dramatic and the reality and difficulties that accompany caring for a child, especially in the first few months of their lives, bring some women to change their mind regarding the desired number of children. The adjustment to having (another) child is less difficult for experienced mothers and thus less likely to affect the desired number of children. Another possible explanation is that first-time mothers in a pronatalist country are motivated to proceed with expanding their family to the least acceptable family size (two children) and are therefore less likely to increase IPI following birth. It is possible that since experienced mothers already have a larger family, they are more flexible regarding their desired IPI compared to first-time mothers. This is also reflected in the prenatal differences in desired IPI which were longer for experienced mothers. Another possible explanation is that having a second or more child makes women feel more familial fulfillment or more exhaustion and thus they would be more inclined to postpone their next birth a little longer.

Strengths and Limitations

The main strengths of our investigation were its prospective design and the large sample consisting of women with varying religious backgrounds. Studies in the field of fertility intention changes are few and limited and so are studies which examine the effects of the birth experience on fertility intentions [39]. By conducting a longitudinal study, we were able to rigorously assess changes in two types of fertility intentions. Moreover, we were able to examine the effects of both the objective and subjective birth experiences in addition to other contributing factors.

Our investigation did have some limitations. It did not account for additional variables which could affect women's fertility intentions such as the infant's temperament, which has been found to affect planned and actualized family size [37]. The generalizability of our study was limited to the Israeli Jewish urban population. Women in the very-religious group had high rates of not reporting fertility intentions. This inclination not to answer is mostly likely because of privacy or common religious reasons [30] and does not reflect different answers [31], thus we imputed data for these women, under the assumption that they would have answered wanting five children or more like the rest of their religiosity group. Even though analyses without this imputation showed similar results (not presented), this procedure should be noted. There were differences between women who dropped out compared to those who did not in most of the study variables. It is likely that most of these differences were because the very-religious women in the study were mostly followed-up by a paper questionnaire sent by mail compared to the rest of the women who had internet access and completed the T2 questionnaire online. This methodological barrier could have introduced bias to our findings, though probably in the form of underestimation. Finally, we asked women regarding their fertility intentions two months postpartum. Despite the methodological and theoretical justification of assessing birth experience at that time point [50, 51] it is possible that with time, women will go back to their initial fertility intentions. Nonetheless, it does not take away from the importance of the findings- a negative birth experience has strong implications on women lives, at least in the first few months postpartum when women must take on the motherhood role and function.

Conclusion

It is possible that in a pronatalist country such as Israel, women's fertility intentions are not easily modified. When social norms, public policy and religious practices and beliefs pressure women to bear children [23], it is less likely that the birth experiences would affect women's family planning. In other words, given these social pressures, women have less freedom to cope with negative birth experiences by changing their fertility plans; they might feel pressure to have another child, even when they are not ready for it. This pressure to conceive is especially strong among very-religious women who speak less about their difficulties and utilize birth spacing methods less often [30]. Mistimed pregnancies, or pregnancies following a negative birth experience can elicit additional distress. Therefore, it is important to detect these difficulties and address them to improve well-being in subsequent pregnancies and satisfaction in future childbirths.

Future studies should examine actual subsequent births, their timing and their effects on maternal adjustment among different populations. Relinquished fertility could cause great distress [37] and it is important to understand why it might happen. More studies need to examine the role of the subjective birth experience in changes to fertility plans, especially in countries where fertility rates are lower and social pressures on having (additional) children are minor. In such countries, the negative effects the birth experience might have on fertility intentions could go unnoticed and potentially hinder attempts to increase birth rates. This could also help in developing appropriate interventions to ameliorate the deleterious effects of a negatively experienced birth.

List Of Abbreviations

IPI- Interpregnancy interval;

Declarations

Ethics approval and consent to participate

Before filling in the questionnaires, participants received an explanation about the study and provided their written consent. The study was approved by the Research Ethics Committees at the Tel Aviv University and all the recruitment sites Institutional Review Boards: Clalit Health Services (approval number 0120-15-COM2), Rabin Medical Center (approval number 0339-15-RMC) and Shaare Zedek Medical Center (approval number 0227-16-SZMC).

Consent for publication

Not applicable

Availability of data and material

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors report no competing interests in connection to this paper.

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Authors' contributions

YB and HP planned and ran the study on which the current manuscript is based. HP performed the analyses and drafted the manuscript. PM, SG and AS contributed to study design and data collection at Shaare Zedek Medical Center. ST assisted in writing the literature review. All authors agreed on the final version of the manuscript, had full access to the data in the study and take responsibility for the integrity of the data and the accuracy of the data analyses.

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Tables

Table 1. Fertility intentions during pregnancy

	Total	Secular	Traditional	Religious	Very-religious
	(n = 1163)	(n = 619)	(n = 220)	(n = 184)	(n = 136)
Number of children					
One	5 (0.4)	5 (0.8)	0 (0.0)	0 (0.0)	0 (0.0)
Two	157 (13.8)	133 (21.7)	22 (10.1)	2 (1.1)	0 (0.0)
Three	436 (38.7)	336 (54.7)	87 (39.9)	14 (7.9)	1 (0.8)
Four	239 (21.1)	106 (17.3)	83 (38.1)	47 (26.4)	3 (2.5)
Five or more	162 (14.3)	5 (0.8)	8 (3.7)	83 (46.6)	65 (53.3)
Does not know	133 (11.7)	29 (4.7)	18 (8.3)	32 (18.0)	53 (43.4)
Interpregnancy interval					
1-1.5 years	150 (13.2)	66 (10.8)	35 (16.3)	26 (14.2)	21 (16.8)
2-2.5 years	372 (32.7)	211 (34.5)	73 (34.0)	56 (30.6)	30 (24.0)
3-3.5 years	237 (20.8)	135 (22.1)	48 (22.3)	40 (21.9)	14 (11.2)
4 years or more	46 (4.0)	31 (5.1)	6 (2.8)	6 (3.3)	3 (2.4)
No more children	95 (8.3)	74 (12.1)	14 (6.5)	5 (2.7)	2 (1.6)
Does not know	236 (21.0)	95 (15.5)	39 (18.1)	50 (27.3)	55 (44.0)

Table 2. Univariate associations between fertility intentions and women's socio-demographic and obstetric background†

	Number of children¥			Interpregnancy interval		
	<i>n</i>	<i>M±SD</i>	<i>t / F</i>	<i>n</i>	<i>M±SD</i>	<i>t / F</i>
Religiosity			423.38***			4.07**
Secular	585	2.95±0.69		443	2.37±0.87	
Traditional	200	3.39±0.73		162	2.20±0.78	
Religious	146	4.45±0.72		128	2.23±0.82	
Very-religious	122	4.96±0.24		68	2.04±0.92	
Education level			2.90**			-2.14*
No higher education	253	3.77±1.10		171	2.16±0.89	
Higher education	796	3.38±0.93		631	2.31±0.84	
Maternal age			6.14***			4.56***
Younger (<35)	810	3.57±0.99		663	2.33±0.84	
Older (≥35)	242	3.14±0.94		142	2.02±0.73	
Parity			-6.66***			-6.47***
First birth	436	3.24±0.96		404	2.09±0.74	
Previously given birth	576	3.64±0.98		399	2.47±0.92	
Fertility treatments			4.36***			3.77***
Spontaneous conception	929	3.52±0.98		700	2.32±0.85	
Had treatments	116	3.09±0.99		95	1.97±0.83	

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

† These analyses excluded women who were not very-religious and answered "do not know" regarding desired number of children and all women who answered "do not know" or "do not want additional children" regarding desired IPI.

¥Desired number of children were reported as 1-5 with 5 = five or more children.

Table 3. One-way MANCOVA of fertility intentions reported during pregnancy ($n = 731$) †

	Desired number of children			Desired IPI		
	<i>MS</i>	<i>F</i>	Partial η^2	<i>MS</i>	<i>F</i>	Partial η^2
Corrected model	42.23	108.68***	0.55	9.11	15.11***	0.15
Religiosity	77.86	200.41***	0.45	4.18	6.94***	0.03
Education	0.17	0.43	0.00	3.38	5.61*	0.00
Income	0.87	0.48	0.00	0.12	0.20	0.00
Age	3.85	9.90**	0.01	22.58	37.45***	0.05
Parity	20.03	51.58***	0.07	38.86	64.46***	0.08
Fertility treatment	0.84	2.17	0.00	4.64	7.02**	0.01

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

†Desired number of children were reported as 1-5 with 5 = five or more children.

Note: These analyses excluded women who were not very-religious and answered "do not know" regarding desired number of children and all women who answered "do not know" or "do not want additional children" regarding desired IPI.

Table 4. Logistic regression predicting changes in fertility intentions

	Change in desired number of children			Change in desired IPI		
	<i>n</i> = 971			<i>n</i> = 728		
	B	OR	95% CI	B	OR	95% CI
Religiosity	-2.77	0.06**	0.01-0.47	0.03	1.03	0.48-2.20
Education	-0.85	0.43**	0.26-0.71	-0.42	0.66	0.40-1.09
Income	-0.01	0.99	0.72-1.36	-0.07	0.93	0.69-1.25
Age	0.12	1.13	0.65-1.96	0.21	1.23	0.71-2.14
Parity	-0.72	0.49**	0.30-0.80	0.55	1.73*	1.10-2.72
Fertility treatment	-0.06	0.87	0.48-1.86	-0.57	0.56	0.26-1.23
Emergency delivery	0.12	1.13	0.62-2.07	-0.29	0.75	0.41-1.37
Birth satisfaction	-0.20	0.82	0.65-1.04	-0.46	0.63***	0.51-0.79

Note: These analyses excluded women who were not very-religious and answered "do not know" regarding desired number of children at either time point and any women who answered "do not

know" regarding desired IPI or that did not want additional children at T1. Religiosity (not very-religious=0, very-religious=1); Education (no higher education = 0, higher education = 1); Age (less than 35 years old = 0, 35 years old or older = 1); Parity (first birth = 0, previously birthed = 1); Fertility treatments (spontaneous conception = 0, had fertility treatments = 1); Emergency delivery (unassisted vaginal delivery or planned cesarean delivery = 0, assisted vaginal delivery or emergency cesarean delivery = 1).

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$