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The Impact of Militarism, Patriarchy, and Culture on Israeli Women's Reproductive Health and Well-Being

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Abstract
Purpose In this paper, we situate and frame Israeli women's reproductive health within the social, historical, political, cultural, and geographical context of Israeli women's lives.
Methods We used a theoretical review in this paper.
Results Militarism, patriarchy, and cultural values heavily shape and influence Jewish and Arab women's access to and experience of reproductive health when it comes to the imperative to have children, pregnancy, birth, access to contraception and abortion, and other reproductive healthcare services. We discuss five main factors pertaining to Israeli women's reproductive health including (1) fertility and emphasis on reproduction; (2) infertility; (3) pregnancy, birth, and miscarriage; (4) reproductive rights including contraception and abortion; and (5) maternity leave and accessible childcare.
Conclusions Israel is a pro-natalist country, in which both Jewish and Arab women share many of the consequences of the social imperative to have children. Though Arab women, as part of their double minority status, are exposed to more mental health risks pre- and postpartum, the personal and public reproductive health decisions and reproductive healthcare services are largely shaped by similar social forces. These include the patriarchal and religious culture that dictates a value system that highly cherishes motherhood, and within the military political context of the on-going Israeli-Palestinian conflict and past social and political traumas. We address four major gaps that need to be addressed in order to improve Israeli women's reproductive health and well-being that include the neoliberal gap, the information gap, the reproductive health services gap, and the leadership and policy gap.

Keywords Israel · Women's reproductive health · Militarism · Patriarchy · Religion

The Political Context: Militarism, Patriarchy and Women's Reproductive Health

Israel is a multicultural society. Seventy-five percent of Israeli women are Jewish, 20% are Arab, and approximately 4.5% are categorized as "other" [1]. Israel is an insecure state. Since its establishment, it has faced seven recognized wars, multiple terror attacks, and recurrent military operations. As a result, the country is highly militarized with the majority of men and women participating in mandatory army service. Wiist and colleagues [2] define militarism as,

> The deliberate extension of military objectives and rationale into shaping the culture, politics, and economics of civilian life so that war and the preparation for war is normalized… Militarism subordinates other societal interests, including health to the interests of the military (p.e37).

The military and the accompanying masculinization of society dominate every aspect of public and private life and have consequences for women's health and well-being. Feminist thinkers such as Cockburn [3] and Enloe [4, 5] suggested that in times of war, or "war-readiness," patriarchal values dominate and intensify [3]. This reality for women becomes even

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more complex in the Israeli context where the country is *always at war, or getting ready for war*. In Israel then, militarism is not merely about gender relations during temporary periods of conflict, it is about how militarism, as a way of life, lays the foundation for how the society operates, including how it deals with women's reproductive health [6, 7].

Weeks [8] used the concept of "social totality" to propose that all phenomenon must be understood as a series of power forces and "systems that traverse the entire social horizon and intersect at multiple points" (p.5). The totality of Israeli society includes several interlocking processes of power relations that shape reproductive health for Israeli women. Some of these include militarism and the Israeli history, tradition, and culture which includes a legacy of loss and an emphasis on family and childbearing for both Jewish and Arab women.

Reproductive Health Within Israeli Military/Patriarchal Society

By militarism, we do not mean the *immediate* effects of war and conflict on soldiers or civilians in times of active conflict. Instead, we draw on Feminist Security Theory (FST) that aims to go beyond "a narrow focus on injuries caused by the armed forces and militias. FST argues for much broader definitions that would include injuries perpetrated in the domestic sphere and legitimized by militarist and patriarchal norms" (p.51) [9]. What are these injuries and more specifically, how do they affect Israeli women's reproductive health?

Fertility and Emphasis on Reproduction

Israel is widely considered to be a pro-natalist country [10–14] that puts great emphasis on reproduction as a significant life goal for Israeli women [15]. Compared to other OECD states, both Israeli Jewish and Arab women have higher number of children on average (1.17, 3.13, respectively), with Muslim women having higher birth rate (3.32) compared to Christians (2.12) and Druze (2.19) [16, 17]. The social pressure to bear children has different antecedents for Jewish and Arab women. Jewish tradition has historically emphasized family as the centerpiece of a worthy life. The responsibility to reproduce in the modern era is also rooted in the holocaust discourse that places the onus on Jewish women's wombs to replace the six million people that died in the holocaust [12, 18]. In Israel, this pressure is compounded by the "demographic problem," or the perceived need for a larger Jewish population to counteract the growing Arab population seen as a threat to the Jewish state [12,]. Similar to Jewish women, for Arab women, living in Israel, the emphasis on reproduction is dually situated in a patriarchal (and religious) culture that emphasizes childbirth and childrearing as women's main occupation [20, 21], and within the military political context of the on-going Israeli-Palestinian conflict. Palestinian Arabs refer to the establishment of the state of Israel as "Nakbah," defined as "catastrophe" in Arabic. For them, the establishment of the state represents the loss of their lands, the disintegration of their society, and a change in status to an ethnic minority population [22]. The chronic displacement and exclusion among Palestinian women, in addition to the impact of war and conflict on their day-to-day lives, affects the ways in which they think about and access reproductive healthcare. For example, when asked about decision-making about number of children, Palestinian women, like some Jewish women, cite the Israeli-Palestinian conflict as a reason to increase their family size [20, 23, 24]. These decisions are based on fear of losing their current children in the conflict and wanting to have a large family in case this happens [21], and wanting to increase the number of Arab citizens in the country because of the political conflict [20]. Moreover, as with some Jewish religious women who base their family size on tradition, some Arab women cite the Islamic tradition as emphasizing the role of women as mother [25]. Both the Jewish and Muslim religions are patriarchal in nature and are powerful social forces influencing women's choices over childrearing.Furthermore, Israeli values uniquely emphasize the "moral right" to biological parenthood as an entitlement for every citizen. In Israel, the infertile body is considered a "sick body" and the inability to bear children is perceived as causing both Jewish and Arab women severe emotional suffering that the state is obligated to attend to as a moral imperative [12]. Looking at Israeli government and media discourses around this topic is instructive. For example, in a government discussion on the possibility of limiting fertility treatments that occurred in 2003–2004, a leading expert on fertility treatments proclaimed:

> The disease of sterility or fertility is no less fatal than cancer. It burrows in and spreads throughout every-body in the childless family. The woman is ostracized, the man cannot be part of the community, and the family ceases to exist. …It's not a question of demographics… In Israel, the most important thing about family is the children… Who among us can say that he would forgo a child? – no one. Maybe a tiny proportion of the population, and they're disturbed. Both Jewish and Arab families must have children, and they'll do anything for it (p.96) [12].

This quote, which is representative of the types of debates that regularly occur in Israeli society (see Gooldin [12] for a review of such discourses) around access to fertility treatments and the imperative of the family, reflects and reinforces the tremendous pressure on women to bear children as her main occupation regardless of ethno/national background. As such, we contend that the intersection of militarism, patriarchy, culture, and religion has created a nationalization of the Israeli

woman's uterus [24]. Whether Jewish or Arab, all aspects of Israeli women's reproductive health including health policy, access to healthcare, societal pressure to bear children, and so on are situated within this social totality of politics, geography, culture and religion.

Infertility

Israel has one of the highest rates of in vitro fertilization (IVF) use in the world and is one of the few nations that provides almost unlimited rounds of IVF, to produce the birth of two live children under the national health insurance plan [10]. In these unprecedented generous fertility policies are one of the clearest illustrations of the intersection between Israeli nationalism, politics, culture, and religion on state sponsored healthcare decisions. These treatments are available to all Israeli women between the ages of 18–45 regardless of her religious background, sexual orientation, or marital status [10]. In 2012, there were nearly 40,000 treatment cycles, resulting in 9746 pregnancies and 7565 live births [26]. Israeli women use IVF treatments nearly five times more than their European counterparts and ten times more than the international average [27]. It is estimated that IVF expenditure alone uses up 2% of the Israeli health budget [10]. While Arab Israelis tend to consume IVF treatments less frequently than Jewish Israelis (partly because they have children at a younger age), when interviewed about their experiences, Arab woman do not perceive discrimination in accessing these services [28].

While the availability of fertility treatments may be seen, as a step forward in provision of women's needs, there are health consequences including multiple embryo pregnancies and prematurity. In Israel, the potential short- and long-term health risks for infertility treatments have not been systematically documented despite persistent calls for a national registry of IVF users. Such a registry began in 2012 and collects only very limited information on women's health outcomes. Fertility clinics have resisted collecting this data out of concern that it would show low success rates and lead to the closure of clinics. As a result, there is little Israeli data on the short- and long-term effects of IVF use on women's health [10].

Although limited in number, some studies on the mental health effects of infertility treatments in Israel, found that failed fertility treatments can be accompanied by depression and stress [29–33]. In one study aimed to identify the variety and extent of difficulties experienced by infertile women, Benyamini and colleagues [31] found great variability in the difficulties (i.e., lack of control, family and social pressures, impact on self and spouse, and treatment induced problems) and coping strategies with infertility treatment [34]. These findings highlight the need for a more nuanced attitude to understanding the experience of infertility and the treatment associated with it.

The unprecedented use of IVF treatments in Israel must be understood in the social context described above. The availability of practically unlimited fertility treatments within the Israeli patriarchal and militarized society creates a context in which one of the criterions of being a "good mother" is viewing motherhood as worthwhile and essential. As Benjamin and Ha'Elyon [19] noted, "In the context of pronatalism in Israel, which is institutionally supported by both religious and demographic ideologies, motherhood is the predominant normative requirement" (p. 668). Choosing not to have children in this context where everyone "can and should" be a mother is not an acceptable option.

In one of the very few in-depth studies to deal with the taboo of choosing childlessness in Israel, Donath suggested going beyond the binary division of choice/no choice [35, 36] in explaining these women's decisions to forgo having children or in expressing regret over having them. The child-centered Western cultural idea that views children as economically useless, yet emotionally priceless supports the notion that children are a "blessed burden" that should be desired and appreciated at all costs [37], including the consumption of endless rounds of IVF regardless of the consequences. This notion is compounded in the Israeli context, which is emotionally loaded by the "demographic" problem and past traumas for both Jewish and Arab women. This pressure to have children does not leave room for ambivalence, conflict, distress, and regret. In Donath's interviews, women described the path to motherhood as "automatic," which means they are engaged with the cultural identity as mothers without deliberate thought about the consequences of this supposed choice, as is evident in the following quote:

> I don't even know if you can look at it today and know that you'd wanted it. It's like something that you know that is socially dictated … I think it's something that moves us, even without noticing it. (p.4) [36].

The paucity of research on the short- and long-term physical and mental health impact of fertility treatments in Israel not only undermines the efforts to comprehend the complex experiences of women but also contributes to the silencing of any alternative discourse that supports a more multifaceted understanding of the "will"/"desire"/"consent" of women to have children [35, 36]. This discourse also does not allow for women to move beyond the "choice/no choice" binary when it comes to having children, nor does it allow for a more expanded and nuanced discourse that would include the acceptability of expressing conflict, hardship, and ambivalence that is inherent in thinking about and/or becoming a mother.

Pregnancy, Birth, and Miscarriage

Pregnancy is highly medicalized in Israel resulting in a significant amount of screening. The majority of women undergo at least four ultrasounds (many opt for more) throughout their

pregnancy including the first trimester screen, the nuchal translucency, the second semester organ screen, and the third trimester fetal growth estimate. For women over the age of 35, amniocentesis and/or chorionic villus sampling is also available free of charge, though women of all ages often opt to have the screening regardless of medical need. Israel has very low rates of infant mortality in general, although disparities exist among Jewish and Arab women. For example, in 2008, Jewish women experienced 2.9 deaths per 1000 births, versus, 6.8 deaths for Arab women [38]. Some reasons for this disparity include mortality from congenital malformations and inherited diseases due to consanguinity among approximately 31% of the Arab Israeli population [39]. Other potential causes of this disparity include increased poverty, poor nutrition during pregnancy, lower education levels, closely spaced pregnancies, and increased number of pregnancies among Arab women when compared to Jewish women [40]. Militarism, reproductive issues, and health can be associated in a number of ways. One study among women living close to the border of Israel found that those who were exposed to life threatening rocket attacks had significantly higher rates of miscarriages compared to the non-exposed group (6.9, 4.7% respectively) [41] as well as higher risk for preterm birth and low birth weight [41]. The continuous exposure to chronic political violence and the militarization of civilian life put pregnant women at particular risk for complications. For example, a study conducted among Jewish women residing in the Southern part of Israel found that fears and anxiety during the course of pregnancy increased the probability of experiencing a negative and traumatic childbirth and were also significant predictors of negative experiences during subsequent childbirths [42].

In another study about Israeli Jewish and Arab women's perceptions about birth, Halperin et al. [43] interviewed new mothers 24–48 h after childbirth. They found that 43% of the respondents reported feeling helpless, and 68% reported feeling lack of control during childbirth. Importantly, the rate of self-reported traumatic birth was significantly higher among the Arab women than among the Jewish women (32 versus 14%). A higher percentage of the Arab women reported being afraid during labor, expressed fear for their newborn's safety, and reported that the level of medical intervention was excessive in their opinion, as compared to the Jewish women. Although these differences may be attributed to the fact that Arab women were less likely to attend childbirth preparation classes than the Jewish women [43, 44], they may also be understood within the context of medical distrust, which was found to be particularly prevalent among minority groups in the USA [45, 46], though this was never examined in the Israeli context. It is worth noting that both the Arab and Jewish women reported similar numbers of medical interventions and levels of satisfaction with their medical treatment, yet, it was their subjective perceptions that differed [43], and expression of pain during labor was higher among Arab compared to Jewish women [44].

Studies, mainly in the USA have found that the risk for antenatal and postpartum depression is higher among women from ethnic minority groups due to psychosocial stressors such as lack of social support, low socioeconomic status, and restricted access to health care [47, 48]. Similar findings were documented in Israeli studies that found higher prevalence of antenatal and postpartum depression among Arab women compared to their Jewish counterparts [49, 50]. The increased risk can be attributed to their double minority status (on basis of gender and ethno-national identity) and to the patriarchal society which characterizes the traditional Arab culture. These findings, at least in part, can be imputed to social causation factors, such as adversity and stress [51], arising from the disadvantaged social status of the Arab minority [52, 53] within the Israeli militarized society and chronic political conflict.

Reproductive Rights

Contraception and Abortion: Reproductive rights in Israel are somewhat paradoxical, although they keep in line with the emphasis on childbearing. While the pro-natal ethos described in previous sections allows for policies such as generous fertility treatments and extensive free prenatal care, unlike the majority of European countries where contraception is considered a human right and is covered by health insurance, contraception is not covered under the national health insurance plan in Israel. It is, however, widely available and considered inexpensive (e.g., approximately $3–10 a month for the birth control pill).

Abortion is another paradoxical area of reproductive health in Israel. On the one hand, access to an abortion is decided by a committee made up of two physicians and a social worker on a case-by-case basis, thereby, limiting women's choices. On the other hand, acceptable reasons for an abortion have a wide scope and include any physical or mental danger to the mother or to the fetus. Moreover, while nearly all requests for abortions are approved by the committee, women do not have full agency over their reproductive bodies [18]. To our knowledge, limited or no research exists on the consequences of voluntary induced abortions in Israel and on the consequences of having to appear before the abortion committee in order to access care (for a feminist critique of Israeli abortion laws, see Amir and Benjamin [54]).

Maternity Leave and Accessible Childcare

Israeli women receive 14 weeks of paid maternity leave and are eligible to extend their leave unpaid for another 9 months without losing their jobs [55]. Childcare up until the age of 3 is expensive ranging from NIS 3000–5000 ($750- $1244) per month. Subsided childcare is also available, however, the conditions are considered by many women to have unacceptable child to adult ratios [56].

While the state encourages women to have as many children as possible, it does not provide women with social safety nets in which to raise these children. The lack of social resources in which to help women maintain, grow, and prosper in their careers means that women are burdened with childcare duties while trying to move forward in their careers. This stress has consequences for the health and well-being of Israeli women and affects their socioeconomic standing. For example, a review on the work-family conflict and its consequences on women identified outcomes that are related to work (e.g., work satisfaction and performance), network (e.g., marital and family satisfaction), and stress (e.g., depression, physical symptoms and chronic pain) [57]. These findings highlight the importance of the context in which young mothers live and work post-delivery. The short maternity leave, limited options of affordable good quality childcare until the age of three, and the cultural value perceiving motherhood as fulfillment of femininity creates added pressures on women in their roles as mothers.

Discussion

In this paper, we have situated Israeli women's reproductive health within the social, historical, political, and cultural context of Israeli society. We have suggested that militarism, patriarchy and cultural values shape Jewish and Arab women's access to and experience of reproductive health when it comes to the imperative to have children, pregnancy, birth, access to contraception and abortion, and other reproductive healthcare services. We have argued that personal and public reproductive health decisions and healthcare services that are available to Israeli women are mediated by the militaristic, patriarchal, and political and cultural context in which Israeli women live. In this final section, we outline implications for Israeli women's health based on our analysis, and point out some gaps that need to be addressed in order to improve Israeli women's reproductive health.

Minding the Gaps: Implications and Recommendations for Improving Israeli Women's Reproductive Health

The Neoliberalism Gap: "Choosing" Motherhood?

Critiques of neoliberalism posit that social, economic, and political state agendas affect, influence, and shape individual citizens so that our life decisions and choices feel like personal decisions rather than influenced by state agendas. In this paper, we have used concrete examples to show how the social pressure on Israeli women to have children is influenced by the military and political context, by religious patriarchal values around women's worth and purpose, and by state policies that allow for unlimited resources in the form of fertility treatments to become mothers. These social, political and cultural pressures are internalized by both Jewish and Arab women and become a personal imperative to achieving a worthwhile life. While we are not questioning the value of motherhood, we do think it is worth pointing to the absence of alternative options for Israeli women. As noted throughout, choosing not to have children in Israel (or expressing ambivalence, regret or conflict over having them) is not considered a viable option; it is considered pathology. One implication and recommendation, therefore, must involve lifting the taboo over choosing to forgo motherhood and/or the taboo about expressing conflict or ambivalence about becoming a mother, and in the process, opening up a space for Israeli women to imagine a different type of life for themselves if they so desire it.

The Information Gap

Our critical review points to empirical gaps in the literature on women's reproductive health. For example, we pointed out the stunning lack of data on short and long term mental and physical health consequences of fertility treatments in this country. Given that Israeli women are the largest and most frequent consumers of fertility treatments in the world (and have been for decades), the limited information on the health consequences of these treatments in the Israeli context urgently needs to be addressed. Other information gaps include the consequences of having to appear before abortion committees, data on women who choose not to have children in Israel, more data on the differences (with explanatory factors) between Jewish and Arab women when it comes to perceptions of labor and birth, and epidemiological data on how Jewish and Arab women access contraception, abortion, and prenatal care in the peripheral areas of the country, and/or when they elect not to go through the public healthcare system.

The Reproductive Health Services Gap

Our analysis also revealed paradoxical gaps in reproductive healthcare services. On the one hand, fertility treatments, prenatal care, and birth care are excellent and largely accessible and affordable to all citizens. Israelis have one of the most generous and comprehensive prenatal health services in the world resulting in low mother and infant mortality rates for both Jewish and Arab women. On the other hand, once a child is born, Israeli women are largely left to their own devices with very little state services to help them raise their children. Maternity leave is short, childcare is expensive, and very few services exist to help women balance work and family life and/or succeed in their careers while also raising children. Based on this analysis, we recommend that state policies address the whole woman and her needs; while prenatal care is

essential, the state is obligated to implement policy that takes a long term view of women when it comes to reproductive health. For example, in recent years, there has been a grassroots lead initiative to extend maternity leave to 6 months by working mothers [58, 59]. Demands for these types of policy changes illustrate both the needs of working mothers after childbirth, and the types of policy changes that may be implemented if more women were involved in reproductive health decisions.

The Policy and Leadership Gap

Finally, as might be expected in a militaristic and patriarchal culture, women's voices are largely left out of advising on the policies that govern them. In Israel, the path to political leadership is primarily funneled through the military. Since the majority of women do not serve in combat positions nor reach higher ranks in the military, women have a hard time advancing in politics, and thus, have little say in the policies that govern them. In 2013, for example, only 22.5% of the House of Representatives were women and that included only four female ministers [60]. This lack of representation of women's voices was evident in the types of policies and decisions made in the government around women's reproductive choices (e.g., access to abortion and contraception, spending on childhood education). State policies that are perceived to be in the best interest of the militaristic nation (e.g., multiple births to combat the "demographic problem" and increase the number of soldiers) are approved by largely male government officials, while policies that profoundly affect women's lives (e.g. length of maternity leave) are not considered from a woman's point of view. Research that does involve women and their experiences reveals a far more nuanced understanding of the impact of these policies on women's lives. Thus, including the women who the policies are set to effect in all research and policy making is essential. Our analysis also points to a concern about conflicts of interest in testimonies used to shape reproductive policies in the government. For example, in the case of fertility treatments, while it is important to include the medical establishment, it is essential that those who have a conflict of interest should not be allowed to take part in these discussions. Those who run fertility clinics, particularly private ones, have a financial incentive and agenda to include generous fertility policies in the healthcare basket, while also minimizing the release of information on the potential hazards of these treatments on women. Their testimonies should either be eliminated or taken in context of the other motives in pushing for increased treatment access. Moreover, while religious leaders, whether Jewish or Arab, are significant players in the Israeli government, their influence on women's reproductive healthcare policies should be weighted and understood within the religious and patriarchal context of their backgrounds. Although Israel is a modern democratic state, there is no separation between state and religion. Approximately, 49% of the Jewish population (40% of total adult population) defines itself as secular, whereas 29% are traditional/moderately religious and 22% are religious or ultra-Orthodox [61]. Male religious leaders making decisions about women's reproductive health policies pose a problem, particularly, for those who are not religious. Their influence should be limited, or at the least, weighted as representing only one sector of Israeli society.

Conclusions

In line with the Feminist Security Theory, our critical review of the literature on reproductive health of women in Israel shows that militarist and patriarchal norms shape women's choices and experiences around reproductive health—including the very decision to have children and the healthcare services consumed once this decision is made. Both Jewish and Arab women share many of the consequences of the social demand and any deliberate consideration of other options is socially sanctioned. Though Arab women, as part of their double minority status, are exposed to more mental health risks pre- and postpartum, including postpartum depression, their "choices" and experiences are largely shaped by similar social forces as Jewish women. These include the patriarchal and religious culture that dictates a value system that highly cherishes motherhood [20, 21], and within the military political context of the on-going Israeli-Palestinian conflict and past social and political traumas.

Israeli society can greatly benefit from bringing these power dynamics and influences to the front and opening the discourse to other voices, informed by systematic research, where women can truly make choices and own their experiences en route to becoming mothers if they so wish.

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Conflict of Interest The authors declare that they have no conflicts of interest.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

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