As of June 2009, Israel’s population was 7,424,400 people, 5,604,900 of which were Jewish, 1,502,400 were Arabs, and approximately 317,200 had no religion or are non-Arab Christians. Established in 1948, Israel is a highly urban and industrialized country. Its gross domestic product (GDP) per capita (based on exchange rate) is US$23,257, positioning it among the European developed countries. Life expectancy is 79 years for males and 82 years for females, with infant mortality rate of 4 cases per 1,000 live births. Of Israel’s GDP, 7.7% is spent on health.

A distinctive characteristic of the Israeli society concerns its approach on reproduction and parenthood. Israel has one of the highest birth and fertility rates in the world, especially within the developed countries. These are encouraged by its religions, culture, politics, public policy, and law. According to data retrieved from the Population Reference Bureau referring to the year of 2007, the birth rate in Israel was 21 in comparison to 14 in Northern America (Canada and the United States), 11 in Europe, and 19 in Asia. In the same year, the fertility rate was 2.9 in Israel, whereas in Northern America it was 2.0 and only 1.5 in Europe. To illustrate, the fertility rate in Israel was also higher than the average fertility rates in Latin America (2.3), Central America (2.5), South America (2.2), and Asia (2.3).

Although the general fertility rate in Israel has slightly reduced in recent years (from 2.95 in 2003 to 2.84 in 2005 and 2.9 in 2007) as a result of decrease in the fertility rate of Druses, Christian-Arabs, and Muslim-Arabs, the fertility rate of Jewish women has remained stable for more than 10 years and is on average 2.65 (2.8 in 2007). Moreover, in the past decade, the average age of women giving birth for the first time has dramatically increased in 10 months (to 29.7 in 2007), and since the 1990s, there has also been an increase in the birth rates for unmarried women, from 3.6 births for every 1,000 unmarried women in the early 1990s to 10 births in 2006. The most significant increase in births of unmarried women (80% increases in 10 years) has been observed among unmarried women aged 35–39. These changes have occurred with and been encouraged by the development and extensive use of in vitro fertilization (IVF) treatment in Israel, represented by a striking rise in IVF cycles from 16,396 in 1996 to 25,552 in 2006. The large number of treatment cycles is also evidenced in the case of older single mothers who conceive both by egg and sperm donation, undergoing up to 17 cycles per woman. It is thus unsurprising that Israel has more fertility clinics per capita than any other nation.
IVF was first introduced in Israel in 1981 and ever since then the number of IVF public and private clinics has gradually increased. As a result of the escalating use of fertility treatment in recent years, there has also been an increase in multiple pregnancies (from less than 4% of live births before the 1990s to 4.6% in 2006) and in babies born from multiple pregnancies (an increase of 29% in the past 10 years). The significant increase in multiple pregnancies since the 1990s brought about an additional increase of 1% of babies born with low weight (less than 2.5 kg; 8.2% in 2005).

Explanations of Israel’s Pro-Natalist Approach

The exceptional figures of IVF treatment and use of assisted reproductive technology (ART) in Israel are supported by the country’s advanced pro-natalist approach in providing fertility treatment and promoting reproductive liberty. Such an approach derives from the country’s unique religious, cultural, and historical backgrounds as well as the complexity characterizing the mere fact of its existence. Israel is a unique country, which is legally defined as Jewish and democratic, with a strong emphasis on the political and legal power of Halachic tradition, especially in matters of family law, but with a very progressive and advanced liberal approach on many issues, such as extensive recognition of single-parent families, liberal policy on adoption by and registration of children to gays and lesbians, significant protection of minorities by the Supreme Court, and effective management of corruption and unethical behavior of public figures, including its president, prime ministers, and the like.

The country’s attitude and policy to encourage childbearing mainly stems from its strong religious tradition, shaped most notably by the biblical commandment and collective duty to “be fruitful and multiply” (and its equivalent in other religions), accompanied by biblical matriarchs’ narratives concerning Sarah, Rachael, Rebekha, and Hannah’s desperate desire for children. Other explanations concern the dreadful memory of the Holocaust, the permanent loss of life in terrorist attacks and military battles, the demographic concern caused by competition with surrounding Arab nations, and the strong cultural perception of raising a family as a patriotic endeavor. On a related aspect, the Israeli approach to reproduction reflects and strengthens the supreme significance of the family and childbearing, echoed in the Jewish quest for survival.

Moreover, the centrality of militarism in Israel creates a discernible tendency in Israeli society to analogize and make parallel similarities between military service for men and childbirth for women. Through childbirth women become true members of the collective or the nation, thereby deserving respect and social recognition. Such a perception is also reflected in the usage of military terms to express maternity issues, like the word “shmirah,” which is used both to mean the duty of guarding and bed rest prescribed to avert miscarriage. Israeli women accept this order of priorities in which security, nationalism, and demographic superiority over enemies outweigh women’s issues, and they adhere to policy constraining their own choices and preferences.

Professionals’ behavior in other issues similar to that of fertility treatment may also indicate a tendency toward a pro-natalist approach encouraged by medical practice. For example, a doctor’s referral for prenatal tests was found to be one of the key factors predicting performance of such tests in a national survey.
another area concerning requests for late abortions, it was found that decisions made by professionals are beyond those purely medical so that doctors, rather than pregnant women or the legal system, decide whether to permit or refuse requests for abortion. It is estimated that doctors are also actively involved in the process of IVF, so that their personal beliefs and professional incentives have a significant contribution to such procedures, and indeed studies also echo medicalization and social control by doctors in the area of prenatal care and testing, management of pregnancy, and childbirth.

It is of no surprise that under such a social, political, and cultural environment, childless women (and men) in Israel suffer enduring stigma that can only be "repaired" through the use of assisted reproductive technologies. These women cannot be said to exist unless they overcome their infertility and become mothers.

Reproductive Law and Policy in Israel

Israel’s pro-natalist approach is best manifested in law and public policy and can be traced back to the first years of its existence. One year after the country’s establishment, it is reported that Prime Minister Ben Gurion stated he would offer a symbolic award for heroine mothers who delivered their 10th child. Following that, the first social benefit created by the state was a 12-week monetary leave, and two important governmental bodies, namely, the Natality Committee and the Demographic Center, were established to provide a favorable atmosphere within which natality could be encouraged and stimulated. A few years later, in 1968, the country created the “Fund for Encouraging Birth” offering low-interest loans to couples wishing to extend their families. However, the fund was not open to Israeli Arabs, as one of its eligibility requirements was military service.

Israel’s pro-natalist policy arrived to its climax by a decision of the Israeli government to fund every citizen and resident of the country an unlimited number of IVF cycles until the live births of two children. Fertility services are now available to single and married women until the age of 45 (for women using their own ova) or 51 (for women using donated ova). A Ministry of Health initiative to reduce the number of publicly funded IVF cycles to seven resulted in intense public resentment. In addition to fertility treatment, the country funds the importation of fertilized eggs from abroad and is now proposing a new bill to legalize local egg donations for some compensation and a program to allow single women above the age of 33 to freeze their eggs for future fertilization. Providing free maternity service and hospitals, maternity grants to fresh mothers, and substantial child allowances benefiting large families are other means to promote the state interest in encouraging reproduction and childbearing. This outstanding governmental policy expresses, as Susan Martha Kahn argues, an ideology of reproducing Jews at any cost, reflecting a strong form of social control on women’s bodies.

In addition, Israel is one of the single countries and the first in the world where surrogacy is legal. Single women, including lesbians, are fully eligible to access IVF services funded by the State. There are precedents approving the retrieval of sperm from a dead body (including a request from parents of a soldier killed in a terrorist attack) and the use of sperm deposited before the death of a person. The delivery of a child from a brain-dead pregnant woman is not considered a “surgery” under the Anatomy and Pathology Act 1953 and therefore is not
subordinated to the general requirement of informed consent. Ministry of Health regulation allows the use of IVF and Preimplantation Genetic Diagnosis (PGD) for sex selection of future children for medical and nonmedical purposes. Professional guidelines permit, in some circumstances, the implantation of up to four fertilized eggs in the womb. Recent case decisions allow women to use sperm of a nonanonymous donor including married and separated men, and they approve the insemination of a married woman who is in the process of divorce, contrary to specific provisions requiring anonymous donation or the consultation of the husband of a married woman. Courts’ decisions are followed by new regulations validating agreements for fertilization between a man and a woman who are not partners.

Additionally, Israeli law protects the right to pursue IVF in many instances. Thus, the Supreme Court of Israel acknowledged the right to become a parent in the landmark decision of Nechmani, and the District Courts ruled that such a right is protected under the Human Dignity and Liberty Basic Act, constituting part of Israel’s constitutional law. The Women’s Labor Act protects the right of a man or a woman to be absent from work for fertility treatment and prohibits employers from firing any employee (man or a woman) who undergoes such a treatment. Finally, case law establishes that fertility clinics hold a duty of care to genetic contributors of frozen eggs deposited in the clinic and are liable in case of damage to eggs or negligence in their storage.

However, the right to receive and access fertility treatment or assistance in procreation was raised in several cases but did not receive coherent or substantiated treatment in Israeli law. The Supreme Court issued an order in favor of a political murderer’s request for artificial insemination of his wife under security limitations, but denied access to surrogacy by unmarried women, although it ruled that current law is discriminatory and violates the principle of equality. In other cases, courts refused to allow visitation rights to an HIV life prisoner having not been convinced that such a prisoner would protect the health of his partner, and they reversed a previous labor court decision denying public funding of fertility treatment from a Palestinian woman although her infertile husband was an Israeli citizen. Currently, another interesting petition is pending before the Supreme Court. This petition seeks to allow HIV infertile Israeli women to access fertility treatment in Israel or abroad at public expenses.

The seemingly broad IVF consensus and acceptability of the pro-natalist approach may therefore be illusionary. As research also shows, the state uses a strategy of a careful and deliberate selection of participants for the public discussion of IVF, by which active elimination of potential disagreement—together with a passive role of feminists and other contesting parties—is sophisticatedly being made to enhance and promote the state interest in procreation. Through reproductive policy and law, the state enforces its moral beliefs on what counts as good parenthood, thereby medicalizing and publicizing intimate and private decisions, feminizing infertility and its medical treatment, and one-sidedly shaping the views and allegedly free choices of mature citizens.

The Future of Reproductive Law and Policy in Israel

Three major issues emerge for future consideration. As scientific knowledge and understanding of risks associated with IVF advance, it is time to rethink Israel’s
fertility policy, especially that of encouraging women and couples to undergo unlimited IVF cycles until the live birth of two children. Studies show that ova stimulation and IVF more generally result in increased risk for women to develop ovarian, breast, uterine and endometrial cancers, ovarian hyper stimulation syndrome (OHSS), renal failure, intrauterine polyps, ovarian cysts, thromboembolism, adult respiratory distress, and hemorrhage from ovarian rupture. There are also high risks for morbidity in children born after ART as a result of multiple gestations but also among singletons, including preterm delivery and increased risks for birth defects and congenital malformations. These serious health threats together with continuing financial constraints on the state’s healthcare budget should raise—and more powerfully—the issue of whether it is not the time to ration IVF provision in Israel and limit the number of cycles. Two major worries that will need to be considered are consumers’ resistance to ART rationing based on earlier attempts where interested parties opposed rationing through, for instance, complaints to the Ministry of Health Ombudsman, challenges to policies brought to courts and public protests, and the induction of a more dynamic private market for IVF raising equity and fairness issues and foreshadowing on healthcare privatization more generally.

The second and third issues relate to the applicability of Israel’s reproductive policy. Such policy applies to all the Israeli population, including Orthodox and secular Jews, Orthodox Muslim-Arabs, Muslim-Arabs, and Christian-Arabs (Catholics and Protestants), despite the fact that most of the explanations to support such a policy apply to the Jewish sector only. Indeed, multitude is also highly recommended in Islam, begetting children is the purpose of marriage, and family planning contradicts the will of Allah. Under the Islamic tradition, the larger the number of Muslims and the larger their growth rates, the more powerful and closer they are to pleasing God. Hence, social structures among Muslims support strong kinship bonds and pro-natalist values promoted by the country’s policies. One of the major questions is whether the pro-natalist policy, which has tremendous financial implications—roughly $40 million per year and the average of $40,000 cost for a baby—should apply to all citizens, especially the non-Jewish, and, if not, what would the effect of a discriminatory policy toward Jews be like? Studies show that states in which insurance coverage for IVF services is fully or partially mandated use these services more than those with no mandated insurance but have decreased number of embryos transferred per cycle, a lower percentage of cycles resulting in pregnancy, and a smaller percentage of pregnancies with three or more fetuses. Other studies show that mandated coverage does not have an effect on access to fertility treatment among racial and social minorities. These issues should occupy decision makers in future years.

A third related issue concerns the fact that, on the one hand, childbearing and parenthood are regarded and constituted as an imperative and collective and religious mission but, on the other hand, because of religious influence and lack of moral pluralism, important segments of the Israeli population are prevented from receiving assistance and support from the government in advancing their reproductive interests, such as single males, gay couples, infertile women in need of egg donation, or fertile women who are incapable of carrying a fetus to full term. Under such a harsh and oppressive social environment, these groups, if they want to fulfill their wish to become parents or adhere to social norms and
become “good citizens,” have to travel abroad and use the reproductive services of other countries like the United States, India, or the former Soviet Unions at their own expense and occasionally with a fear of breaking the law. It is imperative that the Israeli government consider these populations as well when rethinking existing laws and regulations to increase or control birth rates in Israel in the years to come.

Notes

4. Birth rate signifies the annual number of births per 1,000 total population.
5. Fertility rate signifies the average number of children born for a woman within a life period.
7. Data obtained from the Department of Health Information, the Ministry of Health (through e-mail correspondence between the author and Dr. Yoram Lotan).
10. Today there are 24 IVF units in Israel. It is interesting that, although IVF is fully and, as will be argued below, exaggeratedly funded by the state of Israel, the businesses of private clinics in Israel continue to be on the rise. For some important comparisons between the attitudes of IVF providers in public and private clinics, see Sperling D, Simon Y. Review of attitudes and policies regarding access to assisted reproductive technologies in Israel (submitted).
13. See note 9, Waldman 2006. The strong effect of religious parties on reproductive policy and biomedical issues more generally is the result of the significant participation of rabbis and Halachic experts in policy formation processes and national committees and the substantial representation of Orthodox Jewish parties in the Parliament, as was also recently evidenced in the legalization of brain death in Israel. See Sperling D. Israel’s new Brain–Respiratory Death Act: One step forward or two steps backward? Reviews in the Neurosciences 2009;20(3-4):299–306. Interestingly, in the area of reproduction, rabbis managed to overcome serious Halachic prohibitions associated with ART, most notably male masturbation, coparenting with a man to whom one is not married (by sperm donation) and having the risk of children who are Mamzers (half siblings by the same donor).
14. Most famously is a former chief of staff and former minister of health, Mordechai Gur’s contention that “IVF is anyway cheaper than bringing in a newcomer.” See note 12, Birenbaum-Carmeli 2006:906.
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20. Hashiloni-Dolev Y. *A Life (Un)Worthy of Living*. Dordrecht, the Netherlands: Springer; 2007:90. Abortions are legal in Israel only after the approval of an institutional committee consisting of a social worker, a religious authority, and a physician. According to data relating to the year 2007, 99% of requests to terminate pregnancies have been approved (overall, 11.4% of all pregnancies result in intentional abortions). These high figures are stable for a recent 9 years. Seventy-seven percent of requests are from Jewish women, 9% from Muslim women, and 2.8% from Christian women. Interestingly, although in the past decade there has been an increase in requests by Muslim women, there has been a decrease in the number of Jewish and Christian women seeking to terminate their pregnancies. Some 98.8% of requests relate to week 12 or below, 9.8% to weeks 13–23, and 1.4% to week 24 and onward (with 1.4 times more requests among Muslim women to terminate pregnancies during the second and third trimesters than Jewish women). Central Bureau of Statistics. *Application for Pregnancy Termination in 2007 and Temporary Data 2008* available at [http://www.cbs.gov.il/reader/newhodaot/hodaa_template.html?hodaa=200905200](http://www.cbs.gov.il/reader/newhodaot/hodaa_template.html?hodaa=200905200) (last accessed 19 Nov 2009).


25. Media coverage of IVF has also been relatively positive, emphasizing with much glorification and admiration the miracles of reproductive technologies and portraying mothers who gave birth after exceptionally long and painful fertility treatments as brave and courageous. Such coverage offers a personalized discourse of IVF as a benevolent and effective treatment for anguished women. See note 12, Birenbaum-Carmeli 2004.


27. Kahn SM. *Reproducing Jews: A Cultural Account of Assisted Conception in Israel (Body, Commodity, Text)*. Durham, NC: Duke University Press; 2000. Along with the Jewish–Zionist emphasis on reproduction, there has also been a complementary secular focus on selective pregnancies, resulting in the fact that Israel boasts a world’s record in the number of prenatal tests, also supported by permissive abortion laws and public subsidizing of these tests and screening programs. According to some scholars, such laws and policies helped develop a pattern of rejecting defective children and stigmatizing impaired appearance. Weiss M. The ‘chosen body’: A semiotic analysis of the discourse of Israeli militarism and collective identity. *Semiotica* 2003;145:151–73. But compare Zlotogora J, Carmi R, Lev B, Shalev SA. A targeted population carrier screening program for severe and frequent genetic diseases in Israel. *European Journal of Human Genetics* 2009;17:591–7, arguing that the existence of such tests did not result in stigmatization.

28. Most of Israel’s reproductive regulations and policies are formalized as Ministry of Health regulations and policies are formalized as Ministry of Health regulations and only recently, with the enactment of the Embryo Carrying Agreement Act and with few bills pending, can one witness a shift to a more statutory formalization.


31. Before the enactment of the National Health Insurance Act in 1994, medical services were provided by four sickness funds, *Kupot Chalim*. With regard to IVF services, each sickness fund...
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decided for itself the number of IVF cycles that were covered by membership at the fund. Thus, for example two funds limited the number of IVF cycles to seven and set a minimum on the women’s age (40 and 47) and another fund required a 1-year minimum of membership for eligibility. The largest sickness fund, Kupat Cholim Clalit, was the most generous one, placing no restrictions on the number of IVF cycles, although this was for technical reasons: The fund could not trace women’s previous treatment and entitlement efficiently. As with all medical services, services provided by Clalit before 1994 became standard provision by the National Health Insurance Act. See note 12, Birenbaum-Carmeli 2004.

35. See note 17, Morgenstern-Leissner 2006.
37. Embryo Carrying Agreement Act (Agreement approval and the status of the child), 1996.
38. B.S. (Haifa) 2808/03 A.S. v. Attorney General; B.S. (Haifa) 1130/01 S.V. v. Rambam Hospital et al. (PsakDin) (Decisions in Hebrew).
39. T.M.S. (Tel Aviv) 58540/05 K.B.L.A v. M.S. (Tel Aviv) 11870/03 Y.S. v. The State of Israel (PsakDin). Recently, the parents of a 25-year-old son who died from cancer submitted a petition to Tel-Aviv Family court to validate the will of their son asking to use his sperm after death. Regev D. The son passed away—His parents want to bring his child into the world, available at http://www.newfamily.org.il/ (in Hebrew). An organization advancing family rights in Israel has initiated a program to establish sperm bank for Israeli soldiers, terminal patients, and others for future insemination.
42. T.M.S. (Tel Aviv) 56170/04 H.S. v. Attorney General (PsakDin); H.P. 3419/04 X v. Minister of Health Takdn-Mechozi 1706 (3) 2005; H.P. 386/07 X et al. v. The Legal Department at the Ministry of Health et al. (PsakDin).
43. T.M.S. (Tel Aviv) 62300/06 New Family et al. v. State Attorney at Tel-Aviv (Civil) (PsakDin).
44. Regulations of Public Health (IVF) 1987, §§ 5,6, 14b.
45. Director General of Ministry of Health Guidelines 20/07 on Management of Sperm Banks and Artificial Insemination § 31.
46. See note 41, X v. Minister of Health et al.
47. When such a dismissal occurs, employers pay huge sums of money to compensate the employee, as in a recent case where a woman was paid 108,000 NIS (17,285£) for being discharged from her duties and status after telling her employer that she was undergoing fertility treatment. Niv S. Compensation of 108000 NIS for a woman fired during fertility treatment. Globes Online 2009 Jul 29, available at http://www.globes.co.il/news/article.aspx?id=1000485405&fid=829&nl=1604 (last accessed 26 Nov 2009).
48. T.E. (Kfar Sava) 6880/03 Nir Sobol v. Rabin Medical Center (PsakDin).
49. See note 48 Nir Sobol v. Rabin Medical Center (PsakDin); T.E. (Tel Aviv) 1122/95 Ronit Arena v. Medinvest Hertzela Medical Center Ltd. (Nevo); H.P. (Tel Aviv) 1922/96 X v. International Medical Services et al. (PsakDin). Ministry of Health regulations state that embryos can be stored with no further cost up to 5 years from fertilization and then may be discarded or donated to another couple. New guidelines hold that a couple should express their wishes in advance as to the fate of their embryos, including their request to continue storing them (with payment) for 5 more years or donate them for research. If, toward the end of the 5-year period, the couple does not express any direct wish, guidelines state that the clinic must discard the embryos.
50. Bagatz 2245/06 Knesset Member Neta Dovrin et al. v. Israeli Prisons Services (Nevo).
52. R.I.B. 2416/05 X v. Israeli Prisons Services (PsakDin).
53. I.A. 141/07 X v. Sherute Briut Clalit et al. (Nevo).
54. Bagatz 9830/06 X v. Minister of Health (Supreme Court of Israel).
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