Hidden voices: Orthodox Jewish women and infertility

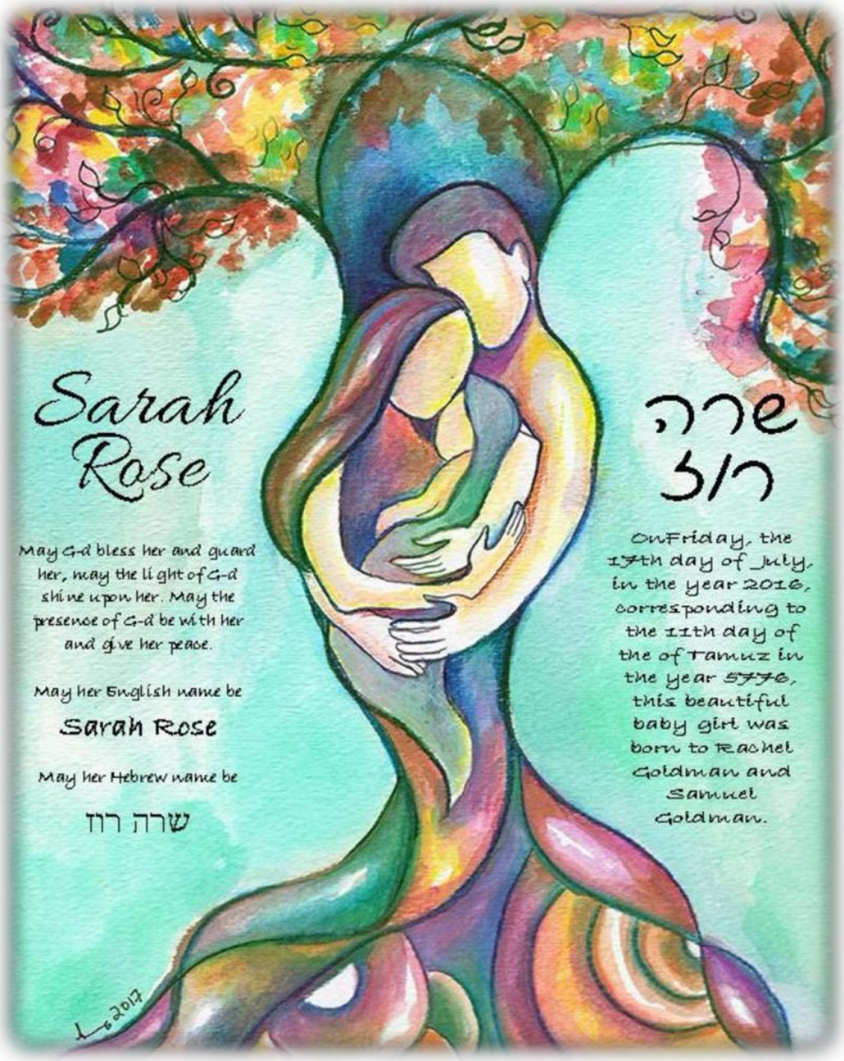

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Image from: https://aaketubah.com/products/tree-of-life-jewish-baby-naming-certificate-in-green

DECLARATION

This dissertation is the product of my own work and research which I carried out with much excitement, eagerness and respect for the Orthodox Jewish women of London. I confirm that this dissertation does not include work that was carried out in collaboration. Furthermore, I have indicated where information has been derived from other sources.

I confirm that this dissertation does not exceed the 100.000 words limit.

Alegria Vaz Mouyal

ABSTRACT

Vast research has been carried out on the way Jewish women feel about their infertility and their use of assisted reproductive technologies (ART). This has been particularly researched in Israel, a distinctly pro-natalist country. Building on this scholarship, this thesis explores the infertility experiences of Orthodox Jewish Women living in London. Based on twenty-six interviews, conducted between 2017 and 2018, with Orthodox Jewish women living in North West London, this thesis presents some of the challenges these women faced when experiencing infertility, and the ways in which they found strength and support to navigate their journeys through ART.

This thesis is comprised of two parts. **Part I** provides the background context for the thesis in three chapters. Chapter 1 introduces the reader to Judaism and British Jewry along with the development of its denominations and the meaning behind 'community'. Chapter 2 broadly discusses Jewish meanings attributed to fertility and infertility alongside studies on the way individuals experience infertility, reproduction and pregnancy with a particular focus on Jewish scholarship. Chapter 3 outlines the methodology used, explaining how this thesis was developed from thought into fruition. **Part II** of the thesis concentrates on original data, with four data chapters each concentrating on a key theme emerging from the data – My destiny (Chapter 4), My Rabbi (Chapter 5), My Relationships (Chapter 6), My Identity (Chapter 7), a discussion chapter (Chapter 8), and a final chapter for conclusions, reflections and future work (Chapter 9).

The key findings of this thesis illustrate that while all women believed their infertility was God given, their acceptance of these perceived 'tests of faith' was not smooth. The relationships that appeared to suffer the most were those the women held with their mothers. Inversely, the relationships that flourished most, as a result of infertility, were those which the women held with their Rabbis.

This research gives useful insight into an under researched population. Its findings could offer guidance to medical professionals, counsellors, policy makers, and religious leaders. Additionally, this work could be encouraging for other Orthodox Jewish women when facing infertility.

IMPACT STATEMENT

My thesis presents the infertility experiences of 26 Orthodox Jewish women living in London. These women viewed infertility as a challenge or rather a test of faith sent by God. The women accepted that this was their destiny and path in life. This challenge was made easier by the presence of the Rabbi. For some women this relationship takes on another level. The Rabbi takes on the role of medical and clinical advisor and at times also that of someone who helps women decide when to start or stop fertility treatment. The women in my research also saw their relationships with their husbands, families, friends and communities change because of their struggle. The way the women live and cope with infertility is very much related to these relationships.

For some women, being infertile distanced them from their families, friends and communities because they could not relate to those around them or be part of their social groups. It was also found that some women face an identity crisis as a result of their infertility. Women were forced to think about what it meant to be infertile and how that would be viewed within a very pro-natalist religion and thus community. Additionally, most women in this study believed that they would not be fulfilled as women if they could not conceive. This idea was so internalised that for some their infertility journey lasted for more than ten years.

My thesis presents the first study on the way Orthodox Jewish women living London experience infertility. With it I highlight the way some Orthodox Jewish women experience infertility and use of ART. I believe this information provides knowledge to medical professionals, social workers, laboratory workers, IVF professionals, psychologists and many other professionals that might come across Orthodox Jewish women facing infertility. Most importantly, this information can be of use to other women embarking on journeys of infertility, particularly within the Orthodox Jewish community.

I would like to use my thesis as a platform for the women's stories by writing a book about their infertility journeys. I believe this book would serve as a

reminder to a lot of other Jewish women that they are not alone, that they are “normal” and that infertility does not have to be hidden. I believe this book would impact the Jewish community tremendously as it would provide information and support to women who might not want to go directly to their families and friends for support. It would additionally raise awareness on the pressure and struggle some infertile Jewish women experience within the Orthodox community in London.

ACKNOWLEDGEMENTS

This doctorate has been my dream since I was a little girl growing up in Gibraltar. As a curious child I knew I needed to do a PhD. My subject and research choice were willed into existence by my upbringing and later on my decision to dedicate myself to the field of human reproduction and women's health.

My thesis would be nothing without the stories and experiences shared by all the women I interviewed. For their participation and will to relive their challenging journeys to parenthood I am for ever grateful. I am grateful for the way these women welcomed me to their homes. These women took me in, a stranger who came to discuss their most private and sensitive stories of sadness, segregation and pain. In doing that they allowed this thesis to be created. I am thankful that these women found the strength and will to open up and share with me these experiences. They are the soul and body of this work. I hope my study has done justice to their infertility experiences and that it has offered them an anonymous and safe voice for them to share their challenges. I have developed and grown as a person thanks to these women. I am humbled by the stories analysed and explored in my study. These have taught me about sensitivity, about what motherhood means to those women who cannot conceive and more importantly they have given me an idea about how my community, the Jewish community, has a long way to go to help those couples struggling with infertility.

I have learnt through my thesis that in life nothing is a coincidence. For that I must thank God for sending me to you Joyce. I am so happy and thankful that you believed in me and accepted my proposal. I am grateful that you took me on for a qualitative study when we initially had no clue what this was really about. My PhD was only made possible because you believed in me and you gave me the freedom to explore my own ideas. I am thankful for your guidance and your ability to always be available despite your crazy busy schedule. I thank you Joyce for having helped me develop and accomplish my thesis. I have

become an independent and hard-working researcher thanks to this journey I went on with you.

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I feel an immense gratitude towards the government of Gibraltar. The government has funded my studies throughout the years the last ten years. I have accomplished a Bachelor of Science, a masters and now my PhD thanks to this financial support I have received. I am so thankful for this opportunity which has allowed me to fulfil my dreams and fulfil myself as a young researcher.

A mis padres,

Muchas gracias mama y papa por todo. Por trabajar tan duro durante todos los anos que yo eh vivido en Londres. Gracias por sacrificar todo lo que tenias para que yo pudiera estudiar y seguir mis suenos. Nada de esto hubiera sido possible sin vuestro amor, carino y ayuda. Os dedico mi tesis que para mi representa mi salto de nina a mujer. Sois los mejores padres que cualquiera persona puediera tener. Mama tu me has ensenado que en la vida una mujer puede ser y tener lo que quiere. Papa tu me has ensenado que con trabajo y dedicacion un persona tiene el mundo en su mano. Todos los dias le doy gracias a Dios por haberme echo vuestra hija. Gracias por siempre, gracias por todo.

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Eitan what can I say to you. Thank you. Thank you for challenging the way I think, thank you for pushing me to always think differently and look for other perspectives in life. You have been on this journey with me for 6 years. I have realised that because of you I have learnt about myself. You have pushed me to think about my past and my childhood so that I could understand who I used to be and who I wanted to become. In doing so I have been able to learn about the women I interviewed. In discovering myself I was able to build connections and bridges with the struggles the women faced. Thank you Eitan for reminding me of my worth when things were hard and when often I felt like I would not be able to finish. I am so grateful to have you in my life; you are my number one fan. Thank you for that.

I dedicate my thesis to the women in Orthodox Jewish communities whose voice is not heard. I bring in my thesis 26 unheard stories in hope that this will inspire and motivate other women to open and share their infertility journeys. I hope that this platform will open and as a result better the way Orthodox Jewish women face infertility.

Alegria Vaz Mouyal

CONTENTS

“And when Rachel saw that she bare Jacob no children, Rachel envied her sister; and said unto Jacob, give me children, or else I die.

And Jacob's anger was kindled against Rachel: and he said, Am I in God's stead, who hath withheld from thee the fruit of the womb?”

Genesis 31 Verse 1 and 2

INTRODUCTION

Judaism has been recognised as a strongly pro-natalist religion. As such, fecundity has a very important place within this religion and specifically in Orthodox Jewish communities. This importance can be noted from the various references of fertility in the Bible. For instance, the first commandment and blessing given to humankind:

> *"God blessed them and said to them, be fruitful and multiply, and fill the earth and subdue it; rule over the fish of the sea and the birds of the air and every creature that crawls upon the earth." (Genesis 1:28)*

Not only was it commanded, it was also bestowed as an innate desire in women and men (Moss & Baden 2015). The ability to conceive is perceived as a sign of prosperity or being favoured by God, and infertility or 'barrenness' is often seen in a less positive light (Brand 2010). Therefore, infertility is frequently viewed as a big challenge that usually requires change in the lives of those who cannot conceive.

Orthodox Jews adhere strictly to Jewish law and feel bound by this commandment. Having children and creating a family becomes an obligation in their lives. For many Orthodox Jews life is based around fulfilling ones' life mission. Usually this only really starts when one is married. There are various steps that lead to marriage; some of these include: preparation for the right match (*Shiduch),* learning how to sustain and maintain a relationship with one's husband or wife and preparation for marriage by learning all the rules involved in sexual relations, family purity (*Niddah)* and lastly how to keep the peace in the home *(Shalom Bait)*. Sexual intercourse prior to marriage is forbidden therefore young adults are usually not introduced to any form of information on sex, contraception or fertility in general. It is common for people to only receive this information when they have found the right *Shiduch*. Young adults are encouraged to marry young and start a family as soon as they are married. This is further emphasized from the prohibition to waste seed (*Talmud Niddah 13a*).

These couples are usually known for having large families (Birenbaum-Carmeli 2008; Kasstan 2019; Tarragin-Zeller 2019). Due to their high parturition rates Orthodox couples are usually overlooked when considering infertility (Taragin-Zeller 2019). Unfortunately, Chana, a Jewish organisation based in London that helps couples struggling with all aspects of infertility, reports that one in six couples struggle with infertility (www.chana.org.uk/ 13/03/2019).

Based on the first commandment in the Bible couples are encouraged to seek help from their Rabbis, families and doctors when failing to conceive. Helping couples have babies is considered a great "*Mitzvah"* (Appendix1 for Hebrew words glossary). For many couples this could mean the use of ART.

Since the birth of Louise Brown, the first IVF baby, some 40 years ago (Steptoe & Edwards 1978) ART have developed and become an essential part of our society by helping couples, single women and men in their hopes and dreams of parenthood (Zhao *et al*., 2011). In 2016 over six million children were born as a result of ART and in 2018 this number increased to eight million children (Dyer *et al*., 2016; www.icmartivf.org 13/03/2019 and European Society of Human Reproduction, 2018). Fertility treatments include a wide array of options for couples such as: IVF, Intracytoplasmic Sperm Injection (ICSI), Preimplantation Genetic Testing (PGT), sex selection, gamete donation, and genome editing (Appendix2 for ART glossary). Their existence has become an essential tool for Orthodox Jews who want overcome their infertility.

Broadly speaking, IVF is permitted under Jewish law if the entire IVF process is strictly supervised by a trained third party, who must be Jewish, commonly known as rabbinical supervision and if the couple's gametes are used. Nevertheless, some Rabbis forbid IVF on the grounds that the level of supervision needed to ensure that treatments are kosher are impossible to attain and based on the problems that arise from the use of donated eggs, sperm and surrogacy (Brand, 2010).

The growing need and use of ART have propelled research on the way people: use, think, feel about ART and more importantly how their infertility struggle

changes and impacts their lives. This is an area that has been particularly researched in Israel. Most studies have focused on Israeli Jewish women who are recognised as the "*world's most active consumers of IVF*" (Collins, 2002; Nyboe Andersen *et al.,* 2007 & Schenker, 2003). Kahn has researched the way Jewish women in Israel face infertility and how they accept the difficulty of being infertile in a pro-natalist climate (Kahn, 2010). This work also explored the way Rabbis are very present in these women's lives. The Rabbi-infertile woman relationship was similarly studied and observed by Ivry in 'Kosher Medicine'. Her work extrapolated the delicate and intricate relationship that exists in Israel between Rabbis-patients-IVF doctors (Ivry, 2010). Other research has focused on the political climate in Israel and how the country's pro-natalist views along with the paid treatments have led Israeli women to "jump on" a metaphorical treadmill of non-stop infertility treatments (Birenbaum-Carmeli 2004). This has led researchers to look at how Israeli women decide when to stop treatments and more importantly how they feel about their bodies and reproductive health (Benjamin & Ha'elyon, 2002). Remennick's study (2000), found that Israeli women recognise childlessness in Israel as a voluntary act. The extent of the pressure that some Israeli Jewish women feel to procreate has also led them to consider solo motherhood (Teman 2010).

Despite the available scholarship on how Jewish women feel about infertility and their use of ART in Israel, little is known about how Orthodox Jewish women experience their infertility as Orthodox Jews. This can be taken further as no study has ever looked at how Orthodox Jewish women in the UK feel about and experience their infertility. Orthodox Jewish women all over the world live in communities that are usually closed from the outside world. When dealing with infertility these women are forced to leave their "bubbles" and face difficult challenges.

This thesis aims to investigate how some Orthodox Jewish women in London experience and navigate through their infertility. It further aims to look first at how women experience their infertility as individuals and then how this might have an impact in their day-to-day life and their social systems.

Furthermore, this thesis aims to be in conversation and contribution to past and present scholarship available on the way Orthodox Jewish women around the world experience infertility. It also aims to broaden the current knowledge that exists on the way Orthodox Jewish women in the UK live and face infertility.

The thesis is divided in to two parts: Part I context and Part II data. Part I: Context, consists of three chapters. Chapter 1 introduces the reader to Judaism; British Jewish History; the development of Jewish denominations; to the understanding of 'community'. Chapter 2 disscusses the global understanding and impact of infertility with a particular focus on the Jewish understanding of fecundity, reproduction and infertility. This chapter ends with a concise discussion on the available scholarship of Jewish women's experiences of pregnancy, fertility, infertility and the use of ART. Chapter 3 outlines the methodology used, explaining how this thesis was developed from thought into fruition. Part II: Data, consists of four data chapters each concentrating on a key theme emerging from the data – My destiny (Chapter 4), My Rabbi (Chapter 5), My Relationships (Chapter 6), My Identity (Chapter 7), a discussion chapter (Chapter 8), and a final chapter for conclusions, reflections and future work (Chapter 9).

PART I: Context

CHAPTER 1: BRITISH JEWRY

In this chapter I start by introducing Judaism as a religion. Followed by the introduction to British Jewish history. This is followed by an attempt to draw out definitions and understandings of what Jewish denominations and community mean in contemporary Britain.

CHAPTER 2: GLOBAL AND JEWISH INFERTILITY EXPERIENCES

In this chapter I briefly describe some of the works that have shaped our knowledge of fertility, pregnancy, infertility and of the use and practice of ART. This will also include works that focus on the Jewish experience of infertility, in Israel and America. These pieces are essential in the illustration of the meaning some Jewish women give to womanhood, fertility, fecundity, reproduction and infertility.

CHAPTER 3: METHODOLOGY

The methodology chapter consists of eight sections. The first section will explore how the study was set up and how research quality control was kept. Secondly, my background, position and proximity to the chosen and studied group will be disscussed. The third section will focus on the literature review. This is followed by a discussion on ethical considerations which explores confidentiality and anonymity of interviews. The fifth section briefly disscusses background research carried out in Israel, interviews with British Rabbis in London, focus group with Ma'ayan women and seventeen face-to-face interviews carried out with women about their knowledge of ART in London. The sixth section explains access to the community and recruitment of infertile women. The seventh section discusses interview set up. Lastly, the eighth section focuses on the analysis of interviews and how I went about understanding what the women unveiled throughout our discussions.

CHAPTER 1: BRITISH JEWRY

In 2012, more than eight out of ten people in the world associated with a religious group (Pew Research Center, 2012). The Pew Research Center carried out a comprehensive demographic study on religion and public life with more than 230 countries and territories. This study demonstrated that 5.8 billion people, including adults and children around the globe, had a form of religious affiliation. This represented 84% of the world's population in 2010 which was 6.9 billion (Pew Research Center, 2012). Of those affiliated, 14 million identified as Jewish (Sallam & Sallam., 2016; Pew Research Center, 2015; Pew Research Center, 2012 and Hackett *et al*., 2015).

Judaism is the oldest Abrahamic religion. It is a religion characterized by the strict belief that God is one and that the *Torah,* the code of Jewish law, was handed to all Jews in *Mount Sinai* thousands of years ago. A few principles and ideologies hold Judaism firmly as a religion. Some of these include monotheism, loving-kindness, and respect for one another, family life and procreation (Benor 1975).

In this chapter I aim to underline the context in which British Orthodox Jews live nowadays. I start by introducing British Jewish history followed by an attempt to draw out definitions and understandings of what Jewish denominations and community mean in contemporary Britain. This thesis particularly focuses on the area of North-West London as it was from this location that women in this study were recruited.

The Jewish people

The story of the Jewish people can be traced back to the beginning of the Hebrew Bible with the stories of Abraham, the first monotheist. Abraham fathered two children: Isaac and Ishmael, from whom the three main religions Judaism, Christianity and Islam have sprung. Judaism as a religion encompasses the philosophy, culture and way of life of Jewish people. The

basic tenet of Judaism is that the *Torah* is the revealed word of God which was handed down on Mount Sinai, 3500 years ago in front of 600,000 people (Johnson & Perinnial, 1988). Judaism embodies the passing of tradition. Its people firmly believe that Judaism has been passed on from generation to generation accurately through the millennia since the receiving of the *Torah*. The passing of the Jewish tradition has been made possible by the observance of Jewish law. Jewish law takes two, equally respected and observed, forms according to Judaism. The *Torah*, considered as the written law and the commentaries on the *Torah* that have developed over the centuries since the receiving of the *Torah* which have been recorded and are observed as the oral law. The Jewish people can be divided into three main branches. The S*ephardim* which refers to the Jews originating from Spain and Portugal, the *Ashkenazi* which refers to Jews of Central and Eastern European descent and the *Mizrahi* which characterises Jews from Middle Eastern and Oriental descent (Benor 1975).

The highest worldwide population of Jews was recorded at an estimated 16.5 million on the eve of the Second World war (Kahn-Harris 2020). The majority of this growth took place in Eastern Europe, America, Palestine and then Israel. The Second World War saw the loss of six million Jews; dropping its total population to about 11 million. This loss disrupted what had been, up until that point, a continuous build-up of European Jewry (Kahn-Harris 2020). Seven decades after the greatest Jewish genocide, the Jewish People Policy estimated that the global Jewish population had reached 14.2 million (Staetsky & Boyd 2015). By 2018 the world Jewish population stood at 14.6 million (DellaPergola, 2018). Currently, according to a report released last year by the Jewish Agency, the global Jewish population stands at 14.8 million (Jewish Agency 2019). While the rise in the Jewish population has been global a more local decrease in numbers can be recorded in the population of European Jews (Kahn-Harris 2020). Over the last 50 years, Europe has lost almost 60% of its Jewish population; only about 9% have remained compared to the nearly 90% that habited Europe in the 19th century (Kahn-Harris 2020). This shift in numbers can be explained by the concept of '*Aliyah*' (ascent to the holy land meaning emigration to Israel), which according to the 'Law of Return',

from the 1950s, enables any Jew from around the world to become an Israeli citizen (Jewish Agency 2018). This decrease in numbers can also be explained by the intermarriage between Jews and non-Jews as children in these families will often not be brought up as Jewish (Kahn-Harris 2020). Most recent statistics indicate that Israel holds the largest number of Jews with a population of 6.7 million Jews, followed by the USA with 5.7 million, France with 453,000, Canada 391,000 and the UK with 270,000 Jews (Jewish Agency, 2019).

London Jews: Brief history and background

Despite the fluidity and mobility of the Jewish community in Britain, with members emigrating and immigrating to and from Israel, Spain, France, Italy, the United States and elsewhere, the majority of Jewish families living London have been settled here for more than three generations (Taylor-Guthartz 2019). The London community of Jews dates back to 1656, when a small number of Sephardi Jews escaping the Spanish and Portuguese Inquisition, were permitted to stay (Alderman 1998). Thirty-four years after the arrival of the first Jews, the first Ashkenazi Synagogue was founded (Bermant 1970; Brook 1996 & Alderman 1998). Throughout the eighteenth and nineteenth centuries, the British Jewish population propelled itself largely due to the influx of Ashkenazi immigrants arriving from Germany and Poland; amounting to 35,000 by 1851 (Taylor-Guthartz 2019). The majority, 20,000 of the Jews, were established and living in London (Numbers are an approximate Alderman, 1998). Many of these Jews (5,000), moved and set their homes in the newly fashionable West End (Taylor-Guthartz 2019). Throughout the nineteenth century the restrictions on their political, economic and social activities gradually disappeared. As such, schools, community institutions and Synagogues were slowly established. These changes elevated the Jews to a more middle-class status (Alderman, 1998).

By 1880, the established British community reached 60,000 Jews. Their way of living was drastically changed by the immigration of Jews from Eastern Europe and the Russian Empire (Taylor-Guthartz 2019). Between 1881 and 1905, a total of 100,000 Jews arrived in Britain. In the early 1900s, London had an

approximate population of 144,000 Jews. The majority of these Jews (83%) made of their home the East End (Alderman 1998).

At the time, the solid Jewish middle-class establishment was shocked by the primitivity of the new settlers and by their exhilarated religiosity (Taylor-Guthartz 2019). As such, these middle-class Jews felt that "*Anglicise the new*" was the only thing they could do (Bermant 1970). Using schools and youth clubs to influence the development and teaching of immigrant children their project was largely successful. By 1914, after the end of immigration, the process of 'middle-classing' the newcomers in London proceeded and successfully led to the East End moderately replacing its Jews by the new middle-class suburbs (Taylor-Guthartz 2019).

In the 1930s, the arrival of 50,000 immigrants, from Nazi Germany and Austria marked the last mass Jewish migration to the United Kingdom. The majority of these "*new Jews"* were not necessarily observant Jews and were neither part of the German Reform movement (Bermant 1970). The late twentieth century saw smaller groups of Hungarians, Iranian, Yemenite, Iraqi, Adeni and other Middle Eastern Jews arrive and settle in Britain. Most recently, several thousand Israeli Jews have moved to the United Kingdom, settling in London (Rocker 2008 at the Jewish Chronicle). The arrival of these groups has had a smaller effect on the British community. The majority of these Jews are usually secular and only live in Britain for a short period of time (Rocker 2008 at the Jewish Chronicle). These groups also prefer to keep Israeli social networks instead of becoming part of the wider British Jewish community (Rocker 2008 at the Jewish Chronicle).

The 2011 National Census stated that a total of 263,346 Jews live in England and Wales (2011, National Census). However, most recently, Kahn-Harris (2020) in an article for the Institute of Jewish Policy Research, highlighted that this number could actually be 290,000. Despite the multi-ethnic background of the British Jewish community, the majority of Jews present in Britain recognize themselves as Ashkenazi (Graham *et al*., 2011).

The majority of British Jews, (172,000), live in London clustered around North-West London; predominantly in Golders Green, Hendon and Finchley (Graham *et al*., 2011). The 2011 National Census noted that just in the Borough of Barnet the population of Jews is recorded at 54,084. Due to housing costs, many newly married couples and younger families have established their homes in satellite towns as Borehamwood and Radlett. Stanford Hill and Golders Green also host between 4,500 and 7,600 individuals (18%) belonging to the UK's Charedi (Ultra-Orthodox) population (Graham *et al*., 2011).

According to a report by the Jewish Policy Research from 2003 London Jews can be described as:

> *"A relatively affluent group of people with middle-class values and middle-class lifestyles. It is an ageing population [...] the Jewish population is far from uniform and [...] comprises a complex social and religious fabric [...] there is a far from simple situation with regard to the religious-secular continuum. Even indubitably secular Jews still observe many customs that are of a religious origin. Many prefer to have their parents cared for in Jewish care homes; their children attend Jewish youth organizations and they engage in Jewish-based leisure and cultural activities. Many of them have their children educated in Jewish schools and more would if Jewish schools with a more attractive Jewish ethos were available. What is absolutely apparent [...] is that London's Jews have long since ceased to comprise a religious group. They are truly an ethnie within British society, with shared historical memories, a myth of common ancestry, differentiating elements of common culture and an overall sense of solidarity [...] it would not be untruthful to state quite clearly that among Jews in London ethnicity overrides belief, except perhaps for the belief that being Jewish is important."*
>
> (Becher *et al*., 2002)

The Development of British Orthodoxy

This thesis focuses on the infertility experiences of Orthodox Jewish women living in London. As such, it is important to understand the peculiar version of Orthodoxy that exists in Britain.

Webber notes that the category of 'Orthodoxy' is modern in origin (Webber 1992). Samet thought that it is "*more a mutation than a direct continuation of the traditional Judaism from which it has emerged"* (Samet 1988). The term began to be used in the early 19th Century when the more traditionalist Jews started to define themselves in opposition to the Reform Jews, who at the time started promoting changes in Jewish thought and to reform the ways in which Judaism was practised (Blutinger 2007 & Taylor-Guthartz 2019).

In the 1970s 'Orthodox' became the accepted denomination for traditionalist Jews who antagonised the uprising Reform movement. Due to their firm opposition to the perceived threat of reformation of traditional Judaism, the Orthodox, suddenly became an easily identifiable group (Taylor-Guthartz 2019).

Samet emphasises that initially there were different tendencies and levels of Orthodoxy, particularly, between the German and Hungarian types (Samet 1988). These trends and differences in the levels of Orthodoxy underlie the denominations and divisions that exist today; Modern and Ultra Orthodoxy. The German Orthodoxy, led by Samson Raphael Hirsch, had a bright outlook towards the non-Jewish ever-evolving contemporary world (Taylor-Guthartz 2019). While they rejected the Reformers and their way of living they encouraged a certain level of lay study and encouraged involvement in social cultural life. Their way of practising Judaism stood on the principle '*Torah with the way of the land'* (Silber 1992). However, the Orthodox of North-Eastern Hungary firmly rejected all accommdation and acceptance of the non-Jewish world (Taylor-Guthartz 2019). As such, a new system of manipulation of Jewish law was developed to explain their strict views (Silber 1992). Their way of practising Judaism stood on the principle that *'All that is new is forbidden by the Torah'* (R. Moses Sofer, 1753-1839, Taylor-Guthartz 2019). This group of Orthodoxy was similarly opposed to the Reform movement.

In Britain, since the19th century a more conventional rather than the obvious Orthodox outlook has persevered (Taylor-Guthartz 2019). In 1840, a small group of Reform Jews established the first Reform Synagogue. This was not a threat to the traditionalist community as most of them had been Anglicized by

the late 19th century (Taylor-Guthartz 2019). Alderman points out that the political deliberations which encouraged German Jews to accept and adopt Reformity never existed in England (Alderman 1998). However, this was not always as straighforward. By the 1880s thousands of Eastern European Jews immigrated to England. While most of these Jews were traditional the large cathedratic synagogues of Anglo-Jewry along with their singular practices were completely foreign to them (Taylor-Guthartz 2019). They preferred the smaller more intimate way of praying, they wanted to have their own *'hevras'* (societies) (Bermant 1970). Further, these Jews favoured the leadership of Eastern European traditionally-educated Rabbis rather than the English speaking, university educated, United Synagogue Rabbis (Taylor-Guthartz 2019). As such they set-up their own schools, communal organisations and their own legal institution which authorised marriages, divorces and kosher slaughtering.

In response to this new wave of Orthodoxy, in 1887, the Anglo-Jewish establishment, led by Samuel Montagu a Liberal MP (1832-1911), founded the Federation of Synagogues in hope of providing an umbrella organisation to emcompass all the uncontrolled Synagogues of the East End. The Federation aimed to bring in the immigrants and prevent the schism of the community (Bermant 1970). Eventually, the Federation absorbed the majority of the members of the Eastern-European community in what was known as the "*largest sinlge instrument of Anglicization, as well as social control*" of the time (Bermant 1970). By the mid 20th century the new members of the Federation had lost their Eastern European characteristics. All members now had a very similar lifestyle, religious practice and aspirations to those of the United Synagogue. However, within their practise they refused to recognise the authority of the Chief Rabbi (Bermant 1970).

In 1886, the continuous dissatisfaction with the Orthodoxy practiced by the United Synagogue propelled Jews mostly from Germany, Austria and Hungary to independently establish their own 'neo-Orthodox' Synagogue; the North London Beth Hamedrash (Taylor-Guthartz 2019). In early 1900, Rabbi Dr Victor Schonfeld (1880-1930) was invited to head the congregation. This led to the adjournment of several smaller Synagogues. In 1926, they established the

Union of Orthodox Hebrew Congregations (commonly known as Adas) (Bermant 1970). The Union had its own communal court for Jewish law, its own Kashrut authority (Kedassia) and burial society (Taylor-Guthartz 2019). However, constituent Synagogues could govern themselves freely. The 1930s influx of Ultra-Orthodox Jews fundamentally altered the character of the Union. This was further, intensified by the second arrival of Ultra-Orthodox Jews, following the 1956 Hungarian uprising.

Liberal Judaism, another breakaway movement from mainstream Orthodox Judaism, was established roughly at the same time as the Union of Orthodox Hebrew Congregations. This movement was founded by individuals that were unhappy with the lack of 'spirituality' of the United Synagogue (Taylor-Guthartz 2019). Claude Montefiore (1858-1938), a Bible scholar that encouraged a universalist, ethically focused Judaism and Lily Montague (1873-1963) who actively battled poor housing, unemployment and the exploitation of workers, co-led the Liberal movement (Taylor-Guthartz 2019). Together, in 1902, they set up the Jewish Religious Union. Their first synagogue was established in 1911.

The last major breakaway from Orthodoxy was the Assembly of the Masorti Synagogues in 1985. This schism in the Anglo-Jewry was brought about by the departure of Orthodox Rabbi Louis Jacobs (1920-2006) from the United Synagogue. As a result, more than 300 congregants from the New West End consequently exited their Synagogue. The group purchased the building where the old St. John's Wood Synagogue stood and established there the New London Synagogue which effectively was directed by Rabbi Jacobs. While Rabbi Jacobs regarded his practice as Orthodox, this Synagogue and other smaller communities, stimulated by his new establishment, united themselves with the American Conservative movement creating the first Masorti movement in Britain (Taylor-Guthartz 2019).

This compounded history of the separation and denominational expansion underlies and shapes the current religious geography of Anglo-Jewry. More importantly, this history forms the foundation of Orthodoxy, the form of Judaism that the women in this study observed.

British Jewish Denominations

Moving from left to right, left being more secular and less strict on *Halachic* observance, current British Jewish denominations include Liberal Judaism and Reform Judaism; Masorti Judaism (these three are outside the scope of this study) and Orthodox Judaism (the group which this thesis focuses on) (Taylor-Guthartz 2019). In Britain, Orthodox Judaism is itself subdivided, on an institutional level into, the United Synagogue, the Federation of Synagogues and the Union of Orthodox Hebrew Congregations (Taylor-Guthartz 2019). Generally, the present Sephardi Synagogues are Orthodox. Similarly, to the United Synagogue, in practise they embrace a wide range of beliefs and practices (Graham and Vulkan 2010). A 2010 survey on British Jewry Synagogue affiliation found that 54.7% of Jews are part of the 'Central Orthodox' Synagogues (predominately United Synagogue and Federation) (IJPR 2010).

With regards to more specific denominations the National Jewish Community Survey carried out in 2013 on the UK Jewish Community reflected that a quarter of British Jews (26%) describe themselves as '*Traditional',* similarly, 24% describe themselves as *'Cultural'/ 'Secular'*, 18% as *'Reform'*/*'Progressive*' and lastly, a minority (16%) as *'Orthodox'*/'Charedi' (2013 NJCS Survey of the UK Jewish Community).

The focus of this thesis lies on Orthodox Judaism as such it is important to further look at how Orthodoxy is divided. Orthodox Jews in London increasingly live Orthodoxy as two separate, briefly overlapping, communities (Taylor-Guthartz 2019) – The Charedi, also known and recognised as '*the black hats'* (referred to in this thesis as the Ultra-Orthodox) and the non-Charedi, known as *'United Synagogue'* (Characterised in this thesis as simply Orthodox and Modern Orthodox). As an overarching theme, for these Jews, religious law cannot be separated from social life and practice (Benor 1975). It is thus, integrated in all they do and in their day-to-day life.

Understanding 'Community'

The concept of 'community' has been one of the most attractive, compelling and elusive themes to define in modern social science (Cohen 2001). 'Community' provides a means of enclosing a wide variety of societal processes and a way to understand and observe symbols, ideologies and values that have popular currency in certain groups (Cohen 2001). As such, when one observes 'a community', one can learn about the way individuals live, understand life challenges and more importantly how they make decisions (Taylor-Guthartz 2019). Further, on a deeper level it is also possible to look at the 'community spirit', which largely refers to the feelings of belonging that people often exhibit when 'belonging' to certain small-scale social and cultural entities which can at times be bigger than the feeling of 'family' but yet less impersonal (Cohen 2001).

As Taylor-Guthartz (2019) explains, belonging to a specific 'community' may encourage people to behave and act in certain ways to upkeep their 'membership' in that 'community' and to be part of the 'norm'. This in turn can influence people's actions and cause them to change their perspectives and opinions in a form of compliance to their 'community'. Causing for some an identity crisis. For others, being part of the 'community' grants a more positive and grounded life. It allows people to identify with other beings and to feel a sense of belonging and grounding (Taylor-Guthartz 2019).

In Cohen's Book, '*the symbolic construction of community'*, he chooses to follow Wittgenstein's advice to 'use' rather than to seek the 'lexical meaning' of 'community'. In this thesis, I choose to follow this particular way of thinking to understand 'community' (Cohen 2001). Cohen, argues that there are two related meanings for the word 'use'; members of a group of people (1) have something in common with each other, which (2) differentiates them from the members of other presumed groups (Cohen 2001).

'Community' further expresses a relational idea: *"the opposition of one community to others or to other social entities"* (Cohen 2001). Thus with this

definition, ‘community’ with the boundaries that it establishes and upholds, marks the beginning and end of a community. These boundaries that further encapsulate the identity of the ‘community’ and in doing so the identity of any individual belonging to the ‘community’ can thus decide who can and cannot belong to any particular community (Cohen 2001). As Cohen notes, these boundaries are largely composed by the ‘community’ members and they are further developed by people in interaction (Cohen 2001).

The expression ‘community’ is used regularly by Jews. Taylor-Guthartz suggests that there are two distinct senses for the term (2019). The first, she describes as a more popular term used in a more general sense to describe Jews who identify as Jews and who participate in Jewish activities be them cultural or religious (Taylor-Guthartz 2019). For instance, Taylor-Guthartz gives the example of a man who attends Synagogue regularly, belongs to a Jewish organisation and who helps to raise funds for Jewish charities, he might be described as an *‘active member in the community’*. This same phrase, ‘*active member in the community’*, she explains could be used to describe a man who does not belong to one particular synagogue and does not observe any Jewish laws but attends a Zionistic parade, volunteers weekly at Jewish old age home and is part of a Jewish bridge club (Taylor-Guthartz 2019). As such, ‘Community’ membership is not necessarily coextensive with ethnic Jewish origin, it is rather perceived to be set by “active involvement and self-identification” (Taylor-Guthartz 2019).

The second and narrower sense for community, Taylor-Guthartz describes as belonging to a sub-group (2019). This she explais to be obvious to congregants especially when speaking of ‘*my community’*, ‘the Sephardi community’, ‘the Ashkenazi community’ and ‘the *Frum (religious)* community’ to name a few (Taylor-Guthartz 2019). This narrow subdivision could refer respectively to the congregants of a specific Synagogue, Jews of a set denomination and Jews of a certain origin or provincial town. Taylor-Guthartz (2019) states that the majority of Jews who identify as members of the Jewish community also belong to multiple of these ‘sub-communities’. All of these ‘sub-communities’ further

overlap with social, family and friends' circles within the Jewish and wider communities (Taylor-Guthartz 2019).

The symbolic construction of 'community' implied by Cohen (2001), accords well with the London Jewish 'community'. As Taylor-Guthartz (2019) describes, this is a community that is hard to define or delimit in terms of institutional structures, ethnic origins or even locality. This 'community' is thus, made up of overlapping 'boundaries' which are demonstrated by denominational religious affiliation, marriage patterns, educational choices, dress, living habits and cultural activities.

In this thesis, 'community' is used to describe the Jewish community as a whole, and the individual 'sub-communities' that each woman was a part of. Women were recruited from various 'sub-communities' of North West London. All women recognised themselves as Jewish women belonging to the 'Jewish Community' primarily and secondarily as a community member of their particular; Synagogue, Jewish denomination, and Ashkenazi or Sephardi group thus defining the 'sub-community' they belonged to. Women's demographics will be explained further in Chapter 3.

CHAPTER 2: GLOBAL AND JEWISH INFERTILITY EXPERIENCES

In 1978, the birth of the first “test-tube” baby via in vitro fertilization (IVF) gave hope to infertile couples and to all those who previously had not been able to conceive naturally. Over the last four decades, a myriad of ART have emerged to further assist infertile individuals and to improve the original IVF technique. Some of these technologies can simply be seen as variants of IVF, others, bridge and cross the fields of human genomics and ART (Inhorn & Birenbaum-Carmeli 2008). Today, depending on geolocation, ART can be used across the globe to succour childless couples, enable solo-motherhood and fatherhood via surrogacy or gamete donation, for gender selection, to avoid genetic and chromosomal diseases, to preserve reproductive ability and most recently to enable births from uterine transplantations. According to Inhorn and Birenbaum-Carmeli (2008), ART have become a key symbol of our times. These technologies have not only allowed the formation of new families but have also changed and challenged individual, familial and collective identities globally (Inhorn & Birenbaum-Carmeli 2008).

The individual practice and use of ART in each country has been the subject of vast scholarship and research by social scientists and anthropologists globally. Multiple scholars in this field have helped advance our knowledge on the way both women and men across the globe experience infertility, motherhood, fatherhood, consumerism, and how culturally ART has come as a ‘saviour’ from the shame and burden of infertility or as a ‘challenge’ to test the religious perspectives of God and what is destined for every person.

The proliferation of research in this area, sociologically and anthropologically speaking, would be impossible to put together in a simple and just summary. However, in this chapter, I attempt to concisely describe global infertility, fertility through the Jewish lense and explore some of the works that have shaped our knowledge of the use and practice of ART on and by Jewish individuals. These

pieces are essential in the illustration of what some Jewish communities around the world experience when faced with infertility and the impact that ART has had on their lives.

Infertility

It is estimated that more than 80 million people worldwide struggle with infertility. The World Health Organisation defines infertility as "*a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse*" (www.who.int). According to the WHO, infertility generates disability, "*an impairment of function,*" which on the 2011 World Report of Disability ranked as the 5th highest serious global disability. Infertility has also been shown to impact the psychological health and wellbeing of the infertile individual (Denton *et al*., 2013). The inability to conceive can be caused by a wide and various range of physiologically male and female related factors. In men, the causes vary from sperm immobility to azoospermia. In women, from blocked fallopian tubes to premature ovarian failure. Despite the existence of male-factor infertility, globally, it is the woman who is firstly 'investigated' for infertility (Inhorn and Birenbaum-Carmeli 2008 & Inhorn and Van Balen 2002).

The geographic pattern of infertility prevalence indicates that the highest infertility rates are found in developing countries. The WHO estimates that 34 million women from these regions struggle with infertility that resulted from unsafe abortions and maternal sepsis (www.who.int). The highest prevalence can be found in Sub-Saharan Africa, particularly in West, Central and Southern African countries (Mascarenhas *et al*., 2012; Ericksen & Brunette 1996; Larsen 2000). This pattern has been greatly attributed to the elevated cases of untreated reproductive tract infections such as Neisseria Gonorrhoea and Chlamydia Trachomatis and other infections from unsafe obstetric practices such as abortions (Cates *et al*., 1985; Mayaud 2001; Collet *et al*., 1988). In such cultures, children are not only desired to fulfil a biological need but for "*social reasons*" (Inhorn and Van Balen 2002). For many of these couples'

reproduction becomes a mandatory obligation in order to circumvent cultural and social shame and severe stigmatisation.

The experiences of involuntary childless are noted to change according to religion, cultural system, time and place (Jenkins and Inhorn, 2003). For instance, some couples and individuals may feel pressured to conceive in order to obey the precepts of their religion and thus fulfil their religious obligations. Their failure to comply with the procreation imperative may result in ostracism and exclusion from their families, communities and social groups. Such is the case for many Muslim and Jewish couples (Al-Bar & Chamsi-Pasha 2015 & Taragin-Zeller 2019). The pressures to fulfil their fertility obligations may lead couples to undergo multiple infertility examinations and to undergo countless rounds of ART. Due to multiple social factors, when these couples fail to conceive, it is women in particular who are usually labelled as infertile. Depending on the culture and religion of each couple, many of these cases end with women being abandoned, shamed, ostracised, divorced or part of an unwated polygamous marriage (Gurtin 2013). As a result, infertility may lead to deep distress, depression and discrimination (Cui 2010).

In recent decades, the trend of voluntary delayed childbearing has been subject of interest and great public debate (Baldwin 2018). The London office statistics have shown that since the mid-1970s the average age of first-time mothers has increased from 26.4 years of age to 30.4 (ONS 2015 & 2017). As the age of motherhood in many Western countries continues to rise, so does the growing public health concerns over delayed childbearing and age-related infertility (Balasch & Gratacós 2011; Maheshwari *et al*., 2008; Baldwin 2018; Baldwin *et al*., 2018). Because of their choices, these women who postpone motherhood are often presented in contrast to the more normative parents and are usually described as ‘unnatural’, ‘risky’ and ‘selfish’ (Baldwin 2018, Budds *et al*., 2013, Ylannee 2016 and Lahad & Madsen 2016).

Impacts of facing infertility

There is no doubt that infertility impacts the lives of those that find themselves childless. It may be on a physical level, where individuals will question their physical ability to conceive or carry a baby to term, or on a relational level, encompassing relationships with spouses, parents, siblings, friends and community members. All of these relationships change due to individual, as well as, collective expectations of parenthood. On a deeper level, infertility can also impact the internal relationship that individuals' hold with their values, goals and expectations. For instance, important definitions of 'mother', 'father', 'fertile', 'woman' and 'healthy' can be broken down due to the challenges experienced as a result of infertility. Some of these redefinitions have been brought about due to the introduction of IVF. The birth of Louise Brown in 1978 gave infertile parents hope for a successful conception and thus a treatment for infertility.

Ardakani and colleagues point out that the birth of IVF and the ensuing ART have revolutionized the "*natural practice of biological reproduction*" (Ardakani *et al*., 2021). The permutations of IVF have reached out and affected almost every institution in socity. Of those most profoundly impacted we find family and kinship (Ardakani *et al*., 2021). Bamford confirms "*Technological conceptions pay attention to the way in which innovation in science and technology along with reproductive medicine have impacted how kinship is created and experienced*" (Bamford 2019). As a result, reproduction has gone beyond two individuals biologically producing a child. Instead it has developed into a dynamic process in which various social instituions closely interact underpinned by biological, environmental and social factors (Behjati-Ardakani *et al*., 2017).

The use of ART introduced new conceptions of motherhood, fatherhood and self-identity. As Unnithan-Kumar states "*Reproductive technologies in themselves do not bring out social transformation but it is in how they are made socially meaningful that their power lies"* (Unnithan-Kumar 2010).The rapid proliferation of ART and in particular the introduction of third-party gamete donation and surrogacy has led to the further fragmentation and reconstruction

of the '*traditional family'* (Ardakani *et al*., 2021). Further, the introduction of new genetic material into the familial equation has propelled the redefinition of parenthood, relatedness, gender and gender roles (Franklin 1997, 2006; Birenbaum-Carmeli & Carmeli 2010). In particular it has segregated parenthood into two major categories the "biological" and the "social".

Thus, ART have given our society 'modern families'. These families are composed of children that might have several different types of mothers and fathers. For instance, a child from a such family can simultaneously have a genetic mother (in the case of mitochondrial donation), a biological mother, a birth mother, a biological father and both a 'social' mother and father ('social' refers to those that raise the child and thus are involved in the nurturing side of parenthood).

The development and establishment of these families as well as the birth and acceptance of these new definitons have been substancially explored globally. Within the discipline of anthropology and sociology, various works have focused on the ways different cultures and religious groups accept and consume ART (Schencker 1999; 2007; Kahn 2000; Inhorn 2006; Inhorn & Birenbaum-Carmeli 2008; Inhorn *et al*., 2017; Birenbaum-Carmeli 2008; Tremayne 2012; Gurtin 2011; Kasstan 2019). Some of these works have explored the definition of family, kinship, parenthood and the way ART impact, challenge and expand the family norm ([b]Sandelowski 1993; Franklin 1997; Becker 2000; Birenbaum-Carmeli & Carmeli 2010). Other works have explored the ulization of ART by region, culture and religion. Due to the monotheistic pronatalist discourse, the Middle East has received particular significant scholarly attention (Inhorn *et al*., 2017). Vast scholarship has focused on Israel as a pro-natalist and ART accepting state (Birenbaum-Carmeli 2004; Teman 2010; Ivry 2010; Kahn 2000; 2002; Nahman 2013; Taragin-Zeller 2019). Similarly, on the Muslim Middle East vast scholarship has scouted the differences between the practice and the disputed acceptance of ART by the Sunni and Shia Islamic schools of thought (Clarke 2008; Inhon 1994; 1996; 2003; 2012; Inhorn and Tremayne 2012 and Al-Bar & Chamsi-Pasha 2015). These stirring works have greatly explored what Gurtin referes to as the

"*cultural construction of ART"* (2013). They have also studied the diferences between various religions and their varying accepting attitudes towards ART and the breaking down of kinship and the birth of 'modern families'. This scholarship has shown that the use of ART continue to affect the family form and kinship more than any other institution in society today (Ardakani *et al*., 2021) Ardakani and colleagues (2021) state "*the diversity of the cultural responses to ARTs is, therefore, a culmination of the interaction between social, political, legal, ethical and religious institutions in different cultures, determining the structure of the family and concepts of relatedness*". Thus, one thing is clear, there is much that can be learned about a society from their use of ART and their views on reproduction.

In order to step closer to the women in focus of this study, I now turn to the meaning, understanding and experience of fertility and infertility within the Jewish context.

"Be fruitful and multiply" vs "Bareness"

Fertility within a Jewish context has been charged as a communal quest for procreation of one's own family, for survival and for the replacement of the six million Jews that were lost at the time of the Holocaust (Gold 1988). This is part of the Jewish discourse that bases motherhood as a vital weapon to the survival of the Jewish nation. Motherhood within the Jewish context is what grants women identity and a place in society (Berkowitz 1997).

Further, when digging deeper and looking at the most important principles needed for a moral Jewish life we find procreation. While 'sex' before marriage is prohibited and only discussed before marriage, in what is known as *Hatan* (Groom) and *Calah* (Bride) lessons, sexual intercourse post-marriage is essential to fulfil the obligation of procreation. In an effort to remind us that only God can grant fecundity, it is commonly thought in Judaism that children are the product of a triadic effort between the man, the woman and God (Niddah 31a). Along with this belief sits vast amounts of Biblical literature that through

the stories of the infertility struggles of the Jewish matriarchs and patriarchs remind Jews nowadays of the necessity to comply with the blessing and obligation to procreate.

Further, the Talmud highlights fecundity as the purpose of 'creation':

> *"The world was created solely for the purpose of being fruitful and multiplying; in the words of the Prophet Isaiah, 'G-d did not create the world to be desolate, rather, He formed it so that it should be inhabited." (Talmud Bavli, Gittin 41b; Isaiah 45:18 & Ezekile 23:37)*

In more recent writings, Rabbi Menachem Mendel Schneerson, also known as the Lubavitcher Rebbe (Rebbe) one of the most influential Jewish leaders of the 20th century, used to say:

> *"Jewish wealth is not houses and money. Jewish wealth, which is eternal, is the observance of Torah and Mitzvahs, and bringing children and grandchildren into the world who will observe the Torah and its Mitzvahs." (Lubavitcher Rebbe Hayom Yom, 9 Nissan)*

Thus, for some Jews, the sole purpose of the creation of the world is to procreate and increase the human race. Bringing children into the world will often become the *mitzvah* that some couples will strive to accomplish at all costs be them physical, financial or emotional.

The extent of fulfilling the *mitzva*h of procreation also encompasses the number of children a couple should have. There are varying opinions as to how many children a couple should have in order to fulfil the obligation. *The Oral law and* in specific the Mishna records a great discussion held by Shammai and Hilel. The school of Hilel insisted that a couple should have a boy and a girl to reflect God's creation of man and woman *"Male and female He created them" (Genesis. 5:2).* Whereas the school of Shammai urged couples to have at least two boys *(Genesis. 5:2).* Actually it is common for couples to follow the ruling of Hilel and thus seek to have a male and female child. Further, it is commonly believed that having a large family is considered the greatest

Mitzvah. For many Orthodox couples, particularly for the Ultra-Othodox following this obligation will mean having families of 6-13 children (Kasstan 2019; Taragin-Zellar 2019; Birenbaum-Carmeli, 2008; Teman *et al.,* 2010). It is not a rarity for these couples to abstain from using any form of contraception (Taragin-Zeller 2019), as such, pregnancy becomes a way of life (Taragin-Zellar 2019; Birenbaum-Carmeli, 2008; Teman *et al.,* 2010). In England, Ultra-Orthodox Jews are the fastest-growing minority (Staetsky and Boyd 2015). They have the highest fertility rates in the country; estimated to be three times over that of the general English population (Kasstan 2019; Staetsky and Boyd 2015).

The importance to have children extends to divorce and remarriage for some couples. A childless man that has been married to the same woman for over ten years is permitted to seek a divorce to pursuit fatherhood with another wife (Mishnah Yevamot 6:6). On the other hand, a childless woman will simply obtain the title of "barren" and will be encouraged to marry a widow or a divorced man who already has children in order to quench her maternal instinct (Talmud: Yevamot 65a). It is difficult to estimate how many of the couples afflicted by infertility will practice this *Halachic* ruling. Thus, it is important to note that while men are encouraged to pursuit biological fatherhood, women are simply told to adopt the mentality that '*social motherhood'* will suffice.

The origin of this *Mitzvah* can be found in the *Torah*. It is believed in the Jewish Bible that after the world was created God blessed and commanded Adam and Eve to "*Be fruitful and multiply*" (Genesis 1:28). This blessing can be read again on several occasions throughout the Old Testament. It is a blessing given to Noah and his family "*And you, be fruitful and multiply; swarm upon the earth and multiply thereon."* (Genesis 9:7), to Jacob when he changes his name to Israel (Genesis 35:11), to Abraham *"I will make you very fruitful*" and Ishmael *"I will make him very fruitful and multiply him greatly"* (Genesis 17:20). The verses from which these references have been extrapolated, have for generations reminded Jews that procreation is not only an obligation but also a *mitzvah* that everyone must strive to complete. Simultaneously, these verses also remind

Jews that it is God who blessed the patriarchs and the matriarchs with fecundity.

Moreover, the Hebrew Bible is flooded with stories of the importance of having children and often these stories are marked by its protagonists' inability to conceive. The dominant picture that emerges from reading the Bible is that God has the power to "open the womb" and decide who will or will not be fertile. Further from reading the biblical stories, we gather that fertility can appear as a divine blessing, procreation as an obligation and infertility as a sign of moral failure and divine judgment (Moss & Baden, 2015).

The history of the Jewish nation begins with its pioneers' inability to conceive. In Genesis 11, we are told that Abraham marries a woman called Sarah who is described, *"was barren; she has no child*" (Genesis 11:30). As the story develops, we learn that God tells Abraham that he will be the father of many nations and that his descendants will outnumber the stars in the sky (Genesis15:5). Sarah famously doubts and laughs at God's power to make her, an old woman, fertile (Genesis 18:12). She encourages her husband to use her maid Hagar to have a child. Despite Sarah's doubts, God delivers the promised child to the old couple. It is between the age of 90 or 91 that Sarah gives birth to a son she names Isaac "*God has brought me laughter*" (Genesis 21:6).

To follow, a similar story is recorded with Rebecca, the wife of Isaac. The biblical descriptions that exist of Rebecca are entirely positive until we are told that Isaac must plead to God on behalf of his wife "*because she was barren*" (Genesis 25:21). Isaac's prayers were answered, and Rebecca got pregnant with twins. The *Talmud* hints for this story that it was Isaac who was infertile because he was the one who prayed to God (*Yevamot 64a)*.

Jacob and his two wives, Leah and Rachel are the next biblical individuals to face infertility. While the *Torah* goes to a large extent in describing Jacob's life, the biblical narrative is strikingly quiet on both women. However, what is said about them is focused on their ability or inability to conceive. After being tricked into marrying Leah, Jacob finally marries Rachel after working 14 years for his

then father-in-law. After Jacob and Rachel are married we learn that "*Rachel was barren*" (Genesis 29:31). Some sources say that Leah was hated by her sister as they were concurrent wives of Jacob. As a result, God "blessed" Leah with children and cursed Rachel with "bareness" in order to compensate for the lack of love Leah felt (Genesis 29:31). Leah mothered four sons: Reuben, Simeon, Levi and Judah. Then we are told that "*she stops bearing*" (Genesis 29:35). Leah has done nothing wrong, at least we are not given any reasons for her sudden secondary infertility but in order to keep having children, she gives her husband, Jacob, to her maidservant Zilpah (Genesis 30:9). Leah considers herself as a barren woman despite her four sons. Nevertheless, after Zilpah has Gad and Asher, Leah starts to conceive again. She gives birth to Issachar whose name means "*God has given me my reward*" (Genesis 30:18). After Leah has yet another son whom she names Zebulun:

> *"God has presented me with a precious gift. This time my husband will treat me with honour, because I have born him six sons". (Genesis 30:20)*

All along, through the names, Leah gives her children we see her desperation for love and respect from Jacob. Leah hoped that her fecundity would grant her a special place in her household. Leah goes on to birth a girl, which she calls Dinah. Upon seeing this situation, Rachel, who was still barren, calls out to Jacob *"Give me children or else I die." (Genesis 30:2)* Rachel seemed to be ashamed because of her inability to conceive and bear children. She appears to feel inferior to her sister Leah and the other maid-servants that helped in the creation of the 12 tribes and Dinah. Rachel was consumed with jealousy and feelings of inferiority. However, as Rachel confronts her infertility she does not pray, nor repent for any sin or ask for forgiveness of any kind, she does not turn to God, instead, she turns to Jacob who replies: *"Am I in the place of God who has withheld from you the fruit of your belly." (Genesis 30:2)*

Jacob's reply to Rachel reminds her that only God can grant children. This echoes the stories of the other matriarchs: Sarah and Rebecca. As it happened in their cases, it was believed that it was God, who controlled their ability to have children. This was also the case for Rachel, after much prayer and

devotion, she was able to conceive. Her ability to get pregnant is described as an act of kindness from God: "*God remembered Rachel and God heard her and God opened her womb*." Rachel's first-born son is called Joseph, whose name means "*God has taken away my disgrace*." (Genesis 30:22). With Joseph's name Rachel gives us an insight into what infertility felt like to her. She describes her situation using the Hebrew word "*herpa*", disgrace, which is used in a few other places in the Bible to describe uncircumcised men (Genesis 34:14), men with their eyes gouged out (1 Samuel 11:2), cowardice (1 Samuel 17:26), a rape victim (2 Samuel 13:13) and the collapse of the city walls of Jerusalem (Nehemiah 2:17). Infertility had made her feel disgraced, shamed, external to her community and not even her husband's love could appease her.

It can be assumed that for the matriarchs their infertility made them realise that only God could answer their requests and desires to have children. This was noted in the way they named their children: every child received a name that reminded both its parents and himself that he was granted by God. Additionally, it seems that in the Bible, infertility may appear as a test sent by God to challenge and encourage individuals to get closer to God. It appears that the key that opens the womb and blesses women with children is prayer and proximity to God. Further, the Rabbis in the *Talmud,* upon discussing the matriarch's stories conclude that "*God desires to hear the prayers of the righteous."* (Yevamot 64a)

Throughout time these stories have been read weekly and yearly by both Orthodox Jewish men and women. As such, for some, they have become an introduction to infertility and bareness. They have also become a reminder of the negative feelings surrounding the inability to conceive and the pressures women might feel as they become rejected from their societies and communities because of their childlessness.

The matriarchs were often referred to as barren and infertile. The Hebrew term for barren woman "*Isha Akara*" does not exist for men. As such, it places women culturally at the centre of infertility (Irshai 2012). Further, the aforementioned stories mostly related to female infertility. There are no known stories in the

Hebrew Bible that retell stories of male infertility. As such, the stories of the matriarchs have overtime helped build a stigma around infertility and thus have helped increase the patriarchal thoughts around women being the blame carriers for infertility (Irshai 2012).

When a woman cannot conceive and she visits the stories of the Jewish matriarchs, she could potentially start to see herself as barren, empty and abandoned by God. For some women, this could initiate a drastic change in the way they relate to her religion. Some women might become more or less observant depending on how they feel towards God.

On the other hand, these stories have also demonstrated that for some infertility can be overcome. They have illustrated that a plausible way to overcome infertility is through faith, prayer and by building a stronger relationship with God. As such, these stories may give courage to many women today struggling with infertility. Further, for some Orthodox Jewish women, the matriarchs have become the epitome of faith and hope. While they struggled with what we would nowadays call “unexplained infertility” they all managed to become mothers by the hand of God. The infertile matriarchs have become metaphors for motivation, comfort, consolation and hope for the future.

The pressures of a pronatalist religion

When considering the meaning of infertility, conception and the obligation to procreate one must take into account the pronatalist view that the Jewish religion takes towards (in)fertility treatments. The *Halacha,* commonly known for its rigid and unwavering ‘fence’ like structure, when faced with infertile couples suddenly bends over backwards to allow even the most controversial, unusual and otherwise restricted treatments. While there have been and continue to be debates on who establishes Jewish identity on the cases of surrogacy and egg donation, the vast and wide array of ART are loosely permitted to Orthodox Jewish couples seeking parenthood (Schencker 2013; 2008; 2007). Usually, cases are discussed on a case-by-case basis by a

Halachic court of Rabbis or by the couple's Rabbi depending on the severity of each case (Ivry 2010; Kahn 2000).

There are several explanations for this uncommon open and 'lenient' aspect of the *Halacha*. The first explanation revolves around the first commandment given to man, "*Be fruitful and multiply*". This commandment is one that Orthodox Jews comply with and one that helps determine and establish, their faith, their life and their duty in this world. Parturition rates have risen in the Orthodox Jewish population from an average of six to seven children per family in the 1980s to eight children per family in 2008 (Friedlander & Feldmann 1993; Hetzroni 2009). Towards the stricter side of Orthodoxy, The Central Bureau of Statistics in 2019 confirmed that in their reproductive years, most Ultra-Orthodox Jewish women birth at least seven children each. Pregnancy, for these women, is a way of life, they spend the majority of their life either pregnant or caring for children (Ivry *et al*., 2011; Teman & Ivry, 2011; Birenbaum-Carmeli, 2008). In a study carried out by Ivry and colleagues, the majority of Ultra-Orthodox women interviewed described pregnancy as "*a woman's God-given mission*", "*participation in creation*", "*fulfilling my role*" and "*the reason why I came into this world*" (Ivry *et al*., 2011). Further, the women from the fore mentioned study were all from families of eight to eighteen siblings. Large families are commonplace for Ultra-Orthodox Jews. Moreover, for many Ultra-Orthodox Jewish women this pregnant "*way of being*" becomes a distinctively gendered route of religious pity; a particular way to "*worship*" and be closer to God (Ivry *et al.,* 2001; Teman and Ivry 2011).

The second, a more straightforward and statistically important reason for the "all is allowed" perspective of the *Halacha* stands on the collective Jewish aim to replace the six million Jewish souls that were lost during the Second World War (Birenbaum-Carmeli 2004). Similarly, when looking at the state of ART in Israel, a predominantly Jewish country, we are faced with the third reason; political strength in numbers (Benjamin and Haelyon, 2002). This can be further broken down into two main reasons; the Zionistic ideology and the religious establishment of Israel. Zionistic ideology prioritizes increasing Jewish birth rates to ensure demographic advantages due to Israel's position in the Middle

East. The Jewish religious establishment prioritizes large families committed to the religious way of life in order to shape Israel's cultural characteristics (Portuguese, 1998).

Over the years, due to these ideologies, Israel has developed into the world's leading 'IVF Capital' with a ratio of 22 IVF units per seven million people (ESHRE, 2014; Israel Ministry of Health, 2013; Collins 2002). In line with the country's pronatalist attitude, all forms of ART are practised, allowed and are publicly funded to every Israeli citizen irrespective of religious or nationalistic affiliations (Rosenblum, 2013; Gruenbaum *et al*., 2011; Bundren, 2007; Shalev, 1998; Birenbaum-Carmeli and Inhorn, 2009). Including all women aged 18-45, single or married and from all sexual orientations, extending up to the birth of two children (Birenbaum-Carmeli, 2004). When using egg donation, treatments are funded for women up until the age of 51 (Yogev *et al*. 2003). The state of Israel also grants women and their partners to some extent, generous paid leave and employment pension while they undergo fertility treatments. This ability and almost encouragement by the state has reputed Israeli women as the most active consumers of ART (Collins, 2002; Nyboe Andersen *et al*., 2007; Schenker, 2003). The vast institutional support Israeli women receive for these medical treatments has also led them to cooperate with any treatment, at any time for however many cycles are needed until they become mothers (Remennick, 2000; Landau, 2003; Portuguese, 1998).

As a result, Israeli women have also become subjects of vast anthropological investigation as they have developed into conflicted 'users' of ART. Various studies have demonstrated the immense pressure Israeli Jewish women face when it comes to deciding if to and how to become mothers and more importantly when to stop trying to conceive (Benjamin and Haelyon 2002; Haelyon 2006; Remennick 2009). Remennick's empirical fieldwork with 73 Israeli women from three distinct sectors of Israeli society described the deeply embedded pressures Israeli women feel when it comes to childlessness and infertility. In Rotem's words, a participant from Remennick's study, "*Since IVF became widely available and common in Israel, a childless woman can no longer remain in the shadow, she is expected to step into public spotlight and*

*seek solutions to her private problem" (*Remennick *2009).* Childless women are not a common sight in Israel (Remennick 2009). Those who do decide to remain childless, as Rotem explains, are seen as "*selfish women*". The Israeli mentality takes this further by associating infertility with the inability to take part in the collective mission (Haelyon 2006). Further, deepening women's guilt when they fail to conceive (Haelyon 2006). Miri another participant from Remennick's study, was childless despite three unsuccessful years of IVF treatments, she emphasised that "*Jewish women in Israel cannot afford to be selfish*". The duty to Israel and the Jewish nation was so embedded in her will to become a mother that she felt childlessness in Jewish women "*puts in jeopardy the future of our people" (*Remennick 2009*).*

Israeli Jewish women have seen themselves caught in a battle between their maternal instincts and a duty to the Israeli State and the Jewish Nation as a whole. Nonetheless, motherhood always wins. The pursuit of motherhood for these Israeli Jewish women has been demonstrated to take over their thoughts, their actions and their day-to-day life.

Vast scholarship has been dedicated to the way Jewish women experience infertility and use ART around the world. The majority of studies have concentrated on Israel and North America due to the elevated Jewish populations in these localities. The next section will disscuss and highlight some of this scholarship to explore the views, attitutes and experiences some of these Jewish women have of fertility, pregnancy, infertility and womanhood.

Jewish women's reproductive experiences

Procreation has, is and always will be greatly advertised and encouraged to every Jewish woman irrespective of the denomination or religious affiliation that she finds herself in. This clear pressure resulting from either the Jewish commandment to procreate, the grave minority of Jewish population or the pressure to protect the relatively novel State of Israel, continuously challenges Jewish women to try to "do their part" for their people, their state and their nation. This continuous struggle leads women to permanently question their

identity, their place and role within their community, society and families. As Marcia Inhorn, who analysed the perceptions of womanhood and motherhood among Egyptian women, states "*infertility as a barrier to motherhood… throws into question a woman's gender identity, her sexual identity and her very sense of selfhood*" (Inhorn 1996).

This section will explore Jewish women's experiences of pregnancy, infertility, their definitions of womanhood along with the special relationship that exists between Rabbis and IVF doctors. In order to facilitate the discussion of experiences, the literature will be explored in three themes, 'in relation to God', 'a fulfilled woman' and 'Rabbi vs Doctor'. Each theme will help understand how some Jewish women perceive their destiny, God's role as the commander of people's unique path in life, what it means to be a fulfilled woman and lastly the relationship between Rabbis and Doctors. Further, with these themes, I wish to highlight some of the views that Jewish women hold on reproduction, fecundity and infertility. Due to the limited number of studies conducted solely on Orthodox Jewish women this section will focus on studies carried out on Jewish women irrespective of their denomination.

In relation to God

In order to begin to understand the role that women give God in their life, I turn to the uncertainty and fear that women experience when they are pregnant. Uncertainty during pregnancy has previously been described as "*universally experienced*" (Sorenson, 1990). Some women can experience this uncertainty due to several aspects of the gestational experience and its conclusion, for instance, the health of the foetus, potential maternal complications, possible pre-term birth and the length of pregnancy and course of birth (Melender and Lauri 2002). Uncertainty in pregnancy, in contemporary Western societies, is fuelled by the discourse of risk (Teman *et al*., 2010). Women are consequently fed by public health messages that encourage them to avoid risky behaviours (Mitchell, 2010). Technological interventions, such as genetic testing and screening, that are usually advertised as highly accurate in predicting babies' health, are vastly encouraged to mitigate uncertainty (Finkler *et al*., 2003;

Mitchell, 2010). The majority of women who opt for prenatal testing seek to mitigate uncertainty and gain reassurance (Marteau *et al.,* 1991; Browner *et al.,* 1999). However, these same women might not fully understand that almost all foetal anomalies cannot be cured and that the only prevention method is selective termination of the affected foetuses (Browner, 1997). Scholars in the past have argued that faith may ameliorate the uncertainty that women face by increasing peace of mind in finding meaning and hope (Schumaker, 1992; Ahmed et al., 2006; White, 2009). Orthodox Jews are generally avid users of medical technology but when it comes to prenatal diagnosis and screening it is not so clear (Mittman, 2005). Teman and colleagues explored a case study of Orthodox Jewish women to understand how faith shapes and helps women manage the uncertainties they faced during pregnancy (Teman *et al*., 2010). These women ascribe to a worldview that can be summarised as "*divine providence*", it imparts the belief that it is God who oversees the universe and that humans are not in control of their own destiny (Teman *et al.,* 2010). This concept extends to and includes the understanding that God has an overarching plan and mission in life for every person. In the words of Shainy a mother of four "*We're not God. God chooses to make things happen. Who knows what he chooses? Who knows why he chooses*?" (Teman *et al*., 2010). Teman and colleagues state that the major difficulty for individuals who adhere to this worldview lies not only on their faith in God but also on the trust and certainty that God will take them on the right path, even if this path is not what they would have desired or envisioned for themselves (Teman *et al.,* 2010). The authors further described that during their interviews the term an '*ideal woman of faith'* emerged from the way women described other women who had "*proved the strength of their faith and certainty through their unwavering commitment to carrying out any task God had envisioned for them*" (Teman *et al*., 2010). These women faced the uncertainties of their predicaments with a strong and unwavering faith and conviction that what God had decided for them was best life plan. The *'ideal woman of faith'* can be further described in Sheterna's words "*God's giving me another blow- I'll deal with it and we'll go on. He'll give me a healthy child*" (Teman *et al*., 2010). Sheterna here described a woman who had faced four miscarriages but who still chose to see her ordeals

as being sent by God. This woman similarly thought that it would be God too who would remedy her misfortunes.

Further, in Teman and colleagues study, women faced the uncertainties of pregnancy as a '*test of faith'*. Chavi, one of the participants explains "*a test of faith is when you're given something that you would normally, not necessarily want. And your faith is tested to be able to understand how this is really for the best*" (Teman *et al*., 2010). The concept of '*test of faith'* partly allows Orthodox Jewish women to find meaning in an experience that otherwise could be understood as "*senseless suffering*" (Teman *et al*., 2010). However, as Nechamie stated, knowing that you are being tested by God does not take away from the anxiety and struggle of the *'test'* (Teman *et al*., 2010). The women in their study demonstrated that they had no power, choice or control over their destiny. Further, their rejection of prenatal testing became a proclamation of their deep faith and belief in God, thus, the outcome of their pregnancy was entirely dependent on 'divine providence'. Doing so, these women embodied the ideal gendered model of faith. While for these women it was easy to reject prenatal technologies, the same was not true for how they felt about reaching the status of *'the ideal woman of faith'*.

There is an overarching belief that God controls the destiny, life path and mission of every human being. As noted above some Jewish women believe that God not only sends them 'the good' but also 'the bad'. The bad which they believe to have been sent to strength people's connections to God. On a more nuanced level, there is a more specific belief that children are God-given and that it is one's duty to pursue motherhood. As stated by Meir, a participant from Taragin-Zeller's Israeli multi-sited ethnography, '*Conceiving God's Children*', "*He is God's child. We don't make children. We accept them as a blessing from God*" (Taragin-Zeller 2019). This is the reproductive view that many Orthodox Jews hold. Further, demonstrated in her study which explored the way Ultra-Orthodox Jews negotiate birth control and family planning, Taragin-Zeller uncovers the hesitation some individuals feel towards contraception, as with its use, reproduction is no longer a sphere of life in which God's presence is essential but rather a place where "*scientific knowledge threatens to displace*

God from the human/ godly partnership". Further, as another participant, Yitzchak, questions *"how do I make room for God so that when I sit with my kid I can tell him he is a child of God?" (Taragin-Zeller 2019).* Delaying or postponing childbearing takes away from the path that 'God created' for each individual. In another study conducted by Ivry and colleagues, which explored '*God-sent ordeals'* and Orthodox Jewish women's use of pregnancy as a gendered route to piety, pregnancy was described as a divine mission, the work of fulfilling God's purpose (Ivry *et al*., 2011). Orthodox Jewish women, as demonstrated above, will go above and beyond any challenge in order to bring into the world the 'children of God'. The women from this study described pregnancy as "*essence, nature, participation in creation, a higher purpose and a woman's God-given mission*" (Ivry *et al*., 2011). However, the meaning that Jewish women give to motherhood can be further questioned and developed in order to understand what a 'fulfilled' woman is according to these Jewish women.

A fulfilled woman

Motherhood has often been compared to femininity and womanhood. As a result, childless and infertile women are almost always deprived of the most central element of their gender identity (Miall, 1986; Stanworth, 1987; Whiteord & Gonzalez, 1995). In this context, motherhood has the power of constituting the feminine subject and defining her social value (Phoenix & Woollett, 1991). Feminist scholars in the past have claimed that motherhood myths and ideologies originated from patriarchal power systems, which have sought to sustain hegemony and authority (Inhorn 1996; Becker 2000; Rothman, 1989). In order to understand the meaning that Jewish women give to motherhood I will refer to Inhorn's view on motherhood, "*the importance of motherhood… is perhaps best understood from the perspective of the infertile – from those who are barred entrance to the cult of motherhood*" (Inhorn, 1996). Most cultures consider infertility as the opposite to motherhood, thus rendering it a female problem (Remennick 2000; Inhorn 2002; Hollos 2003; Jenkins 2002; Sundby and Jacobus 2001; Nahar *et al*., 2000). Further, as Lober suggested, it is women who mostly bear the social onus of childlessness (Lober 1989). Inhorn

suggests, "*Deficiency associated with infertility covers many aspects of female identity, such as sexual identity, normative femininity and maturity*" (Inhorn, 1996). It appears that women may lose the meaning of their identity when motherhood is not fulfilled. Moreover, when infertility becomes a barrier to the establishment of motherhood, a woman's gender, identity and sense of self are questioned (Inhorn, 1996). When focusing on the Jewish culture, the idea of infertile woman has for generations been integrated on the Hebrew language in the form of '*Isha Akara'* meaning barren woman (Irshai 2012). Infertile women may, as such, appear as victims of infertility because of the denied access to the collective of fertile women (Berg, 1995). Therefore, in this context treating infertile women is understood as rescuing women from a position that is culturally unacceptable (Benjamin & Haelyon, 2002).

Moreover, as Pfeffer (1985) suggested women's gynaecological visits and illness may train women to accept their bodies as pathologized. Gatens (1992) explained that as a result, women's bodies are inferiorised. With regards to infertility, it is easy for women to accept the sole 'blame' for the couples' infertility problem. As Benjamin and Haelyon found in their interviews with 22 Israeli Jewish women, it is easy for women to publicly accept infertility and as such publicly pathologise their bodies (Benjamin & Haelyon, 2002).

Haelyon's study of 25 infertile Israeli Jewish women undergoing IVF highlighted some of the views that Jewish infertile women held of femininity, womanhood and motherhood. In Niva's words "*femininity is mainly connected to my body. Feminine women are those who are pregnant*" and in Nofit's words "*to be a woman is to give birth. I believe that this is the essential distinction between man and woman*". (Haelyon, 2006). Women in this study perceived conception and childbirth as a gain in their identity but as they had not yet succeeded in becoming mothers they felt they were lacking that advantage (Haelyon, 2006). As Hanit adds "*Femininity is a privilege… I'll feel feminine when I achieve motherhood. Merely walking in the street with a pram will make me feel feminine*" (Haelyon, 2006). Motherhood for these women was quiete literally seen as "*the peak of human creation*" as Dina another participant from Haelyon's study highlighted.

Remennick's study of the infertility experiences of 26 Israeli Jewish women highlighted similar views. While these women lived and understood the Israeli pro-natalist discourse as the constant social pressure to push them to procreate they still defined their longing for motherhood as instinctive, natural and a built-in feature of every 'normal' woman (Remennick 2000). As Eti describes, "*Maternal instinct is essential in every woman, and in a Jewish woman it is double. If we want to be true to our nature, we just have to become mothers*" (Remennick 2000). Shira describes the way infertility made her feel "*I just dont feel as a whole woman, something very central is missing*" (Remennick 2000). For these women, the only way to feel like 'real' women was to become mothers. Therefore, the main way to fulfil their womanness was to achieve the goal of motherhood. This goal justified any means. As Ravit from Haelyon's study put it "*I kept telling myself that I must cope with it… that I have to do anything for a child*" (Haelyon 2006). For some, this meant undergoing several rounds and several years of infertility treatments, for others it meant becoming solo-mothers. These women felt that they had no choice as one informant stated: "*if you know there is a problem, it is your only moral choice to seek medical solution. There are no women I know who just accept the verdict of childlessness and do nothing about it*" (Remennick 2000). For these women, their infertility was overemphasised because of their Jewish Israeli societal values. One participant summarised how most women felt "*you become totally obsessed with achieving pregnancy, it becomes your only focus and preoccupation in life*." (Remennick 2000). While these women recognise how deeply they are affected by the Israeli climate their lives only remained meaningful insofar as they were in the journey of becoming pregnant. The women admitted to pressures such as, the over-medicalization of pregnancy in Israel along with the societal pronatalist views which focuses on the motherhood imperative. As a result, they felt pressured to undergo infertility treatments while not being able to separate their internal instincts from what was expected from them (Birenbaum-Carmeli 2003, 2004; Shalev and Gooldin 2006). This very notion was best described by Liat "*I don't know how to decouple my own intrinsic wishes from what is expected from me as a woman*" (Remennick 2009).

Jewish women are faced with varying levels of pressure to procreate. While these pressures may vary according to their geographical location as is the case with Israeli Jewish women, two factors never change. First, the obligation towards the commandment to be "*fruitful and multiply*" and secondly their own intrinsic maternal instincts, which as the women described above, is "natural" in every woman. For these women, the meaning of womanhood goes hand-in-hand with fecundity, fertility, motherhood and pregnancy. These women did not feel complete or whole as women if they were not able to achieve their goal of becoming mothers.

Rabbi vs Doctor

The accessibility and the leniency that *Halacha* places on ART has encouraged many infertile couples, who as a result of the pressures they feel to procreate, to be faced with multiple rounds if not years of infertility treatments in order to attain their desired children. In such cases, putting God aside figuratively, there remain two authoritative figures in the lives of such individuals. First the Rabbi as an angel from God and second the Doctor as a messenger of God. Relationships with either of these two authorities are not often smooth and thus this becomes another challenge in the life of an infertile Jewish woman. This section discusses some of the studies that have explored the relationship between Jewish women and their Rabbis and between the women and their doctors alongside the relationship that exists between Rabbis and IVF doctors in Israel particularly.

Previously, ethnographers have greatly reported the views of religious experts on ART (Clarke 2009; Inhorn 2003, 2006; Kahn 2000; Paxson 2004; Roberts 2006, 2007; Tremayne 2009) and their role in shaping the legal framework of the technologies (Clarke 2009; Inhorn 2003, 2006; Tremayne 2009). Rabbis have the power to negotiate *Halacha* to make '*koshe*r' any reproductive technology they see fit, including surrogacy and gamete donation (Kahn 2000;

Teman 2010; Seeman 2010). Rabbis are also the 'guardians' of the kinship ties between ART users and their resulting children to ensure that the legitimacy of children is known and kept (Ivry 2010). Like for Suni Islam, Judaism is a religion that is deeply concerned with the legitimacy of children resulting from ART as this ensures religious identity (Inhorn 2006; Clarke 2009). A Rabbi thus must ensure that all *Halachic* regulations are followed, maintained and understood when considering and discussing infertility treatments. The Rabbi has a particularly important role in the lives of Orthodox Jews. As the strictest followers of *Halacha,* Orthodox Jews rely on Rabbis to ensure that they are following and observing Jewish law as it is required of them.

Remennick's study on infertile Israeli Jewish and Arab women's views of ART highlighted that some women glorify ART and simultaneously attribute supernatural powers to medical science and its practitioners (Remennick 2009). Women in this study had faced infertility for several years, some remained childless. These women had adopted the view that reproductive technologies equated hope (Bekcker 2000). As such, their IVF doctors were their last option to motherhood. These women also had exaggerated and almost unrealistic expectations as to the success rates of their IVF treatments (Remennick 2009). In simple words, as Ayelet describes "*Reproductive medicine is not just another medical speciality; it has a salient role in the life of Israeli Jews. I see it as special and even sacred*" (Remennick 2009). As best described by Polly, a participant from Becker's ethnography with infertile American women, "*to go through in vitro, to start you have to believe in miracles*" (Becker 2000). The women in Remennick's study adopted this view and further thought that infertility treatments were a blessing that fuelled *"their main hope for motherhood and a good family life*" (Ayelet, Remennick 2009). This faith in the treatment was also placed on those who prescribe and practise them. The vast majority of Israeli Jewish women tended to glorify medical workers and in particular IVF specialists for their "*heroic endeavours to give babies to women striving for motherhood*" (Remennick 2009). Ilanit another participant from Remennick's study further stated: *"My IVF doctor is going to be my idol, the second most important man in my life after my husband".* She then explains how her infertility is due to her husband's low sperm count. Ilanit

muses that the doctor will help them with sperm selection and fertilization. Therefore, he will "*become sort of a third parent, an essential figure for the future of our family"* (Remennick 2009).

On another level as women from Benjamin and Haelyon's (2002) study described there is a deep and unwavering trust that these women place on their doctors. One of their participants stated: "*I trusted my doctor so deeply that I would not take the anaesthetic before my doctor came to my room to assure me that everything was ok*" (Benjamin & Haelyon, 2002). Another participant explained how for an entire year her doctor never considered that her partner should get tested. When asked if other possibilities were ever discussed she simply stated "*No! I trusted my doctor*" (Benjamin & Haelyon, 2002). The unwavering trust and faith that these women placed on their IVF and gynaecological doctors remind us of the trust that exists between a parent and a child. As another participant from the study illustrated "*like a child who holds the hand of an adult and wants to go with her anywhere. I used to throw my body on the gynaecological chair in a kind of trust… a blind trust*" (Benjamin & Haelyon, 2002). It is this "blind trust" that allows women to undergo countless infertility treatment cycles in hope of motherhood. On another level, IVF users cannot afford to lose this trust and faith in their doctors; for it is this faith that keeps them going in their difficult journeys to motherhood. Further, in Benjamin and Haelyon's (2002) study it was identified that women's continuous cooperation with the various demands from IVF doctors was dependent on the faith the women had on their doctors. It is these feelings of faith and trust that enable women to face the physical and emotional challenges of IVF (Benjamin and Haelyon 2002).

While the Rabbinic and medical authorities may appear at opposite sides of the spectrum this is not always the case. In 'Kosher Medicine' (2010), Ivry describes the intricate but plausible relationship that exists in Israel between IVF Doctors, Rabbis and infertile women. Ivry's ethnographic work with infertile Orthodox Jewish couples and Rabbis in Israel, focuses on two processes, the medicalization of Jewish law and the '*koshering*' of medical care. Based on her findings, Ivry states that in Israel it is relatively easy for Rabbis, who have biomedical knowledge, to use it and have hands-on involvement in infertility

treatments. As a result Rabbis establish a physical presence in IVF labs (Ivry 2010). Further, in Israel, this relationship is solely possible due to some Rabbi's positive views of ART and their affluence in biomedical language (Seeman 2010). An example of this triadic relationship can be understood using Rabbi Hayim's discussion of a particular case with an infertile couple.

> *"A couple called me ... Their doctor told them they should undergo hysteroscopy and therefore should not be together [have sexual relations] until the procedure was complete. The test was scheduled for a few days after the woman had immersed in the Mikveh [ritual bath, which then permits her to be with her husband after about fourteen days of abstinence following menstruation]; it had been a long time since they could be together because she had problems, and now this hysteroscopy, and they don't know what to do. So I told her, "I don't know, I haven't heard of this recommendation." I called another doctor—a specialist in hysteroscopy, and asked him, "Tell me, is this recommendation routine?" So he says, "Look, doctors say this to patients, but medically speaking, it has no [basis]. The only danger that could be is that if the couple are together then she might become pregnant, and the hysteroscopy procedure could affect the pregnancy ..." So I said OK, so that's what it's about. I called their doctor and said: "The couple said that ..." He said, "Yes, this is the medical recommendation." I said, "Why?" He said, "We don't know exactly, but we're afraid that ... " So I said, "Look, let's do a simple calculation, simple logic ... , their problem is that she can't get pregnant, I can't remember how long, maybe three years? Five years?" So I say, "What are we afraid of? If she does become pregnant, what are the chances that the hysteroscopy will harm the pregnancy?"... So he says: "I don't know, there is no indication in the literature ..." Maybe he said two percent or five percent ... So I said, "OK. And what are the chances that she will become pregnant this particular time? It has not succeeded for the last three years. Now, let's presume that she does become pregnant this time, what are the chances that the pregnancy will end because of the hysteroscopy? Another five percent? ... So why would you mind giving them [permission to have sexual relations]?" He said, "You know what, I never thought about it." It was too hard for him to tell me "OK" but in the end he said, "OK, so they can do whatever they wish."*
>
> *(Rabbi Hayim, Ivry 2010)*

The Rabbi takes matters to his hands and makes a few phone calls to some doctors to try to help the infertile couple. Various points stand out from this

narration. Firstly, the Rabbi's ability to understand and use medical jargon. Secondly, the Rabbi's due diligence, dedication and network. It is clear from the quote that the Rabbi holds a privileged position among fertility professionals and infertile individuals. Further, while the discussion does not require any clarification on the remit of *Halacha*, the Rabbi's field of knowledge, it is clear that the Rabbi still challenges the inner logic of the medical restriction (Ivry 2010). Thus, in this case, the Rabbi appears as the spokesperson of the couple.

Chana, another participant from Ivry (2010), recalled her experience with a Rabbi from a Jewish organisation based in Jerusalem that helps couples who undergo infertility treatments. In Chana's words "*He (Rabbi) sat with us with all the medical data and told us what he advised us to do. He suggested a number of directions and said specifically whom we should call"* (Ivry 2010). The Rabbi gave and explained to Chana the summary of her diagnosis. In this conversation, he also gave the couple "*his blessing*" and told the couple to see the Jewish organization if they needed any more help (Ivry 2010). This is the sort of behaviour that Israeli Jewish couples' expect from their Rabbi and more specific from Rabbis who work in such organisations. Additionally, these biomedically affluent Rabbis are advocates for couples who would otherwise not be able to communicate or understand their doctors.

When looking at the Doctors' opinions of this triadic relationship, from Ivry's study, we find stories like that of Shaul a Professor "*If this community feels that they need additional supervision [in the lab] then this is their right. It is the right of every human being to ask for another opinion, additional to medical opinion ... theoretically I could have said that I would not work with religious people because they do not go according to my line. But what is this? My line is not sacred. One has to be considerate toward other people who have a faith, who have [another] opinion."* In a lecture Professor Shaul delivered in 2009 he further stated *"In spite of the diversity, the halacha for our patients is the 'urim and tumim'. One would sooner die than violate Halacha".* Professor Shaul understands the value *Halacha* has for his Orthodox Jewish patients. As such, accepting a Rabbi into his lab or his practice will only facilitate the treatments for these couples. Further, as part of the doctors' humble and respectful position

towards Jewish law, doctors in Ivry's study generally emphasised their own lack of knowledge and explained this very point as the rationale for their part in the collaboration. *As* Doctor Baruch, another participant explains "*I am not an expert in halacha so their (Jewish organisation) services actually help me to work with the couples… I am highly supportive of any intervention like this because it helps us reach the goal that we are all working for: a child is our goal" (Ivry 2010).*

It appears that Rabbis and Doctors are not neccessarily conflicting authorities. While this scholarship has been carried out in Israel where it is much more likely for Doctors to be familiar with *Halacha*, it is still noteworthy to observe the way Doctors and Rabbis communicate in a way that facilitates and ameliorates the infertility experience of Jewish couples.

The literature discussed in this section has helped to highlight some significant aspects of the lives of Jewish women. Firstly, these are women that believe that God has the power to control their destiny and path. They believe that God often sends individuals challenges which are sent to test one's faith and thus improve one's relationship with God. Secondly, some Jewish women define womanhood by the ability to conceive and become mothers. This definition often leaves infertile women at a loss in their identity as there is a gap between where they are and where they think they should be in order to be fulfilled women. Lastly, infertile Jewish women not only rely on God when facing infertility but also on their Rabbi and their infertility Doctor. As a result of reproductive medicine and infertility in Jewish couples, a special relationship develops between Rabbis and Doctors where at the centre we find the infertile woman. These aspects will be used when exploring the lived experiences of infertile Orthodox Jewish women living in London.

CHAPTER 3: METHODOLOGY

In this chapter I will explain the way this thesis came about and how it was thought through to fruition. This will be described in eight parts: quality in qualitative research, my background which will discuss and explore my positionality and reflexivity within the study, literature review, ethical considerations, background research, and recruitment of “infertile” Orthodox Jewish women, interviews and lastly analysis.

This thesis is the culmination of four years of: literature and background research, field work and writing. The first year, 2016-2017, I spent reading and gathering the scholarship that was used to build and prepare for the field work. During this time I also learnt about qualitative research and how this research technique would be the most beneficial to answer my research question. I developed my knowledge on qualitative studies and I developed the skills I thought would be essential to carry out this work. Some of these skills included, interviewing skills, transcribing course, coding and thematic analysis, journaling and reflexology. This training was available as part of the UCL doctoral school. Being part of the Institute for women’s Health at UCL also allowed me to network with other members of the institute and learn from the research they were doing. In doing this I was able to build a network of qualitative researchers that I did not necessarily have as part of my direct research group. During this year I also was able to further my knowledge on Jewish texts, *Halachot* to ART and practice of Orthodox Judaism. I learnt to understand the way Orthodox Judaism is practiced on a day to day basis and in doing so I was able to explore the limitations and questions that might arise from *Halacha* with regards to ART. This year was important as it helped me create a literature and support base for my research and data collection.

As part of the preparative work for the main data collection in this study I spent six weeks in Israel interviewing IVF professionals, social workers and Rabbis. This helped me build my knowledge of Jewish law and practice of ART in a predominantly Jewish country. In addition I conducted ten interviews with Orthodox Rabbis in London to try to understand how accessible they would be

to women and if they were knowledgeable on the fields of ART. These interviews were followed by 17 semi-structured conversations with women who did not struggle with infertility, this was in order to try to understand the level of knowledge some Orthodox Jewish women in London have of ART. Lastly as part of background research, I carried out a focus group with women undergoing the Ma'ayan programme in order to understand how sex, relationship and reproductive health education is delivered to the Orthodox Jewish community. This research further helped me enter North West London communities and start conversations with key people in the community in order to gain familiarity with community members and with Rabbis.

Quality in Qualitative research

Qualitative research can be of great value and contribution to many sectors in the field of medical practice, policy making, health administration and service provision and psycho-social aspects of patient-care (Whittemore *et al*., 2001; Dixon-woods *et al*., 2004; Carter *et al*., 2009; Egbunike *et al*., 2010; Wyverkens *et al*., 2014; Hammarberg *et al*., 2016; de Lacey *et al*., 2015; Leung, 2015; Balde *et al*., 2017 & Forero *et al*., 2018). Qualitative research aims to answer questions of "how, what, where, why and who" by recognising and making sense of patterns among words expressed by those afflicted or affected by the research subject (Leung, 2015). In essence qualitative research aims to understand human experiences, attitudes and views in order to paint a meaningful picture of human living experiences (a)Sandelowski, 1993; Hammarberg et *al*., 2016 & Leung, 2015). This science does not aim to presume which variables are important but rather discover which are relevant by observing behaviours, speaking to participants and reading texts (Carter *et al.,* 2009). Further, it gives researchers freedom to become immersed in the research process while creatively considering the meaning in the data (Atkinson *et a*l., 1991).

When trying to answer the research question of this thesis, what are the experiences of infertile Orthodox Jewish women living in London, qualitative

research techniques offered the best way to approach the study group and collect the data. Some research techniques used in this thesis included: purposive sampling, semi-structured interviews, transcribing and familiarity with interviews and thematic and descriptive analysis (Maxwell, 2005). These techniques allowed me as a researcher to gain proximity to the study group and gather from the women directly their infertility experiences. This close proximity was important to portray a meaningful picture of the women interviewed and their experiences. Qualitative research further allowed me to approach these women in a less controlled, more open and flexible way (Carter *et al.,* 2009). Moreover, it allowed me to study these women as individuals in their ordinary, complicated and changing state: for some women from infertile woman to mother (Carter *et al.,* 2009).

Despite the benefits of qualitative research there is difficulty in appraising the quality, authenticity, accuracy, validity, transparency and replicability of research conducted in qualitative ways (Whittemore *et al*., 2001; Dixon-woods *et al*., 2004; Carter *et al.,* 2009; Leung, 2015 & Treharne & Riggs, 2015). A large and divided body of scholarship exists on the “rules” that help to assess these criterion in qualitative research (Lincoln & Guba, 1985; Sandelwoski, 1986; Guba & Lincoln, 1989; Marshall, 1990; Eisner, 1991; Emden & Sandelwoski,1998; Seale, 1999; Mays & Pope, 2000; Yardley, 2000; Pope & Mays, 2006; Flick, 2007; Kitto *et al*., 2008 & Kuper *et al*., 2008). However the most highly cited system for checking the quality of qualitative research includes that developed by Guba, Lincoln and colleagues (Guba, 1981; Lincoln, 1995; Lincoln & Guba, 1986 & Lincoln *et al*., 2011). Their work focused on assessing five key concepts that can assess the quality of qualitative research: credibility, transferability, dependability, confirmability and authenticity (Lincoln & Guba, 1985) see **Table1** for detailed description of five key concepts.

Table1. Lincoln & Guba's five concepts for defining and assessing quality in qualitative research (Lincoln & Guba, 1985) (Taken from Teharne & Riggs 2015)

Concept	Definition
Credibility	Do participants or members of the community being researched feel that the findings represent their experience? Prolonged engagement with participants Case analysis to be used to assess credibility Member checking and peer debriefing with other researchers can be used to investigate credibility.
Transferability	Are the findings applicable to other contexts? Providing a rich description of participants' responses
Dependability	Would similar findings be produced if someone else undertook the research? Auditing can be used to allow another researcher to follow the audit trial
Confirmability	Are the findings a product of participants' responses not the researcher's "biases, motivations, interests or perspectives"? Transparency and Reflexivity to be used to monitor confirmability
Authenticity	Does the research represent a fair range of different viewpoints on the topic? Member checking can be used to inquire about apparent authenticity with participants and other members of the community in question

When preparing to conduct data collection in this thesis I thought about how to observe and practice these five principles. They encouraged me to try to be transparent and honest in my research by forming a rationale for the work, selecting a method to carry it out and lastly by explaining my findings (Elliott *et al.,* 1999 & Yardley 2000). This also meant being reflexive about my position, personal circumstances, privileges, identity, experiences and my place within the research study group (Willig, 2013). However, this was no small task, as this action involved more than a list of personal characteristics (Hellawell, 2006 & Treharne, 2011). Personal reflexivity involves an ongoing process of questioning the relevance of my identity in forming and shaping the research process (Treharne *et al*., 2015). For this reason I decided to journal my reflections as I set up and conducted this research. My reflections will be discussed in the next section of this chapter.

The criterion mentioned above were used to set up the methodology for this thesis. The way they were used to ensure the quality of this thesis will be discussed in the remaining sections of this chapter.

My background: Between Orthodoxy and Modern-Orthodoxy

When trying to understand my position as a researcher I turned to reflexivity. Over the years, reflexivity, has been increasingly recognised as a vital strategy in the process of collecting information in qualitative research (Ahmed Dunya *et al*., 2011; Blaxter *et al*., 2006; D'Cruz *et al*., 2007; Gerstl-Pepin & Patrizion, 2009; Hammersley & Atkinson, 2002; Horsburgh, 2003 & Koch & Harrington, 1998). Reflexivity is commonly understood as the continual internal dialogue and self-evaluation of researchers' position within the research and how this position may affect the research process and outcome (Bradbury-Jones 2007; Guillemin and Gillam, 2004; Pillow 2003; Stronach *et al*., 2007; Jafar 2018; & Chiseri-Stater 1996). In the words of Berger, it further means looking through "*the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation*" (Berger 2013).

Various studies have understood relevant research positionings as: personal characteristics, such as race, gender, affiliation, age, sexual orientation, personal experiences, beliefs, biases, emotional responses to participants, immigration status and political and ideological stances (Bradbury-Jones 2007; Finlay 2002; Hamzeh & Oliver 2010; Horsburgh 2003; Kosygina 2005; Padgett 2008 & Primeau 2003).

Understanding the way research position interacts with research set up and outcomes can monitor and thus enhance the accuracy of the research and "*the credibility of the findings by accounting for researcher values, beliefs,*

knowledge, and biases" (Cutcliffe 2003). This further helps to gain plausibility by securing research's trustworthiness (Buckner 2005; Macbeth 2001).

Using reflexivity to explore my positionality allowed me to find a place within my research as an Orthodox Jew without undermining the truth or validity of my work. To be able to explore my position within my research I used reflexivity to help me define the boundaries that existed between the participants and myself to make sure that this did no impact the results of the fieldwork. This was particularly important to think about prior to data collection and analysis. To ensure that I was learning as well as developing in my research I kept a reflexivity journal where I explored my personal characteristics and my advances in the Orthodox Jewish community. I used this journal throughout all phases of the research process (Bradbury-Jones 2007; Guillemin and Gillam, 2004). This also included personal reflections after every interview (Appendix14).

Here I present a summary of some of my reflections throughout the four years of my research.

I define myself as a Modern Orthodox Jew from Sephardic origins. My father comes from a Portuguese Jewish family and my mother's side originates from Morocco. I grew up in Portugal until the age of ten. Then my parents decided to move to Gibraltar. Gibraltar prides itself of a very large population of Jews. Eighty percent of Jews living in Gibraltar fall under the denominations of Orthodox and Modern Orthodox.

Growing up in Gibraltar Orthodox life was a must. Everyone went to a Jewish Orthodox nursery and then to an equally religious primary school. In these schools I learnt how to read Hebrew and the daily and special prayers required for the Jewish holidays. I also attended Jewish high school which was a very private and strict all-girls school. We had a total of nine girls in my class. The daily time-table included various classes on Jewish ethics, Jewish festivals and holidays, Hebrew reading, reading of the *Chumash (*which is the collection of the five books of the *Torah)*, along with other general subjects such as French,

Mathematics, Science and Computer Science.

As an outsider in Gibraltar I began to notice the way my family needed to change and adapt in order to fit in and be part of the community. Some of these changes included becoming more religious and more observant in Jewish law. As a child this was the feeling that I grew up with; the feeling of needing to belong and be a part of a community and society. I learnt from a small age that in order to belong to this special community everyone needed to have similar values, goals, life styles and even family styles. This was not always the case for me.

At the time of my A levels, I decided to change schools so I went to Westside school which is a public school for girls in Gibraltar. There I was able to continue my studies in the field of sciences as it was my aim to go to university and pursue a PhD. This was not a common dream amongst my Jewish friends. After high school when I left to come to study in London, seven out of nine girls from my class went on to religious seminary in Gateshead and Israel. These girls went on to get married and currently some have three children.

I moved to London in October of 2010 to start my studies. Since then I have lived in Golders Green. Fortunately, I have been welcomed into the Orthodox community in London. Nevertheless, I often found myself different to the other girls my age in the community. Some of the girls I came across wanted to get married and start a family as soon as possible and for me it was important to first have a job and finish my studies. Six years ago when I started dating my partner I started to be faced with intrusive questions from other community members who wanted to know when I was planning on getting married so that I could start a family. Community members could not understand how at the age of 22 and after dating for three years I was not married and I did not have children yet. Soon these were not just random questions here and there, as the years went by this pressure increased especially at most *Shabbat* tables and at other festivals. These questions were pressurising and they created arguments in my relationship. Eventually I found myself isolated from the people around me as I saw most of my friends getting married. Soon we did not

have much to talk about apart from their married life and their children. This for me was a defining moment as I realized that I did not consider myself just Orthodox, I was a Modern Orthodox Jew who valued religion as a structure for life, but a person who also found beauty in following my dreams.

The idea for this thesis was born out of this struggle I faced. It was drawn from the way I experienced Orthodox Judaism growing up and the way I observed those 'different' like me in my community. I knew what it was like to be different to others in the community because of the way I chose to practice my Orthodoxy. I wondered if by being an Orthodox Jew there were more problems when one could not conceive and if this also led women and couples to feel isolated from those they love and feel close to. I also thought about the restrictive Orthodox Jewish way of life and I wondered what I would do if my, religion which I love, told me I could not do something that was important to me. In my mind a link between these women and me started to develop. As an Orthodox Jewish woman I know what it is like to want to be part of a community and be welcomed and accepted into Jewish circles. This feeling of belonging envelopes you with warmth and safety. But what happens when it is not there because you cannot produce children, the tokens of acceptance.

Jewish religion is very particular about the way intimacy and sexuality is discussed. These are topics that are not openly discussed and young people only encounter these discussions and information before they get married. Sexual relations are discouraged before marriage therefore there is a common belief that sex education and information is unnecessary before marriage. For this reason, in my mind there was no doubt that there were multiple couples struggling with infertility in complete isolation from their families, friends and communities, due to the 'natural' and grown sensitivity to discuss intimate topics such as sex, procreation and infertility.

As a Modern Orthodox Jewish woman I started this thesis knowing that I needed to be aware of my position. Jonathan Boyarin in his essay "Jewish ethnography and the question of the book" (1991) discusses the possible problems that a Jewish person might encounter when researching other Jews

(Boyarin, 1991). Due to the nature of my upbringing and affiliation with Judaism and the Jewish community in London I accepted Boyarin's proposition. His proposition suggested that my "critical stance" as a Jew researching other Jews would be affected by my identification with the women in my research and equally their identification with me as one of them (Boyarin 1991). I knew that this could pose a danger to my research therefore I made an extra effort to always be aware of my own beliefs, cultural background and views and try to separate myself from the women in order to remain unbiased to my research and it's analysis. The distance between me as the researcher and my subject was very narrow and this could have created problems such as participants not sharing all information and assuming that I knew exactly what they were saying or them feeling afraid to share information due to the close proximity and familiarity of all Jewish communities. Nevertheless, as Kahn mentions "compelling and convincing ethnography has to do with a lot more than the degree of identification between the ethnographer and her subject" (Kahn 2000). I knew from my own experience how hard it could be to approach the community as a complete outsider so my close proximity to the community was a vital advantage.

Berger discusses researchers' positionality and suggests three main ways in which these can impact research (Berger 2013). Firstly, Berger discusses access to the 'field' as participants might be more likely to share their experiences with researchers whom they understand to be sympathetic to their situation and be more familiar, informative and knowledgeable about certain aspects (Berger 2013 & De Tona, 2006). I found this was true in my case as I was familiar with Jewish laws to some fertility treatments, I knew or had heard of most of the important Rabbis in the field and to some extent I had myself experienced some pressures to change in order to belong to the community. I found this made it easier for me to learn about *Halacho*t and to contact Rabbis to help me understand texts that were only written in Hebrew. Furthermore, I was part of a community in North West London, I attended Synagogue regularly throughout the year, I went to Shabbat diners and lunches and I was ware of happenings in the community. I knew from my own experience what it was like to be a Modern Orthodox Jew living in North West London. These experiences

gave me an understanding of the comfort that radiates from being part of a community. This also gave me the knowledge of what it would be like to be different and therefore not be able to belong.

My close proximity to my research community further allowed me to make connections with some charities involved in the field of fertility treatments and Jewish law. It was also useful when advertising and recruiting participants. Being Jewish also meant that participants knew that I was one of them. This meant that they did not have to explain some of the basic Jewish words or values. This was further helped by the time I spent learning *Halachot* and talking to Rabbis. In some ways this helped women feel at ease and more comfortable when discussing their experiences. The women knew I would understand the limitations posed by Jewish law and the importance that Judaism holds in the life of a practicing Jew.

The second point Berger discusses, explored the relationship between participants and researcher and their openness to share experiences and thoughts. Berger states that the relationship participants have with the researcher could change the information that participants chose to share (Berger 2013). This was true for my outsider position too. Though there was a very narrow gap between the participants of this research and me, I was aware that I was researching Orthodox Jewish women who have faced infertility as a single unmarried and childless Modern Orthodox Jew. This knowledge increased the distance between me and the participants and it gave me a new perspective to my research. I now had an outsider position to this community of infertile Orthodox Jewish women. This was further expanded by my background. I was a Modern Orthodox Jew from Spanish Origin, this meant I was Sephardi and had slightly different *Halachot* and my experiences growing up in Spain were different to these women's. This meant that women had to explain their experiences completely and in some ways this gave them the freedom to express their stories in whatever way they wanted. I did not ask questions directly. I just let the women guide me in what they wanted to tell me about their journeys of infertility. My outsider position also meant that I did not know everyone in the neighbourhood and that I was not completely familiar to

these women. Again in some ways this was beneficial to my recruitment. Women knew that I was not originally from London therefore they were reassured in knowing that I would not necessarily be part of their close community circles. I constantly moved from being an insider and outsider position in my research and this was something I negotiated in order to try to benefit my study and data collection.

The last point Berger makes reflects on the background of the researcher and the way this could affect the language used, the way question are asked and how the information is filtered once gathered from participants. Berger states that this perspective may shape the conclusions of the research (Berger 2013 & Kacen and Chaitin, 2006). This was a point that I was very conscious about. In trying to obtain most valid and unbiased answers from women I tried to stay away from making any assumptions and always tried to let participants do all the talking. It was important for me to remain unjudgmental towards the way the women described themselves and their reproductive choices. My role in this thesis was to let women express their stories in the most open and flexible way.

Literature review

This was the first and most important preparatory step of this thesis. The period of reading and gathering scholarship and literature on the field of ART and Jewish law and Jewish women's experiences and attitudes lasted up to a year.

During this time I collected written articles, books and websites related to any of the fields mentioned above. To start I simply did a google search of infertility and Judaism. Initially this led me to some charities such: as Chana (https://www.chana.org.uk/), Puah (https://www.puahfertility.org/), Tahareinu (https://www.tahareinu.com/), Dor Yeshorim (https://doryeshorim.org/) and ATime (https://www.atime.org/). Only Chana is a London based Jewish charities, the others have a UK base that helps couples outside of Israel and the USA.

Having these charities allowed me to start reading about what were some of the worries that infertile couples in Jewish circles might have. This further allowed me to understand what each charity offered to the women and what was exactly was missing for this community.

My next steps included a broad google scholar search. Using google scholar allowed to identify where the articles that I would need for my research would be. I used this search as means to identify where Jewish scholarship on ART would be published. For this search I used a variety of key words in different orders. Usually I would write Judaism and infertility, Jewish women and ART, infertility in the Orthodox Jewish community, motherhood in Israel, Israel and infertility, Jewish women and fertility. This search led to a list of books relating to Jewish law and ART and Jewish women's experiences of ART (References: Books).

I tried not to place a limit on the age of the book or article and to include not just Orthodox views but also Jewish views in general. I knew that *Halachot* to ART might have emerged from older books as IVF had been around for four decades. This was the case for some books, for example "Jewish law and the new reproductive technologies" from 1997 (Feldman and Wolowelsky, 1997) and "Reproducing Jews" (Kahn 2000). Jewish laws to ART have emerged from Rabbinic debates, these have been going on for many years. These debates were greatly explored in Irshai's book (Irshai 2012). Using these books allowed me to form my knowledge of *Halacha* on ART and to start learning about the restrictions, obligations and views of Judaism on life, fertility, procreation and infertility treatments.

Reading these books further led me to research the authors and their other works. This then opened up the field of infertility and Judaism. In finding papers from these authors, I was able to read their references and co-researchers work to build my knowledge of ART, Judaism, Orthodox Jewish women and infertility.

I further tried to find articles from scientific databases such as PubMed, Science Direct and Nature. These were helpful in finding some publications that then

led me to further my research by reading the references and citations of each article and looking for the papers that were most relevant to Orthodox Jewish laws on ART and publications on Orthodox Jewish women's experiences of infertility.

I tried to include all papers on ART and *Halacha* as I believed that I needed to understand what it would be like to need treatments and be restricted by these laws. Orthodox Jews are bound by *Halacha* on their day-to-day life so I knew that for fertility and procreation this was going to be very similar. Therefore understanding limitations would allow me to see where some women might feel pressured. The same was true for reading all works on Jewish women and infertility. Due to limited availability on works in this field I decided to learn about all Jewish women regardless of their denomination. Finding this limitation in the scholarship is what pushed me further to want to study Orthodox Jewish women as they appeared understudied and underrepresented in this field of science.

To prepare further for the interviews with the infertile women I started to read books and bibliographies of women who had struggled with infertility in order to understand and explore what it would mean to be infertile. I was aware that I was a young unmarried woman of 24 years and I did not want participants to think that because of my inexperience I could not relate to them or their difficult stories. I prepared myself by reading books like Dear you by Tessa Brown, The pursuit of motherhood and 21 miles by Jessica Hepburn, Tears of Sorrow, Seeds of Hope by Nina Beth Cardin and Fertile: nourish and balance your body ready for baby making by Emma Canon. These books gave me an idea of what I was going to find when interviewing women and they helped me prepare myself emotionally for the stories I might uncover.

Ethical considerations

When trying to approach and interview women for the data collection part of this thesis I encountered some problems. Infertility is a very big taboo subject in the Orthodox Jewish community. Some women were reluctant to discuss their infertility openly because of their fear of others knowing that they had

needed fertility treatments. This fear for some extended to their families finding out they had treatments as previously they had not known. These difficulties matched to the reliving of infertility experiences for some women, made recruitment challenging.

I took a few measures when trying to overcome these possible problems. Ethics approval was obtained for this study from University College London ethics committee on June 2016, reference number is 9831/001. Ethics approval and the reference number was written on every document used for this research. I wanted the participants of this study to know that the research was being carried out in accordance to ethical laws of research conduct.

Before starting the recruitment process I spoke to the charities mentioned in the section above and asked them for any recommendations when approaching and speaking to women that had and were still facing infertility. Charities recommended me to read about infertility in the Orthodox Jewish community and to look up blogs online.

I set up a recruitment plan that would respect women and their freedom to choose their participation in the study. I placed adverts on Facebook and Jewish magazines. Then I let the women approach me if they wanted to participate in the study. I did not directly seek them out in case they would get upset or feel pressured to participate. I felt that this would give women freedom to decide if this was a project that was or was not right for them and if they wanted to relive their struggles and discuss them with a stranger. In this way I respected women's space and their decisions on sharing and not sharing their experiences.

Once the women approached me, I discussed the project briefly with them over the phone and tried to explain to them what it would mean for them to participate in the study. I mentioned to the women that even if they initially agreed to participate in the study they could change their minds at any point and this would mean the complete removal of the information they had previously shared.

Prior to the interviews and after the phone conversations, I sent them a consent

form (Appendix 9). The consent form included a brief summary of the project and some information on UCL and the Institute for Women's Health along with the ethics approval number. This was to remind women of the confidentiality of the project and the future anonymity of the information they would share once interviewed.

These two points were vital for these women and often it was what helped them decide if they wanted to participate or not. Therefore women were sent this information via email before the interview and this was again discussed before starting the recordings.

Before starting the interview women were reminded and reassured that their personal information would be treated anonymously. All names and any other identifying information has been systematically changed to protect participants' identity. The use of pseudonyms was done so that the reader could familiarize with the participants and in some ways give an essence of the women I interviewed. This important action gave women freedom to express themselves as they wanted with no worries or restraints because they knew that their information and identity was safely protected. In terms of data storage all information was stored on the UCL server which is crypto-protected.

In conversation with the women before interviews were carried out I emphasised to them that their mental and physical safety was my utmost priority. As such I created a list of possible resources women might need if after the interview they felt upset, angry, sad or lonely (Appendix12). I handed this out to them before starting the interview and as I left I made sure that they had this with them.

I tried to be as open minded and non-judgmental as possible when speaking to these women. I knew that potentially as a young woman and PhD student I could come across as ephemeral and non-emphatic so I tried to connect to the women and let them lead the conversation. Soon from their interviews I also came to understand that these women had experienced in their lives a lot of judgment from family, friends, and community and from healthcare

practitioners. I did not want them to feel that the interview had anything to do with that. I wanted them to know that the reason they were sharing this information with me was so that other women who were in a similar journey of infertility would know that they are not alone.

To ensure my personal mental and emotional safety I wrote down in my reflexivity journal all I had been feeling throughout the research project. This included notes on my personal skills and how I could improve them to better my research outcomes. Alongside writing, I set up regular meetings with my supervisors and mentors. I met weekly with my primary supervisor, Joyce Harper and Zeynep Gurtin and monthly with Jackie Leach Scully from the University of Newcastle. In these meetings I discussed findings and explored the way I was feeling about the interviews. This allowed me to remain calm when speaking to women and more importantly to learn how to actively listen to women's stories and experiences without completely internalising the conversations.

Background research

In preparation for the main data collection of this thesis I carried out background research in Israel over the period of six weeks between July and August 2016. In this trip I visited Orthodox IVF hospitals in Jerusalem, Netanya, Haifa and Tel Aviv and interviewed hospital workers, social carers and ultra-Orthodox Rabbis.

Research in Israel allowed to me see the way *Halachot* are practiced and taken into account when couples use ART in Orthodox Jewish hospitals. Understanding the use of ART in a predominately Jewish environment was vital for me to see great impact that infertility has on pushing couples to use ART and more importantly to try to understand how Jewish law played a part in that relationship.

Upon my return I wanted to learn about the Orthodox Jewish community of London. In order to do so, I decided to interview ten Rabbis from different Orthodox communities in London to learn about their knowledge of *Halacha* on

ART and see how approachable they would be to a woman who was trying to understand these laws.

These interviews concluded that some Rabbis in London are vaguely familiar with the *Halachot* on ART and that these Rabbis were lenient about allowing couples who are infertile to use ART. These interviews resulted in a paper that has been submitted for publication (Appendix 6 for paper).

In the second year, 2017-2018, my primary supervisor, Joyce Harper, was approached by the Chief Rabbi Ephraim Mirvis, because he wanted to start a programme for the Jewish community on women's health, reproductive health, *Halacha* to these matters and family purity. The programme was named Ma'ayan and it was taught at the institute for women's health and in synagogues around London. In 2018 ten women graduated from this programme and became leaders and sources of information for other women in the community (chiefrabbi.org/maayan-programme/).

During one of the sessions led by my primary supervisor in a Synagogue in central London, I carried out a focus group with the participants. In this focus group I discussed with the women sex and fertility education in the Jewish community (Appendix 7 for the discussion with the focus group). I knew that these women were married to Rabbis and that they had some form of leadership in the communities they belonged to. Learning from these women how fertility, sex, relationship and reproductive health education is given in Orthodox communities was important as I wanted to understand what resources and what Orthodox Jewish women could potentially know about their bodies and more importantly their reproductive health. From the focus group I learnt that Orthodox Jewish girls are rarely taught about sex or fertility education at all. They usually learn about sex prior to their weddings only once they are engaged to be married in what is called "Calah lessons" (Bridal lessons). This information is what led me to carry out interviews with 17 Orthodox Jewish women in North-West London communities to try to understand their knowledge of fertility, infertility and ART.

I recruited 17 women who had no apparent fertility problems and conducted semi-structured interviews with them. Here I had conversations with random women from the community to try to understand what they knew about reproductive health and about ART. Interviews resulted in paper that has been submitted for publication (Appendix6).

This background research was vital in the set-up and preparation for the main data collection of this thesis. The interviews gave me an insight into what it would be like to speak to Orthodox Jews about delicate and taboo topics. Conducting these interviews served as pilot studies to explore how to question people in a way that would encourage them to speak and share their opinions, thoughts, views and experiences. During these interviews I explored how much structure an interview guide might need and how many questions I should ask to allow participants to express themselves. Moreover, I learnt from these interviews how to actively listen to participants when they are speaking and if and when more questions are needed to encourage them to speak. I piloted my interview skills with these different groups of people in order to prepare myself for the interviews with the infertile women.

The time invested in speaking, discussing and networking with women and Rabbis in various communities in London helped me understand in some way what all groups thought, knew and expected of fertility and reproduction. Furthermore these interviews helped me to further develop and establish my place in the community and help me build connections with women, Rabbis and their communities.

Recruiting “infertile” Orthodox Jewish women

At this point in the study I was fully integrated in the community, despite this, I was aware that recruitment was probably going to be the hard. The subject of fertility is rarely spoken about openly in the Orthodox Jewish community. At times, it is spoken about in lectures organized by the community for people to

gather and learn about in terms of *Halachot* but never really openly with couples or women who are infertile.

My first step in trying to find these "infertile women" in the Orthodox Jewish community was to approach Chana, a Jewish charity in London that helps women and couples undergoing infertility, emotionally and psychologically. When meeting with the charity I asked them for advice as to how to speak about infertility and ART with Orthodox Jewish women. They were very helpful in sharing with me resources and guiding me to their website for more information (https://www.chana.org.uk/).

After this meeting I started to think about the women I wanted to speak to in order to answer the research question. To commit to the quality of my research I focused on ensuring that the women interviewed were not 'typical' or 'average' (Carter, 2009). I wanted to interview Orthodox Jewish women who defined themselves as infertile, in doing this, I selected the women who were most likely to help me understand what it means to be an Orthodox Jewish woman and face infertility. This is known as purposive sampling (Carter, 2009 & Ames *et al.*, 2019). I stayed as broad as possible in the criterion for selecting which women to interview. I wanted to prevent exhaustive searching and inclusion criterion as this could undermine the understanding of interviews and deviate from the research question (Suri, 2011; Benoot *et al*., 2016 & Ames *et al.*, 2019). Additionally, this was important for my work because it was not trying to find statistical generalizability but rather the meaning behind how and what some Orthodox Jewish women felt when experiencing infertility (Ames *et al.*, 2019).

Therefore, I focused mostly on two criterion, being: Orthodox and infertile Jewish women. Firstly, I decided to only interview women that recognised themselves as Orthodox Jews. Within the denomination of Orthodox I decided to include, Modern Orthodox and Traditional. But within these denominations all women needed to observe the Sabbath and eat Kosher. These two categories were chosen as they were the easiest to ask the women about on the phone when assessing if they could take part in the study.

Secondly, I decided to interview every Orthodox Jewish woman that recognised herself as infertile. With regards to infertility, the criterion for inclusion were very broad. I decided to let women chose what being infertile meant. For some this could have been the inability to conceive for one or two years after unprotected sex, for others the need to have naturally monitored cycles, or the need of ovulation support, the use of any ART to conceive and lastly if they had needed adoption to become mothers.

This was done purposely due the way infertility can be understood. In recent years infertility has become 'medicalised' (Conrad and Schneider, 1980 & Greil *et al*., 2010). Yet, despite this some couples only really define themselves as infertile when they embrace parenthood as a desired social role (Greil *et al*., 2010). Furthermore, this is a "condition" that is not internalised in the presence of pathological symptoms but rather by the absence of a desired state (Koropatnick *et al*., 1993). When thinking about Orthodox Jewish women it is worth taking into account the social aspect of infertility. Infertility can also be understood as a socially constructed process (Greil *et al*., 2010 & Greil, 1997). Allowing women to come forward about their infertility without any exclusions on infertility also helped me to understand what the women understood infertility meant and how they lived knowing that they were infertile and how this then impacted their lives.

I further decided to interview: women who had been infertile in the past and had become mothers over time, women who remained infertile, women who were still facing their infertility and women who had overcome their infertility by adopting. Criterion were kept purposively broad to allow women to express themselves and for them to explain why in the first place they thought they were or had been infertile. This was in order to explore their life experiences.

No limit was put on the women's age, education or nationality. Women needed to be living in London and be part of an Orthodox congregation. These women were not asked which community they belonged to, to protect their identity.

Upon discussion with some friends they suggested that I post recruiting adverts on Facebook groups and on Jewish newspapers. On Facebook, I found many private closed groups for Jews in London. I posted messages on these groups asking if there was anyone interested in participating in my study and stating that any information given would remain anonymous and confidential (Appendix8, **Figure1**). Along with these posts I put an advert in a weekly magazine that is distributed around North West London every Friday morning (http://www.londonjewishadvertiser.com/) (Appendix8, **Figure2**).

The majority of women were recruited from the Facebook posts. Five women were recruited via snowballing sampling which refers to women passing on information of my research from one-to-another (Suri, 2011). In total 26 women were recruited. It is important to mention that the sample size was not fixed. It was set according to the number of women that approached me given the time-frame set for the interviews. I did not want to rely on sample 'saturation' as this would imply that concepts and themes were saturated, meaning that no new concepts were extracted from the interviews (Bowen 2008 & Morse 1995). As such I tried to interview all the women that approached me and be open-minded and flexible about what concepts and experiences I might come across.

Interviews

Qualitative research focuses primarily on exploring how people understand their lives, experiences and the structures around them (Atieno, 2009). In order to focus on such experiences and views, interviews provide a viable and highly useful tool for data collection (DiCicco-Bloom and Crabtree 2006; Jamshed 2014). Qualitative interviews allow researchers to explore in an in-depth manner matters that are unique to the participants of such interviews (McGrath, 2019). This also allows insights into how different human phenomena are experienced and perceived (McGrath, 2019; Cote & Turgeon 2005; Halcomb & Davidson 2006). Additionally, using qualitative interviews could hold the key to give voice to minorities and groups in society that might not be heard elsewhere (Reeves *et al*., 2015). For these reasons I decided that qualitative interviews would be the best way for me to obtain answers to my research question. This

would give me proximity to the studied group and allow me to hear first-hand and meet some women in the Orthodox Jewish community who have been affected by infertility.

Semi-structured qualitative interviews were chosen as the most appropriate method for data collection. Semi-Structured interview guides may contain some predetermined questions, sometimes between 5-15 (Lingard and Kennedy 2010). Having these determined questions allowed me to guide my conversations with the women and see when I needed to probe for more information. However, the flexibility this method provided allowed me to explore issues brought forward by the interviewees.

In order to prepare myself to conduct these interviews I considered conceptual and practical preparations (Brinkmann & Kvale 2005; Brinkmann 2014). To do this I focused on the scope and lends of my research question and compared it the scholarship mentioned in Chapter1. This scholarship had focused on various aspects of infertility and ART within Jewish samples. This was the best place for me to learn from, in order to learn how to set up interviews with Jewish women.

In order to prepare for interviews I attended classes from the UCL doctoral school on how to conduct qualitative interviews. In these sessions a great focus was placed on Active listening. This can be understood as respecting the silence of interviewees and identifying moments of silence as moments of ongoing reflection (McGrath *et al*., 2019). Active listening is a skill that reminds the researchers to talk less and to allow the silence to act as catalyst to drive conversations forward (McGrath *et al*., 2019). This was very important for my research group as I was going to interview women about subjects that would have profound meaning for them. I needed to be prepared and expect there to be moments of deep reflection on behalf of the women. Thus, it was important for me to listen actively and remain honest and open and maintain interest (Bowden & Walsh 2000; Seidman 2013 & Giger 2017). In remaining attentive to how the women responded I also remained flexible with the questions I asked and the adjustments I thought would benefit the interview guide. In some

scenarios I changed the questions asked, or in others I added more questions. I remained flexible and open to changes on the interview guide throughout the interviews.

In order to have a guide and some structure when speaking to the women, I prepared an interview guide that included simple demographic questions and some open ended questions that let women retell their experience of infertility. This interview structure also included some potential additional questions that I used when women felt stuck or unable to continue or when the conversation suddenly needed a refocus (*Appendix*11). Alongside this interview guide I created a list support resources to hand to the women before starting the interviews (Appendix12).

All interviews were carried out between September 2017 and December 2018. Prior to the interviews women were sent a consent form along with an information sheet that gave women some understanding about the project and their participation (Appendix 9 and 10). The information sheet and the consent form were also read on the day of the interview. If women were happy to take part in the study they signed the consent form. All 26 women were happy to be part of the study and signed consent forms. Women were reminded that if at any point they wanted to stop being part of the study this was acceptable and that their information would be removed accordingly.

The majority of interviews took place in the women's houses with exclusion of two that took place in my house because it was easier for the women. I felt that this was most appropriate because it was where the women felt most at ease even if at times it was slightly difficult for me to concentrate in the women's houses as I would occasionally look at their family and baby pictures and begin to see their struggles play out in those photos.

For all interviews I dressed casually and did not intend to appear more religious than I am, for example I did not necessarily wear skirts which is what is expected of an Orthodox woman to wear. I tried to be myself as much as possible. Initially I fretted about how I would speak to women about their

infertility journey without having any experience or understanding about what it meant to have children as I at the time I was a 24 years old without children. This soon changed as I met these women. They were all welcoming and open to share their stories with me.

Before I started recording or properly asking women questions about themselves and their reproductive journeys, I told them about myself and my family and how I had ended up in London researching infertility in the Jewish community. I felt that this was beneficial during the discussions with the women as it made it less formal and made me seem more approachable to them. In the same way that they welcomed me into their private stories I wanted to share something about myself and my life too.

Usually interviews lasted between an hour and an hour and half. All were continuous but on two occasions I had to stop the recording machine after realizing that the women were very emotional and needed a break from the interview. These actions ensured that I protected and respected my interviewees (Varpio and McCarthy 2018). During these occasions I let the women guide me as to when they were ready to continue the interview and gave them space to feel better. Moreover, at the end of every interview I reminded the women of the list of resources that I had prepared in case they felt any negative feelings after the interviews.

On two occasions the women's husbands were present at the time of the interview, per the women's request. On one of those occasions it was because the couple had needed sperm donation and the woman felt that it was her husband's story to tell. On the second occasion it was because the woman's husband was familiar with science and in specific with reproductive medicine.

Transcription can be understood as the process of reproducing spoken words recorded from an interview and converting these into the written form to allow analysis of recorded data (McGrath *et al*., 2019). Verbatim transcriptions are the most common form to transcribe qualitative interviews, this refers to the word-by-word reproduction of verbal words into written words: these are an

exact replication of the audio recorded words (Poland 1995). For this reason and to allow the maximum proximity to the women's narratives when analysing the data every interview was transcribed verbatim alongside notes that I wrote at the time of the interview (McGrath *et al*., 2019) (Appendix 13). The notes included some information about how the women presented themselves with regards to how reserved or open they were about talking and sharing their experiences.

It usually took between four to eight hours to fully transcribe every interview. This close proximity with the women's narratives allowed me to gain further familiarity with the women's stories and to really begin to understand their views and experiences. In the transcripts, pauses and reflective silences were marked with the use ellipses. When I thought it was appropriate I wrote in brackets if the interviewee laughed or giggled. In doing this I made sure to transcribe the interview as it happened. In order to fully do this every interview was transcribed daily after completion. This allowed me to start identifying analytical structures and similarities between interviews (McGrath *et al*., 2019). To check the validity and accuracy of the transcripts, once fully typed, I listened to the recording alongside the transcript to check for errors or mistakes. This was a process I carried out twice for every interview and transcript.

To ensure trustworthiness in my data collection (Lincoln & Guba, 1985) I asked every participant if they would like to read their transcripts, this known as participant validation or member checking (Creswell, 2013). The majority of women did not feel like they wanted to read their transcripts. Only three women agreed to check their transcripts. From these checks, women were happy with what I had done and they felt that the transcript respected and was a replicate of the words they shared in the interview. In order to ensure I was not missing any subtleties and responses some transcripts were checked my primary supervisor and Jackie Leach Scully. This was to ensure that no ironies, silences or other gestures were missed and to ensure another review of transcript accuracy (Birt *et al*. 2016; McGrath *et al*. 2016).

Analysis

The aim of my data analysis was to stay as close as possible to what the women said and shared about their experiences. I wanted to as much as possible provide an accurate representation of the women's journeys through infertility without trying too hard to find connections between what each woman felt and said about their experience. I was more inclined towards finding meaning and understanding the women's experiences and less towards generating theme lists and counting the occurrence of certain episodes (Carter *et al.,* 2009). This also meant looking at how women spoke about certain things. For example, how passionate or upset or happy they were about a certain memory, or happenstance (Carter *et al.,* 2009).

As such, I decided to be guided by the conversations I had with the participants and stay as close as possible to their accounts. This approach can be recognised as qualitative description (Sandelwoski 2000). Qualitative description studies specifically focus on discovering and understanding a process, phenomenon, or the views and perspectives of people involved in the study (Caelli *et al*., 2003 & Merriam, 1998). This was the aim of my research; understanding what Orthodox Jewish women experience when facing infertility.

Though I recognise that as Talbot describes, qualitative description can be seen as weakest technique to carry out research (Talbot 1995) and can often also be doubted for lack of theoretical credibility (Neergaard *et al*., 2009) for me it was vital to let these women express themselves and have their stories shared as they shared them themselves with me without any further or deeper interpretation into what they were opening up about. For the majority of the women interviewed in this thesis, this was the first time that they were opening up about their infertility to a complete stranger and a person outside their intimate, medical or Rabbinical circle. For these women this was a monumental step and as such it was important for me to represent their infertility struggles as raw and as unpolished as possible. I wanted to obtain and present accurate meanings and experiences without adorning women's voices. I reported my data as close and as accurate as possible as to the interviews, steering clear of my personal biases and interpretation of women's stories and experiences.

I tried to give appropriate commentary where I thought it was needed in order to fully try to portray the women's experiences.

I recognise that description can sometimes border on interpretation as Sandelowski mentions (Sandelowski, 2000) and for that reason I tried to share as much as possible from the conversations using quotations from the narratives. Women talked about their experiences in as much details as they felt comfortable to share. It was very important to me to simply expose their experiences. I did not want to interpret their difficulties.

When thinking about analysing the interviews I decided to focus on thematic analysis. This research method focuses on identifying themes and patterns from within the data collected (Braun and Clarke, 2006). Though as Boyatzis explains, this method also relays on interpreting various aspects of the research topic. I was aware of this and as such I tried to simply be guided by what the women shared and what they felt was important to discuss (Boyatzis, 1998). This was in accordance with my decision to strictly follow a qualitative description method. I wanted to let themes emerge from within the interviews I shared with the women without following any concrete structure to identify them. Thematic analysis provided me a way to do this as there is no specific way to go about discovering themes (Tuckett, 2005; Attride-Stirling, 2001 & Boyatzis, 1998).

The full analysis of the data was done in accordance with the six steps mentioned by Braun and Clarke (2006). These steps included:

1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Familiarizing myself with the data was relatively easy. I had spoken to the women, interviewed them and had spent at least an hour in their company. I

had recorded notes from each interview and these helped me try to understand and remember each woman's situation (Appendix13). Transcribing the interviews further allowed me to relive each conversation and really listen to what the women were sharing. This also gave me time to familiarise myself with each woman's experience and journey. Once I had all interviews transcribed I started to break down each interview into key points. In doing this, I looked to see what had affected each woman, what each had found hardest or easiest when navigating infertility.

These initial notes and ideas on the interviews are what is known as codes. A total of 21 codes were derived from the interviews with the women. The codes emerged from what had seemed more important to each woman and how this then related to others' experiences. Some initial codes included: motherhood as defining factor for the identity of the Orthodox Jewish woman, having children at all cost, family pressure, marital pressure, pressure form the community, reasons for not sharing experience, religion advantages and disadvantages, Jewish laws and doing things the right way, problems with clinics, Jewish medical professionals, isolation, Jewish law and infertility and my destiny-my path. These codes highlighted some of the experiences of infertile Orthodox Jewish women.

To ensure that I had done the data analysis correctly I double checked my codes and themes with my supervisors. This was done in order to triangulate and ensure that my biases and perspectives and opinions were kept at bay (Lincoln & Guba, 1985). We set up a plan where each of us would read a transcript and compare notes taken for coding. In most occasions we had come to the same conclusions. When we had different opinions we would discuss each person's view to the codes and decide how to portray this in the themes. This was important as I wanted to ensure that I was accurate and not biased to the codes collection.

Putting the codes together and developing them further was what created themes. This was done by reading the interviews alongside the codes to further find links between the women's experiences and thoughts and the codes I had extracted from the interviews.

Themes are supposed to capture something important about the data collected in relation to the research question (Braun and Clarke, 2006). I remained flexible and open minded throughout my analysis of the codes because I wanted the women's narrations to guide my research. It was important to let their stories illuminate what was to be highlighted in this thesis. With the selection of my themes I wanted to capture the essence of my interviews and discussions with the women. I recognise that I concluded which themes were to be exposed and discussed in this thesis therefore as Becker states I shaped the nature of this ethnography (Becker, 2000). Knowing this made it even more important for me to stay as close as possible to what the women said and how they themselves described their experiences. I simply joined and related the women's interviews in accordance to what they had shared.

Initially themes were very broad and covered various aspects of the women's lives and experiences. Themes were then organized as: major themes and their sub-themes. The final major themes included, my destiny, my Rabbi, my relationships and my identity. These themes were chosen because according to the women's interviews these represented the four main parts of the women's lives that were most affected by their infertility. Women firstly accepted and labeled themselves as infertile (my destiny), some took on the Rabbi as a major pillar of support in this challenge (my Rabbi), their relationships with husbands, family, friends and communities were changed drastically (my relationships) and eventually all these changes had an impact on the way the women understood womanhood and motherhood and their identity (my identity). These themes attempt to answer the research question. As such they represent the four main data chapters of this thesis.

PART II: DATA

This part consists of six chapters. The four data chapters presented here focus on the four main themes that emerged from the interviews: My destiny **(Chapter 4**), My Rabbi (**Chapter 5**), My relationships (**Chapter 6**), My identity (**Chapter 7**). These chapters aim to express the women's experiences of infertility and thus answer the research question. **Chapter 8** presents a holistic discussion of the data in the context of existing scholarship and provides some concluding comments. In **Chapter 9** I conclude my thesis with the potential uses of the data collected in this research and future ventures.

A brief introduction to each participant was created to help the reader understand and put into context the themes identified in this thesis (see Appendix15). Additionally, in **Table2**, women's demographics have been summarised.

The youngest woman was 23 and the oldest was 56. Eighteen was the youngest age at which a participant got married, 37 was the oldest. Nine women in the study mentioned that high school was their highest level of education, 13 mentioned they had a bachelor degree from university and four women mentioned that they had a postgraduate Master's degree. Nineteen women were working full time and seven women were housewives. With regards to Jewish denomination 14 women considered themselves Orthodox, ten Modern-Orthodox, one Ultra-Orthodox and Orthodox but Traditional. The majority of women, 23 women, had a Rabbi to talk to and regularly spoke to their Rabbi on a weekly basis. Only three women mentioned that they did not speak or had a Rabbi to speak to on a regular basis.

The average age that women got married at was 25.5. At the time of the interviews 20 was the youngest age at which a woman had her first child and 46 was the latest. There were three participants that were childless and still undergoing fertility treatments at the time of the interview. In general, ten women struggled with primary infertility, leading them to have IVF or IUI. Three women struggled with secondary infertility meaning they had a child early on in

their marriage but after were not able to continue building their families and as a result needed some form of help to conceive. In total four women needed gamete donation; three required egg donation and one needed sperm donation. One woman used a surrogate to have a child. Four women were able to conceive naturally but it was only after they gave up on IUI and IVF that their natural pregnancies occurred. Lastly one woman was able to become a mother via adoption. Three women mentioned that their inability to have children was due to male infertility. Out of the 26 women interviewed one woman mentioned that she got divorced due to the pressures of treatments. One woman mentioned that she also got divorced after treatments but in her case, she was marrying her friend in order to conceive. All women were married and none were on their second marriage. One woman was married with a man on his second marriage and he had one child from his previous marriage.

Table2. Demographics infertile women

Name	Age	Age*	Denomination	Children	Naturally conceived	Treatments	Miscarriages
Sarah	55	46	MO	2	0	IVF	No
Rachel	56	40	Orthodox	2	2	IUI	Yes
Ana	30	27	MO	1	0	IVF	Yes
Yael	37	38	MO	0	0	Egg donation	Yes
Miriam	38	25	Orthodox	4	2	Chlomid*	No
Shternie	27	25	Orthodox	1	0	IVF	Yes
Shosh	33	0	Orthodox	0	0	IVF/IUI	Yes
Rebecca	32	27	Orthodox	4	4	Chlomid*/ IVF	No
Leah	35	26	MO	3	0	Surrogacy	No
Lisa	36	31	Orthodox	3	0	IVF	No
Naomi	45	42	Orthodox	1	0	IVF & Egg donation	No
Vicky	36	35	MO	1	0	IVF	No
Dina	34	29	Traditional	2	0	Sperm donation	No
Karen	30	0	MO	0	0	IUI/IVF/ICSI	No
Victoria	39	30	MO	2	0	IUI	Yes
Gail	28	20	Orthodox	5	5	IUI/IVF/	No
Sandra	45	32	Orthodox	3	1	ICSI	No
Rina	32	29	Orthodox	2	0	IVF	Yes
Dalia	58	41	Orthodox	1	0	IVF	Yes
Sam	40	30	MO	4	4	IUI/IVF	No
Joana	51	39	MO	1	0	IUI/IVF/ Egg donation	Yes
Maya	23	0	UO*	0	0	IUI/IVF/PGT	No
Jessica	53	30	Orthodox	2	1	IUI/IVF/ICSI	No
Sophie	50	36	MO	1	0	Adoption/IVF/ICSI/ Egg donation	Yes
Andrea	46	32	MO	2	0	IVF/ICSI	No
Ruth	32	25	MO	3	1	PGT	Yes

Age*: Age when first child was born
MO*: Modern-Orthodox UO*: Ultra-Orthodox
Chlomid*: Pill given to women to help with ovulation

CHAPTER 4: MY DESTINY

As Orthodox Jews, many of my interviewees had a strong belief in destiny and referred to this when making sense of their infertility. Many women started their interviews by first accepting and explaining why they thought they were infertile. For many, this difficult acceptance was directly related to their faith, and view of God's control over their destiny and life plan. While some found comfort in their religion and beliefs, or became more religious as a response to the difficulties they encountered, others saw their infertility as a test of their faith. All of these responses gave rise to the overarching theme of destiny. This theme is explored in this chapter.

My religion: Judaism

It is important to first understand the place that Judaism as a religion held in the lives of these women. Most women in this study had a strong relationship with Judaism and thought that religion was not only a guide to living a good, ethical and moral life but also for a lot of them it was the sole purpose of their existence. In their words Judaism is:

> *"My backbone for everything I do." (Sarah)*

> *"A guide, a way of life but I think mainly because it gives life meaning and relationships meaning too." (Yael)*

> *"It defines my daily life, who I am, what I do, how I do it, how I approach everything I do… how I run my household, my family and the community is everything." (Miriam)*

For Rachel, Judaism is everything:

> *"I live by Judaism, for Judaism… without Judaism there is no point in living… it gives me an answer… reason… my mission on earth why I was born." (Rachel)*

These women described Judaism as the guide point for their daily life and a daily guide to living a meaningful and accomplished life. Their life revolved around *Halachot*, Jewish festivals, *Shabbat* practice and having a Jewish family life. For some women Jewish life also meant having a family and with it ensure Jewish tradition is passed on and never forgotten. Judaism gave these women a place to belong to and be a part of. It also gave them a duty in the continuation of their religion. Religion had a further dimension for some women as it allowed them to feel connected to their families and to their communities. Religion gave them something to belong to.

Some women found in religion a daily guide to live their lives. Having this guide allowed them to feel privileged. This feeling extended to being Jewish and belonging to this 'elite' group of people. Other women focused on what Judaism gave them as a religion, for example: being in a community that is like a family, tradition, a sense of continuity and belonging. These were feelings that being a mother gave them too. Yet, when struggling with infertility for some women it was religion that gave them faith and a sense of belonging. Some of these women connected religion to family life as this was what they had seen while growing up. Being Jewish gave them a community and a family even if at times and for some they did not have their own family.

Religion was also seen as a consolation and a promise of hope for motherhood. This was particularly important to some women because of the struggles of the Jewish matriarchs. Some of these women related to their struggle and tried to find meaning behind the reason why they specifically were destined to replicate the matriarchs' fates. This was a common thought amongst women in this study.

Another face of religion included that of faith. Religion gave women hope that all that was happening in their lives was for the best. Further intensified the thought that this was what was chosen for the women as their personal journey to happiness and self-fulfilment. Through prayer and religion women were also able to express their fears and struggles of undergoing treatments and that was an outlet that some women needed as most participants did not share their feelings and experiences with family and close friends.

God given infertility

Judaism had vital role in the women's lives. Along with the importance women placed on their religion came the view they had of God and as such the role he held over their destiny. Women saw God determining the occurrences in their lives and more importantly who was fertile and infertile.

This meant that some women in the study firmly believed that they could not alter their destiny, their path or the direction their life took. They felt that they could undergo treatments and seek out help to get pregnant but ultimately whether the treatments would work or not or if they will have children or not is dependent in God's will. All they could do is "do their part" as they often referred to in their narratives. Ultimately this also meant that some women thought their infertility was directly sent by God as a test for them to overcome.

Their views of God created a space between them and God. Women placed God as an almighty being who sees and controls all that happens 'down on Earth' from above. These women believed that God chose their paths to happiness, success, health and for some lucky ones, parenthood.

Sarah describes her relationship with God:

> *"I have not been perfect in my life and I feel like God has made a miracle for me… I made this thing in my head with God." (Sarah)*

In some ways Sarah felt like she did not deserve to have things easy because of the way she had behaved in the past, but nevertheless, God was there all along for her:

> *"I do not know what possessed me. I think it came straight from God… from day one I felt God had taken my hand and pulled me through this." (Sarah)*

Sarah needed IVF treatment with donated eggs. Despite the slight negative input from her family she decides to go ahead with the treatment. This is made extra hard for her as she is going ahead in a foreign country alone and with minimal support. This faith in God gave Sarah strength she needed to keep going and to face the difficulties of treatment alone and with a positive outlook.

Yael corroborates this idea. While discovering multiple gynaecological problems and uncovering the reasons why she could not conceive, Yael could not help to reflect the meaning behind their timing in her life.

> *"I went to the hospital and had the laparoscopy and the hysterectomy… the good news was that the uterus looked good, small but good, its shape was small but good. At the time, we also did not know about the ovaries in terms of reserves because we did not test that yet. This would be the next thing to test …So, it was God's blessing that I did not." (Yael)*

Yael uncovered the reasons why she could not conceive. This started with a Mullerian anomaly. She had a pelvic kidney which meant that one of her kidneys was in the pelvic region instead of being in the abdominal region. She had known this information since she was a teenager. Later on, through tests she discovered she had a unicornuate uterus which meant that her uterus is smaller than that of most women. Yael tried to stay positive whilst discovering these conditions. Yael's way of doing this was by looking to God and thinking that he controlled the order and time in which she uncovered her infertility. She found meaning in knowing that God looked after her.

The feelings of powerlessness over infertility shown by these women describe and emphasize the powerlessness they felt over their destiny and general path in life. They had feelings of not being in control, being powerless, of being on a path that was chosen for them in a way that they could not change and all they could do was just accept and try to make the best out of it and find meaning behind their struggle. They believed that this was chosen for them for the best, even if it was not the easiest path, it was the best direction for them.

These views of God controlling their life was taken further by other participant's views of how God chose to let them live out their lives.

Sophie focused on how God decided to not give her children:

> *"I think we had more treatments than a lot of people, but it did not work for us and nobody will ever know why. Clearly God just decided that He did not want it to work." (Sophie)*

Sophie struggled with treatments for almost ten years and these never resulted in a child. Sophie did not think that she could change or alter the way things had been decided for her. She was never going to be able to give birth to her own child, this was decided from above and there was nothing that she could do to change it.

Generally, some women tried to find meaning in why things were not happening as they wanted. As one can read from their narratives, some tried to understand and accept why they were not getting pregnant and why they were not conceiving through thinking of the greater plan that God had for them, a path that was already predestined for these women so that they could achieve their goal to parenthood.

Rachel took this notion further by stating:

> *"I looked up to the sky and I said "God, you tell me what to do" I feel like God did tell me, trust me, have faith I am not going to let you down and when I finally surrendered and I said ok God… then God gave me what I really wanted." (Rachel)*

These were Rachel's thoughts when debating whether to have IVF or not after a few failed attempts at artificial insemination. She was worried about IVF, as she felt that a child conceived outside her body would really not be her child. So she sought out God in prayer in order to make sure that whatever she would do would be with God's blessing. Through her narrative one can also see that she was looking for direction. When it turned out that she got pregnant naturally, she felt that God had been trying to tell her all along to trust him so that she could relax and not worry so much about treatments. She felt that God, who could control her life, had throughout all this challenge looked after her and taken her to her personal goal without her having to worry.

Ana and Maya thought similarly:

> *"I always believed that there is a God up there and He orchestrates what goes on in the world and to me that gave me the strength that it will be ok… there is a God in the world and if He feels that this is meant to be then it will be." (Ana)*

Ana found strength in knowing that God was looking after her. She was able to endure the treatments because she felt that at some point things would get better. This was her destiny and if this was sent from God, then there was nothing better for her.

In Maya's case, she uses this idea of God controlling her life to explain why it took so long to be able to start treatments. She felt that God was guiding her to the best time and if things were not working out as she wanted or when she wanted, it was because God had a path set out for her. Like for Ana, Maya also

felt reassured and safer knowing that God will send her down her own path. Their infertility was part of God's greater plan for them.

> *"I just thought God thinks this is not the right time to start treatment so he is making it take longer… the constant thinking about God and that he has a plan; that definitely makes it easier." (Maya)*

Maya felt that having God create a path for her removed some pressure while undergoing ART. She felt like she could only really do what was physically ok for her to do. Like undergoing treatments, seeking help and trying to change all those things that doctors recommended. Maya, like some of the other participants, felt that she could also pray and try to connect spiritually in order to understand her journey and to increase her faith.

For Karen, the idea of God being all knowing, all giving and controlling was also at the centre of her decision-making ability. This was also what gave her peace of mind and what allowed her to take a step back when treatments and miscarriages started to weigh heavy on her daily life:

> *"I really depend on my faith. I think it makes a big difference as in like you feel there is a higher decider. You are in higher hands. I believe in God and I believe that he has a plan so I think actually this is very comforting and my husband probably feels the same way" (Karen)*

Karen heavily relied on God and her faith in him to understand what was happening to her. Like for Maya, Karen felt reassured and had the strength to continue in the pursuit of children.

Along the women's acceptance that their infertility was God given an idea that this was also a test of their faith was uncovered. For these women, infertility was a direct challenge from God. Something that they knew they needed to overcome and a challenge that they knew they would be able to face as they believed that God never sent people tests that he knew they would fail. The

majority of women at the time of the study had already had children. Yet they still remembered their difficulties to conceive as a challenge from God. A test that was supposed to induce their personal growth and development.

Some women like Yael believed that God chose infertility as their path in life so that they could better themselves as: Jewish people, as women, and as friends.

> *"God is giving you tough but saying to you, you can handle it… God was giving me a hard time but still giving me the solution." (Yael)*

Nevertheless Yael believed that she did not really need this experience:

> *"I know it is an opportunity to grow and I am trying to use it as such but honestly, if I could choose thank you very much I could do without this growth." (Yael)*

The way Yael describes her challenge implies that she had no choice but to accept what God had chosen for her. This was her challenge and task in life; her path and destiny.

The way in which Yael negotiates her infertility as God given is interesting. She knows that this comes from God but at the same time she feels like she does need this challenge in her life. Nevertheless, she accepts this and recognises that there is nothing that she can do apart from try to get pregnant by using some form of ART. There is a certain powerlessness in the way she describes her discoveries. She is given these conditions from God and that is it, nothing can change, she can only find solutions to her problems.

Sophie similarly believes that God only gives one what they can handle:

> *"Hashem only tests the righteous, that God doesn't give you any more than what you can cope with and that it was because we are so special and such wonderful people that God is testing us." (Sophie)*

Sophie believed because she had faith and hope in God and faith that he wanted the best for her. In her mind, God was like a father looking after his children. A father who wants the best and knows best for his children. This is how she viewed God. God knows how and when she will become a mother.

Sophie also believed that her infertility was a test sent by God. Here we also see a similar thought to what Yael believed. Sophie's infertility is a test of faith, a challenge sent to the greatest of the community. Like it was believed about the holiest women in Judaism, the matriarchs. Sophie believed that her infertility would be a temporary state as God sent her an ordeal that he knew she would be able to pass.

Rachel also saw her infertility as a test. Similarly she also believed that God controlled her path and her destiny. More importantly she deeply believed that God sent her tasks and challenges in life. This was the perspective she took when thinking about her difficulty in conceiving. She felt that her journey to motherhood was part of her mission in this world. Rachel also related to the stories in the bible of the Jewish matriarchs who like her were inflicted with infertility in order for them to pray and change their lifestyle or in Rachel's, words to get closer to God.

> *"Abraham went through ten tests in his life… so please God in his merit we are not going to flinch, we will make it and God will give us a child… when you know that the four mothers of Judaism also had problems… it was not easy for them, why should it be easy for me." (Rachel)*

Rachel also offers an example of how some women found peace and strength in knowing that the stories that they learn about from the bible and peoples' stories were not so different from their own. Rachel accepted that this was her path, her destiny and her mission in life. Going through infertility was her destiny just like it had been Abraham's destiny to be faced with ten tests in his life. The stories in the Bible gave Rachel meaning and they allowed her to have hope and faith that she too would be able to succeed in her test of faith.

Shosh takes this idea further and describes the infertility experience as a test from God that teaches you something that nothing else does.

> *"It teaches you things that nothing else in life teaches you…. how to be more sensitive… how to listen to people… I would have never chosen that for myself and yet I am so grateful for having gone through it." (Shosh)*

Shosh also found that this test was something that she could have done without but she accepted the challenge and tried to look at the positive side of her infertility. Shosh shows gratitude for this experience. In a way she is grateful that this was the path chosen for her. Again we see this notion of a path, a destiny being chosen for these women. She could not have changed it and now when she looks back she is happy because this experience changed her for the better and made her a more sensitive and stronger person. Her infertility was a test sent by God, something she needed to overcome, in order to grow as a person and as a Jewish human being.

Infertility as a punishment

Some women who accepted their infertility was God given saw their circumstances as a punishment and something they did not deserve. These women were upset with God as they could not understand why they had to endure such difficult journeys in comparison to other women.

Naomi became a mother at the age of 42 after multiple IUIs and IVF treatments. At some point before being able to conceive her daughter with the help of donor eggs she felt really down when she discovered that she needed to look for egg donors.

> *"It felt like it was further punishment for that. I had lived with this pain and now I had to experience a whole new pain… I was angry at the time… I was very angry. I would swear to God and say some really nasty names… we basically rebelled so we struggled." (Naomi)*

Naomi thought that the need for an egg donor was painful and this for her was a new type of pain. A pain that she could not change. She did not find consolation in knowing that God was sending her these challenges. Naomi did not understand why she could not get pregnant. This made her infertility challenge harder for her and her partner.

Similarly, Gail thought her infertility was unfair:

> *"I thought that it was not fair that you know this was happening to us, but then what I took from the experience... you always have ups and downs in life… you don't think about it; you can forget about it and in a way, you forget about God and sometimes you need a reminder… a reminder of who runs the world." (Gail)*

Gail thought what she was undergoing was unfair but she tried to think of positive ways to understand her infertility. She thought her infertility was sent by God as a reminder that she was not doing enough, that she needed to become more religious or perhaps change somethings about her. She mentions that throughout her journey she did change a few things in order to try to be more religious and with doing so to be able to get closer to God.

Joana also had a deep feeling of being punished and not knowing why or what she had done wrong. She converted to Orthodox Judaism in order to marry her husband. Joana was only fully converted at the age of 37. She knew that this was already a late age to start trying to conceive but even so she was positive in her hopes of motherhood. Nevertheless, things only got worse as she realised she was struggling with *Halachic infertility*:

> *"I was 37 when I finished conversion so we got married very quickly after that, literally just weeks after, we got everything ready and as soon as the conversion had gone through we got married. I sort of suspected that we might have problems, my main problem is that I used to bleed up to 11 days, so with the Jewish religions by the time I had been to the Mikveh, I would be past ovulation time, so that was my main problem. I searched and*

> *searched for ways around because I knew biologically being a scientist what was wrong that even if my eggs were ok and everything was working well with my husband and everything was fine, the timing was just out, I was bleeding for too long and there is nothing in the Jewish religion that you can do about it and that is hard very hard because you get by every month knowing that you are too late." (Joana)*

Though aware of her problem Joana continued in her practice of family purity and respected the *Niddah* laws. She saw some doctors and eventually she managed to have a daughter thanks to IVF. After a few years, she started treatment again. Joana got pregnant with twins using donor eggs but she lost one during the pregnancy and the other baby survived. The one baby that did survive died a month later due to epilepsy. At some point in the interview after retelling her difficult story to motherhood and her recount of her loss, she opens up about how she felt punished.

> *"I went through all the hard stuff and I really did feel like I was being punished." (Joana)*

Joana had done everything according to the strictest Jewish laws and still she was not able to get pregnant easily. When she did manage to get pregnant she witnessed the death of two of her children. These challenges were not fully accepted by Joana who did not understand why her "good Jewish behaviour" was not awarding her children.

Jessica similarly felt like she was not a good person and therefore not deserving of having children:

> *"I used to think that I was not as good as other women who had babies. If God hated me… if I had done things and perhaps now I was being punished, I was not worthy… it is interesting because in the past five years I feel like I have made up with God." (Jessica)*

Jessica thought that children were a gift from God. This was a gift that God gave to those people who deserve it. Perhaps this was only for people that were good, people that were deserving of blessings in their life.

Sophie sadly felt like God was punishing her and laughing at her for her inability to conceive:

> *"I just had this vision of God in the corner of my bathroom. I can still see it now. God just pointing. Not that God has fingers, but God pointing his fingers at me laughing at the top of his voice saying 'How could you ever think that I would let you get pregnant' and I had that vision with me for weeks and weeks" (Sophie)*

Sophie felt like she was not good enough like other women who could have children easily. These comments reflect the deep negative feelings that she had about herself. She had undergone so many treatments over ten years and none ever resulted in pregnancies. Every time she had her period she felt that God was laughing at her and reminding her that she was not good enough and that she needed to face harder challenges in life.

Some women felt blame and felt that infertility was directly something to do with their personal actions and how they behaved as Jewish women. Once again, it was noted that some women took on the full responsibility for their infertility and inability to conceive. Some participants reported their frustrations towards God but never once doubted that God was in charge or that they should stop believing and having faith.

Some also mentioned how unfair their life situation was and how they had no choice in the matter of changing their fate and how God controls who does and who does not have children. This ultimately shows the struggle that some Orthodox Jewish women have. They know that God controls their path to pregnancy and healthy births but still there is not much they can do to achieve their goal apart from seeking help and having treatments and becoming more observant Jews.

It can be observed that some of these women had a complicated relationship with God. It was both a mixture of respect, knowing who 'controls the world' and who changes and determines their lives. All in all it appears that God is a dominating being who at the same time is kind to them by giving them the strength they need to undergo treatments and survive the hardest years of their lives. Though some women had this vision it was not easy for them to accept these challenges as at times they felt they did not deserve them.

I became more religious

As a result of their beliefs, some women thought that infertility was God given to test their faith and their characters. As such some decided to become stricter in their observance and practice of Judaism. The women knew that infertility was a God given challenge that required them to get God "on board" of their reproduction. In order to do so, some women bargained with God in the hope of having children.

In Lisa, Victoria and Sophie were examples of this:

> *"I was not getting pregnant as quickly as I wanted to. I was like right, I need to get God on board and I went to the mikveh regularly." (Lisa)*

> *"I felt that if I wanted something from God, I had to give a little bit." (Victoria)*

> *"I became very religious before my daughter was born. I thought I would do anything to bribe God." (Sophie)*

These women acknowledged that God was the controller of all and the "giver" of babies. Therefore if they wanted to accomplish parenthood they needed to become more religious and give something to God in order for him to return the gift.

Sophie talks about it more drastically. She becomes more religious in hope that God would make her a mother:

> *"We started the treatments after we were married and in that time, we started to become religious… many people, when they go through something like this, they go the other way and become less religious but we became more religious." (Sophie)*

Sophie believed that in order for her to become a mother she needed to increase her observance of Jewish law:

> *"I kept thinking if we take on more then maybe it will happen and then eventually we observed Shabbat. I covered my hair, I started to wear a wig and I was still working in the city." (Sophie)*

Some participants like Sophie thought that regardless of how they felt towards God, sometimes good and other times bad and occasionally closer to God, they felt that they needed God on their side and this made women want to be more religious and want to observe more Jewish laws in the hope that God would answer their prayers and grant them children. This meant for some women, they needed to increase or strengthen their religious practice. Some women wanted to follow strict Orthodox laws, even more so now as having children was something they so desperately wanted. Some participants relied on laws to guide their way through infertility treatment and also trusted Jewish law when it came to accepting infertility.

One of the common practices that women mentioned was praying. Women said that they prayed more as this helped them to create a link between them and God. This link helped them contact and communicate with God, all the difficulties of treatment and their daily physical, emotional and social struggles.

Some women mentioned that they prayed and tried harder to connect to their religion in order to protect themselves from their fears and in order for their treatments to work:

Miriam mentions:

> *"I prayed the whole time. I said psalms the whole time… it was a big deal to me." (Miriam)*

Miriam offers us an example of a woman who took on religion and her relationship to God as a support, both a moral and spiritual support. This was a pillar of strength for Miriam as she was undergoing her treatments. She found a link to peace and serenity via prayer and psalms. She was comforted by the peace she obtained from taking a few minutes a day away from the pressure of thinking of the children she did not have or the next treatment she might need to have. This break for prayer gave her faith that she would eventually become a mother.

Sarah mentions that she was very scared of undergoing treatments and that her way of dealing with the situation was through prayer:

> *"I was praying, I was terrified… I remember very clearly praying to God." (Sarah)*

Sarah had a very difficult journey to parenthood and for her it was difficult to take on her challenges as she was mostly alone. Sarah shared her experience with her family but they were not very keen on the person she had chosen to be her co-parent. This isolated her from her family and her community too. In the quote above she mentions how scared she was. She was fearful that the treatments might not succeed and fearful that she might have spent all this money, money that belonged to her family, and not have had any success. To add to the problem, she started fearing her idea of co-parenting with this man she had chosen. Her strict companion throughout her infertility journey was God. Sarah prayed for success and prayed for her treatments to go well and

prayed so that she would not fear the procedures. God was her protector and the grantor of her desires.

For Dalia, things were slightly different. She wanted to pray to God but to thank him first for all the things she did have:

> *"There is another prayer, the prayer of thanks, you say thank you for everything including the things that you do not have." (Dalia*

Dalia gives us an example of a woman who tried to accept her infertility and be thankful for all those good things she already had in her life. This was a recurrent theme in Dalia's interview. She was one of the only women that believed that children were not the answer to all of life's problems. She was an engineer by profession and she loved her work and her life. With Dalia's narration above, we can understand how she tried to focus her life on other things and how she tried to focus on the goodness around her. She was thankful to God and prayed so that she could thank God for sending her the right things in her life. This point links to the idea that God controls all happenings in her life and it is God who decides if it is or it is not right for her to have children and if she is to have them, then when will also be decided by God.

Despite Sophie's beliefs and efforts with Jewish practice she felt that she could not pray:

> *"I was able to take on more laws and stringencies and I loved it because I have always been a fanatic for rules and regulations. I loved learning all the Jewish laws but I could not pick up a book to pray. I would pray and think "what is the point" I felt that God was not answering me. I know He was answering me, but the answer was no and I just felt angry, really angry, but I still liked this new religious way of life." (Sophie)*

These prayers to have children had been unanswered. Now Sophie feels like any conversation she could have with God would be pointless. As she

mentioned previously, she felt that God was laughing at her. She had done all that she could physically and spiritually but still God was ‘telling’ her no. The answer to all her requests was always no. Instead she tried to connect via observance of stringent laws. She could not control her infertility and did not know why she was infertile and why treatments did not work. So in a way, this gave Sophie something that she could control. All treatments were directed and prescribed by doctors and other authorities she visited. Following Jewish laws and restrictions gave her some control over her life and this gave her a sense of power that she had lost over her body and fertility.

CHAPTER 5: MY RABBI

In this chapter I will illustrate the varying relationships that exist between Orthodox Jewish women who struggle with infertility and the Rabbi. This relationship emerged as a theme from the interviews with the women.

Many women in this study spoke about their Rabbi and their relationship with him as a central aspect of their infertility experience and ART journey. For many, the Rabbi was an active means of connection to God. Seeking help or blessing from Rabbis gave some of the women feelings of reassurance, positivity and a feeling that they were being proactive with their reproduction. Women also reached out to their Rabbis for medical advice and practical assistance when going to medical appointments. Women had a deep faith in their Rabbis and at times these were seen as the better and higher authority when compared to doctors.

On the other hand some women were upset with their Rabbis as these had large families who had never experienced infertility and they felt that their Rabbis' rulings were harsh and unfair. The same was true for other interviewees who struggled with *Halachic* infertility. These women felt that the Rabbi had too much power over their reproductive life and despite their strong faith and link to Judaism, this was something they could not easily accept.

Living angel

Many women believed the Rabbi was a messenger of God to help them face infertility. For these women the Rabbi was a source of information on *Halacha.* The Rabbi was someone to guide them in the pursuit of treatments and more importantly someone to give them moral and spiritual guidance.

Shosh for example saw in her Rabbi someone who was genuine, kind, affectionate and caring. The Rabbi was someone she could count on to help her with medical dilemmas, emotional support and spiritual guidance. From her

quote we sense that Shosh adores and admires her Rabbi. This Rabbi, who is devoted and dedicated to others, gives Shosh strength and motivation to go on with her treatments.

> *"The Rabbi is a living angel… he always helped us if there was anything wrong with the clinic. He had all the phone numbers of all these people and one time we had a complication and there was a mix up with Hashcaha (religious supervision) and we called him and 20 mins later he was in the clinic. He dedicates his life to people who do not have any children. Him and his wife do not have kids themselves and they are getting older so it is possible that they will not have kids at all but he lives, breathes for everyone that he can help, even when we had one of the miscarriages, he was crying with us and we are people that are not even from his community and he was literally so caring and you feel that. We usually call him before the Jewish holidays and he always gives you all the time he can and he knows the ins and outs. I had a complication with one of the clinics when they were telling me I only had one embryo and I thought I had more. So, I called him and he called them and he had his records because from every lab observance he writes a record and he writes down exactly what is going on. He said to me you should have five so I called the clinic back and I speak to them and told them that we should have five not one and they said they would call me back and eventually they called and said I was right." (Shosh)*

Rebecca emphasizes the authoritative position her Rabbi had in her life as an advisor:

> *"We became closer to our Rabbi because it is a much more emotional conversation… we spoke to our Rabbi about how to handle moods… and to advise us on how to protect dignity… we also had some surrogacy questions and some Shabbat issues." (Rebecca)*

Rebecca focuses on the fact that her relationship with her Rabbi was strengthened because of her infertility journey. She had him at hand for all possible questions she might have and for her this was a connection that she

needed. Rebecca knew that while facing treatments the Rabbi was going to be her right hand man. For Rebecca this relationship was not just one of *Halachic* advice and ruling, it was a more private and personal relationship as she share her most intimate and sensitive information with her Rabbi.

Blessed by the Rabbi

The Rabbi as a representative of God on earth was held at a very high status for many of the women. This was particularly seen as some women visited their Rabbis before starting any treatment in order to have a blessing to ensure their treatments would have a positive outcome.

Rachel mentions:

> *"We went to the leading figure in the Jewish community… we went to Rabbis for blessings." (Rachel)*

Rachel visited the most important Rabbi in the community before embarking on fertility treatments to ensure that she was doing things according to *Halacha,* but more importantly to make sure that her treatment would be blessed with a positive outcome.

Could we argue that Rachel's infertility made her feel cursed? Rachel had not had any successful treatments and she wanted to be a mother. As an observant Jew she understood the connection between Rabbis and God. Rachel knew that Rabbis are the closest figures to God and in some ways they represent God. Going to a Rabbi for a blessing was her way of ensuring that she was doing the right thing and that God would be on her side.

Rebecca, like Rachel, found a direct link to God via important Rabbis in the community. For Rebecca the relationship involved:

> *"To get pregnant at some point we probably took things on… we went for a check-up once and the place was near the grave yard of an important Rabbi, so we went to pray there on the way." (Rebecca)*

Rebecca wants to be successful in her check-up so to ensure this she goes to pray to the grave of an important Rabbi. Along this idea also sits the fact that Rebecca only started to pray and to be more observant because she wanted to become a mother. She knew that for this to happen God had to want her to have children so she starts becoming more religious to increase her chances of success. In her case we see how part of becoming more religious means getting closer to a Rabbi. Again we see the Rabbi as a mediator between woman, God and children. Rebecca prays at the Rabbi's grave as this is recognised as a holy place so that God will find favour in her prayers and answer them with a baby.

Sophie, who underwent treatments for more than ten years, also describes things she did for these to be successful:

> *"We went to various Rabbis and graves to go and pray. We went to different places in Israel to pray. We had everyone praying for us… we were eating fig jam that had been blessed by somebody from Israel… we were having pomegranate juice that was blessed by the previous Chief Rabbi of Israel… we did everything that you could possibly do." (Sophie)*

Sophie also believed in the power Rabbis hold. Like Rebecca she prayed at the grave of various Rabbis to pray for her success. Sophie was desperate to have children and despite her various failed attempts she did not give up. She went along the years trying harder and harder and adding new prayers and actions so that God would find favour on her.

Lisa shows us a different relationship with her Rabbi:

> *"I emailed the Rabbi before I was about to start IVF and I asked him if there was anything specific I was missing or what I could add to my prayers." (Lisa)*

Lisa, similarly to Rebecca and Rachel, found in her Rabbi an advisor that ensured she was praying in the correct way, with all the prayers she needed to make sure that all would go well. Lisa felt connected to God through the Rabbi and now just before starting IVF she speaks to her Rabbi to make sure she is doing things right. The Rabbi in this case, who knows best, advises her and guides her to make sure that she will pray the correct way.

Lisa finds spiritual strength in her Rabbi. The Rabbi was contacted to reassure her so that she could go on with her treatments. Lisa, like the other women, needed insurance that they had done all they could to make sure that God would answer their prayers with a child. In this case the Rabbi gives guidance about praying and getting closer to God.

The Rabbi knows best

The Rabbi was not just someone who gave blessings but someone who helped, motivated and ensured women that their infertility would pass. This was at times taken further as it was the Rabbis who also helped women and couples decide when to start or stop treatments.

Andrea had struggled through a few IVF treatments and she could not understand why these were not working. Her husband had had a child from his first marriage but now they both struggled with infertility. This was causing her great stress mentally and physically. After another failed IVF treatment she decides to visit a great Rabbi to get some answers. This great Rabbi is a leading figure in her community and someone that usually people go to for advice on important life decisions.

> *"I think we had just gotten a negative result and I scheduled another IVF for March or something like that and he (Rabbi) said to me – by this time next year you will have a child – he (Rabbi) also told me to do A, B, C and I believed him. Not only did I believe him but I was totally confident in him." (Andrea)*

This Rabbi told Andrea what she wanted to hear. She needed something to hold on to, something that gave her faith and would help her find strength to continue on her path to motherhood. The Rabbi gave Andrea just that. Andrea now had a direction and she was positive that this would result in what she hoped for. She was going to become a mother because the great Rabbi told her so. She now had faith and this gave her strength to continue her IVF treatments. As it turns out exactly one year after she saw this Rabbi she gave birth to her first daughter with the help of IVF. This reinforced her beliefs and faith in the Rabbi.

Later on in the interview Andrea mentions another interaction with the Rabbi. This time not such a positive one:

> *"We went to see the Rabbi and my husband explained everything and then I explained everything from my point of view and I said I still want another child. We still have three frozen embryos and the Rabbi said "after hearing your story do not do it, do not have more kids" So, I said what do we do with the three embryos and he said - throw them away - I made peace with it and by the time I was 45 I decided that I was not going to have any more children." (Andrea)*

The Rabbi here took on such an important part in her life and in her reproductive decision making process. This was a very crucial moment for Andrea and not a decision she took lightly. She was struggling emotionally and physically after having several miscarriages. Yet she could not let go of the idea that she still had frozen embryos. She felt that these would be a waste and ethically she

could not get rid of them because she remembered what it was like to hold a new born baby in her arms. Andrea saw the frozen embryos as frozen potential babies and this increased her desire to have more treatments. When Andrea and her husband went to seek advice from the Rabbi to see if to continue treatments or not Andrea was suffering severely due to her physical and mental health. The Rabbi advises them not to continue treatments. Now despite her desire to continue trying to have children Andrea accepts this advice as final ruling. In this scenario the Rabbi tells Andrea something she did not want to hear but she follows it blindly.

In the first encounter Andrea received the news she so much longed for, she was going to become a mother. She was happy, full of hope and joy thanks to the Rabbi. In the second scenario, the Rabbi puts a stop to her IVF treadmill. This is something she is not happy about and as she clearly wants to continue treatments. We see from the quote above that she did not contest this advice and she "made peace" with the Rabbi's recommendation to stop treatments. The Rabbi for Andrea was someone that you listen to for the good and bad even at times if you do not agree with. In some ways the Rabbi here is like an all knowing father who knows what is best. The Rabbi takes on the position as second in command to God. A representative of God, an authority here on earth. So Andrea did as was told by her Rabbi because he knew best.

The Rabbi in these cases is not just a religious and spiritual leader but also a negotiator of medical treatments and clinical procedures. In my study women discussed how Rabbis ensured that all clinics were on board and were informed of all possible Halachic troubles if treatments needed to be carried out on *Shabba*t. This idea of doing things according to Jewish law was very important to most participants in this study.

For example before Rachel started seeking help, and before starting with IUI, she asked one of the leading figures of Jewish law how she could go about her treatment and what she could and could not do.

"Went to Dayan to see what was allowed and not allowed. Jewish law is the law. If they ask you to do something you do it because it is the truth." (Rachel)

Rachel spoke of Jewish law as the guide to her life and the code book of laws by which she lives and guides herself: "the truth". For her there was no question that she was going to follow these laws in her pursuit of motherhood. But for this she needed to contact the Dayan (a leading figure of Jewish laws). She wanted to follow laws and ensure that everything would be done by 'the book'. The Dayan dictated how she should have treatments and for her this meant that the treatment was 'kosher' and allowed. Without the Dayan's guidance and blessing, she would not have continued with fertility treatments. In the quote above we can also note the importance that she places on Jewish law. Rachel refers to it as "the truth". For her this was exactly what Jewish law, religion and God were. All three parts for her were combined. She could not have one without the other. Her life revolved around these things and she knew that she needed to follow all laws in order to be close to God and so fulfil her mission in life whether that included children or not. On another level when thinking about what having children meant to her, one can expect for her to want to have children in the best way and in accordance to Jewish law. Rachel, who followed Jewish law throughout her life, was not going to change this now, especially as it came to obtaining one of the greatest blessings that any person could be given. If she was going to have children she was going to do so in the most holy and "*Kosher*" way.

Rabbis giving medical advice

The deep trust these women had on their Rabbis extended to sharing with their Rabbis medical information and at times attending medical appointments with them too. For some women in this study the Rabbi was also a pillar of knowledge on fertility and reproductive health. A lot of these women did not fully understand reproductive health and as such the Rabbi was their only point of contact.

Ana was lucky to succeed at the first IVF attempt and she gave birth to a girl. When she started trying for her second child, she was not so lucky. Treatments were not successful and suddenly she did not understand what was happening, so she speaks to the Rabbi:

> *"The Rabbi that I spoke to, he said that he thinks that my progesterone levels were very low and they should have picked up on it and I should have had the hormones in a higher dosage… every time I called the hospital they kept telling me, like the first two times they told me not to worry about it, just to carry on as usual and just to take the medication when I am supposed to and that there are women that bleed for the first trimester and that it was nothing to be concerned about and when I was doing the fresh one I did not even call them when I started to bleed. I think we had the transfer on Sunday and we started bleeding a little bit on Tuesday and I thought why should I call, they are going to tell me the exact same thing, continue the medication and take the pregnancy test when we advise. But then it was Friday and we were going into Shabbat and I was thinking I hate knowing that I cannot call anyone in case something happens. So, I just called Rabbi S. just to tell him what was going on and he was really upset and he said "if you are spotting then the chances are that, it is not it's your period trying to come through, because you are not supposed to have your period now" The chances are he said that your progesterone levels are low. So, instead of going into the hospital because it was quite close to Shabbat like three hours to Shabbat, I drove into Stamford Hill instead and there is a mobile phlebotomist and he is a really nice guy so he took my bloods and the Rabbi spoke to my doctor and they were both happy for me to start taking a higher dosage of progesterone because that was their gut feeling for the reason I was spotting". (Ana)*

Ana seems lost but she finds direction thanks to her Rabbi. Her Rabbi was not just the provider of spiritual connection to God, he was also an authority which she admired and followed when it came to talking about treatment and in coordinating procedures. Furthermore, Ana felt reassured that the Rabbi was there to guide her and point out things that she herself was not aware of or things that she simply could not understand. This gave her guidance, not just

spiritually but also medically. For her it was more than just a connection to God and what was right in terms of Jewish law. For her the Rabbi was a friend, someone like her who understood her restrictions as a Jew and someone who looked after her emotional, spiritual and physical health. Perhaps unlike what she saw her doctors as. Her doctors were another completely different level in terms of authority. She did not have such a close relationship with her doctors and in her perspective, this impacted the way she related to them. She trusted her Rabbi more than her doctors and this gave her confidence for her treatment as she felt he was on her side.

> *"In order to find out what was going on we had to go to a doctor and because it is much more complicated in the Jewish community, you cannot have a man just produce a sperm sample willingly so we had to do what we had to do and so they were checking to see what was going on. Unfortunately, they could not find any live sperm and that is what was happening. I am saying that was the results of all the tests. So, then we were referred to a big doctor in that department." (Ana)*

Ana describes what it was like initially to discover that she could not conceive naturally because her husband did not have any live sperm. Comparing back to her previous quotes about her Rabbi, there is a difference in the way Ana talks about the doctors and how she talks about her Rabbi. She discusses the doctors external to her and only there for her so that she can fulfil the purpose of becoming a mother. She went from doctor to doctor without developing a personal relationship to them, just in order to understand her situation better and try to 'fix it'. The relationships she had with the doctors were external, brief, superficially related to her reproductive health and that of her husband's and a fast paced one. In comparison to the relationship she held with her Rabbi. This relationship was a deeper one where she often asked her Rabbi questions on life, religion, guidance, in the case now for medical and treatment related questions. It is also as simple as the way she calls the Rabbi "my Rabbi". This implies a personal relationship. She established a connection with this man because she had faith in him and followed his instructions and rulings. The

Rabbi offered much more than the doctor. The Rabbi gave her a spiritual connection to God, reassuring faith that her treatments will go well and at the same time her Rabbi understood infertility treatments so he could guide her towards a successful medical treatment.

In Maya's case it was her Rabbi who recognised her inability to conceive:

> *"We got married five years ago and I never had my periods that often so at one point I think we went to the Rabbi or something and our Rabbi realised that maybe this was something odd. We just went to him for a different question and he then said that maybe we should see a doctor and that was ten months after we were married." (Maya)*

For Maya, her Rabbi was a leading figure, someone to contact when she needed religious guidance but in this case, someone like a father that helped her understand why 'things' were not working out for her and her husband. It was the Rabbi who suggested that what was happening to her was not 'normal'. Here we notice Maya's lack of knowledge in the matter which is opposed to that of the Rabbi. Maya takes the Rabbi's advice and seeks medical help in order to try to get pregnant.

Later in the interview Maya adds:

> *"I just thought there was IVF and after IVF there was nothing else and that IVF just meant stimulating, egg retrieval and then the transfer. I did not realise that there are different types of ways that you can stimulate and there are other types of things that you can take and progesterone can be taken in two different forms and you can have a three or five day transfer. Like I did not know there were other options and trying other options might help or even genetic testing. I did not know there was that, so we went to the Rabbi to just ask him." (Maya)*

When Maya started discovering that she was infertile she was just 19. Maya comes from a very Orthodox family who considers themselves Charedi. She was not very aware of fertility and what this meant or in this case what happens when infertility pays a visit. She just knew that she should have had children already. She did not know what IVF entailed and what types of treatment were available and what she could or could not do in order to have better successful treatments. Again we see where her trust is with these uncertainties. She contacts her Rabbi to help her understand the treatments that she finds difficult to digest. The Rabbi who helped in the discovery of her infertility also helped in the navigation of the medical and clinical language and decisions. In her case it seems that the Rabbi holds a closer and more trusting position than her doctor does.

Maya takes this further by stating how much she appreciated her Rabbi:

> *"Our Rabbi has really been so helpful. Sometimes he comes with us to our appointments and helps us to ask more questions, because we ourselves we do not really know what to ask. We are just so unclear. Like we did chlomid 25 times and after we did it nine times. We heard that it was not safe to do it more than six times I think and she just made us do it so many times for some reason." (Maya)*

The Rabbi, who is not a qualified medical professional, helped Maya decide treatments and guide her in what was healthy and normal. Similarly Sosh and Ana also trusted their Rabbi more than they trusted their doctor. Maya's Rabbi came with her to some appointments and helped her and her husband ask the right questions. Again, we get this notion that both Maya and her husband do not really know or understand what is happening to them. They seem to just go from doctor to doctor, from appointment to appointment. The Rabbi is their guide and on occasions helps them understand what they need to do in terms of Jewish law and in medical decisions. The Rabbi is Maya's great advisor and teacher. He was the person that taught her what she now knew of fertility

treatments. The Rabbi helped her contest medical decisions that she did not understand and did not agree with.

This theme is completed for Maya when she mentions that she trusted her Rabbi with their infertility on the same level that she did with her family. This was important as she decided not to share her challenge with anybody, just her family and her Rabbi:

> *"Yes, we shared it with parents, parents in law but I have not told any friends, like there is not really anything to say. I guess there is PCOS or whatever, but I have not shared anything with friends or whatever, just with family and our Rabbi." (Maya)*

The Rabbi offered her a direct connection to God but also a direct connection to the doctors that she saw and did not fully understand. The Rabbi provided her with understanding through the Jewish law aspect of treatments and more importantly through the medical side of treatments. In Maya's case the Rabbi was crucial. It was from the Rabbi that she obtained information on reproductive health. As most Orthodox Jewish girls she did not receive any information in school or from her family about her reproductive health or possible infertility.

Ruth similarly shows us how much she needed her Rabbi:

> *"A Rabbi specialised in fertility, he gave me permission to do the treatment and I had his support and I just used to speak to him every day." (Ruth)*

Ruth struggled with over five miscarriages and could not understand why doctors had not done more in her case to try to understand why she was not being able to carry a pregnancy to term. Later on, she discovered that this was due to a chromosomal translocation in her husband. She needed PGT in order to be able to ensure that she would have a healthy child. Ruth, as a Modern Orthodox Jew, wanted to ensure that she was doing everything according to Jewish law. After the Rabbi showed her support she grew attached to him. From what we have uncovered of the deep relationship that women feel between

themselves and their Rabbis we can imagine why Ruth would want to speak to her Rabbi every day during this time. We know that Rabbi's offer emotional, moral, spiritual support and these are all consolations that anyone facing difficulty to conceive might need. In her Rabbi Ruth found strength so she held on to it by speaking to him every day.

He does not understand

Nevertheless, some of the women found that having a Rabbi so deeply rooted in their lives was not always easy. These women understood that at times they had no other option because this was a part of Judaism that they could not change due to its *Halachic* nature. Some women also had a problem with the Rabbis being male and more importantly, how some scholars they had encountered knew nothing of fertility and how this was unhelpful to them in their journey through infertility.

Sandra found it hard to connect to their Rabbi on many levels. She was able to conceive her first child naturally so when she tried to get pregnant again naturally and it did not work she went to ART for help. Before starting treatments she went to her Rabbi to ask him questions regarding Jewish laws and fertility treatments. Below Sandra describes the relationship she has with her Rabbi and the type of questions she asked him usually.

> *"He is someone who I work with on a daily basis so I already had a good professional relationship with him and I found it hard because I knew he would not have any understanding of infertility himself. They have a large family and he admitted that they never had any fertility issues but I did not go to him for emotional counselling but just purely Jewish law questions. Say we are in this situation what can we do, do we have to postpone this cycle because it is all happening on Shabbat or something and he was surprisingly, not saying that he was lenient, but he gave us the go ahead for the treatments." (Sandra)*

Sandra had practical questions in terms of having treatments and doing things in the "*kosher*" way so she went to her Rabbi. Like many of the other participants if she was going to have a child through IVF she was going to do it according to *Halacha*. Nevertheless, this was hard for Sandra despite the good relationship she had with her Rabbi. Sandra felt that the close proximity she shared with him and his family would be a blockage for her. She worried that he would not understand what it would be like to be childless and desperately want to have children but be limited *Halacha*. Sandra knew that the Rabbi was a friend to her but she also knew that above that he was an authority figure therefore if the *Halacha* were to limit her chances of treatment he would give her that advice despite her desperation to become a mother. Nevertheless, the Rabbi did allow her to go through with the treatments.

Sandra's problems with her Rabbi and Jewish law continued:

> *"I seemed to be ovulating a bit too early and so that by the time that I could go to mikveh it was too late and I think that was another issue. So, I found it very frustrating that men who have never had a single period in their lives get to tell me when my period starts or when my period stops etc ... There was this whole time when I was constantly running backwards and forwards with the Rabbi that I used to talk to about when I could go to the mikveh and having to show him my knickers… that was revolting really. I found it degrading and really intrusive. That actually has had an impact on my general feelings about family purity. I have a very negative feeling about family purity in total and I think that is a huge part of the reason why. But yes, I felt like there was an assumption that the problem was mine and I felt like I was just being used as a vessel to have a child rather than a person in my own right that I should have any feelings on the process. I hated this idea that based upon my knickers the Rabbi could tell me if I could go to the mikveh tonight or tomorrow night." (Sandra)*

Sandra found *Niddah* to be a difficult challenge within the infertility experience. Unfortunately, the way Sandra had to practice *Niddah* altered the way she viewed her family purity practice. Nevertheless, Sandra still practiced *Niddah* despite her deep negative feelings about the involvement with the Rabbi each month. This shows us the importance that this had for her. Even if she hated the practice and had a problem with being checked by a man, she still did it. For her observance of Jewish law was more important than her own personal feelings about how things were done. Sandra was able to compromise herself for Jewish law. For Sandra, the ends, becoming a mother, justify the means.

Some participants had difficulty accepting that Rabbis would indicate when they needed to start counting the days of abstinence and when they could have the spiritual immersion in the *Mikveh* to resume sexual rapport with their husbands. This was difficult for some women to accept as women who were already being poked enough by medical professionals and who had their dignity and intimate privacy already picked apart.

Shternie thought religion gave her stability and "something to hold on to" but saw her relationship with Rabbis and religious authorities change as a result of a negative experience with a Jewish counsellor:

> *"I had a very bad experience with the counsellor, at first it was ok and then as soon as she found out I was bisexual, bisexuality is not allowed in the Jewish community because I am going to cheat on my husband and it is my fault that he cannot ejaculate because I cannot turn him on… mentally she made me very ill and when I had my first miscarriage she said it was good because I had mixed sexual feelings." (Shternie)*

Shternie was very distressed by what this counsellor said to her and this was still evident when discussing it in person three years later. When replying about her relationship with Judaism, Shternie replies that this changed and in some way, she was brought further from religion due to the altercation with the counsellor. This deeply impacted her and made her see other religious figures

differently. She felt slightly disconnected from them or simply that she could not trust them as they might judge her for being bisexual, for not knowing with certainty what it was she wanted. At the time of the interview, Shternie still suffered from some mental health problems.

She went on to add about how close she felt to Judaism:

> *"In some ways, further and in other ways nearer, because it meant that we had to speak to our Rabbi more often but then further because of that counsellor. I thought well maybe that is what all Jewish people think and maybe she is right and I am not allowed to be a mum and every time I am finding things hard I think maybe she is right and everything is because I am bisexual. I refuse to see a counsellor. I am still Orthodox but I refuse to see a Rabbi or speak to anyone religious as I am afraid that they will judge me like she did. Nevertheless, last week I have a very good chat with my Rabbi and he was great support." (Shternie)*

Shternie build up a wall towards any Jewish authority because she was afraid of their judgment and their reaction after her previous altercation. Here we see a woman who became traumatised because of a bad experience with one counsellor. Shternie admits that she is still Orthodox but she cannot see a Rabbi or even speak to one because she is scared. Towards the end of her quote we see how surprised she seems to have had a positive interaction with a random Rabbi. She seems to not have expected it and this perhaps could begin to undo the hurt that the counsellor caused her.

In Joana's case, she was struggling with *Halachic infertility*. Joana was upset at her Rabbi as he would not allow her to make the *Niddah* period shorter, therefore she was missing ovulation every month and as a result she was not getting pregnant.

> *"My main problem is that I used to bleed up to 11 days, so with Jewish religion by the time I had been to the Mikveh, I would be past my ovulation time. You just have to give me permission to go to the Mikveh three days earlier, that's all it would take and that is hard to keep going and to keep doing what they say when as a scientist, as a human being, it is your body and you know that you are ovulating before you get to go to the Mikveh. There was no Halachic way around the Mikveh problem." (Joana)*

Above we can read the impotence Joana felt. She could do nothing to change how her cycle went. Again, like with Sandra, for Joana it was important to follow these laws so there was no way that she would just go to the *Mikveh* a few days earlier. Joana had done everything in her life according to Jewish law and by the book and this was not going to change now even if that meant not getting pregnant as soon as she wished. For Joana, this also changed her relationship with her Rabbi. He was very strict with her and this made it harder for her to relate to him as she felt that he did not understand her need to become a mother.

As we have noted the Rabbi had a multi-dynamic relationship with these women who struggled with infertility. This was not just as representatives of God but also as medical, spiritual, emotional guiding points for these women when facing infertility. Rabbis gave women indication as to when to have and how to have treatments according to Jewish laws. In some occasions, Rabbis also gave women medical advice and as noted this was something they held on to and followed as if the Rabbis were doctors themselves.

CHAPTER 6: MY RELATIONSHIPS

For a lot of the women in this study their relationships with their husbands, families and friends were a central part of their life. These relationships, though meant and expected to provide support, instead created additional pressures to the women's infertility. Occasionally this resulted in some women feeling isolated and therefore not wanting to share their infertility experience with family members or friends.

Some women in this study felt that infertility put a strain in their marriage. The pressure to have children changed their relationships as suddenly the focus of their relationships were to procreate. Participants also discussed the pressure they felt as women to help men fulfil the commandment to procreate. Women felt an obligation to their husband's, one that was often extended to them protecting and concealing their husband's inability to conceive.

Other women felt that the difficulty to have children strengthened their relationship with their husbands. As a result these participants felt that the challenge united them more than any other experience they could have had.

Women discussed the immense pressure they received from their parents to have children. Particularly the pressure women felt from their mothers and their desires to be grandmothers. The negative maternal relationship for some of these women was the reason they wanted to have children. These women wanted to create the bonds they never shared with their mothers.

Other changes included the way women related to their extended families, communities and friends. The relationships suffered the consequences of negative comments, suggestions and invitations. Women highlighted the strong pressures they felt from seeing their families increase and be able to have children while they could not. Other thoughts included the way their communities expected them to have a child after the first year of marriage and how this pressure led women to feel isolated and weird in their communities.

The way women expressed the change in the fundamental relationships when facing infertility is explored in this chapter.

My husband

Marriage, which holds an extremely valuable place in Jewish life, is the source of the most intimate relationship for a Jewish woman. The duty to procreate, which although sits on Jewish men, does at times hover over women's heads too as a duty and obligation to help their husbands in this mission. Some women in this study, due to their infertility and inability to conceive naturally, saw their relationship with their husbands' change. Some of these women started to feel like they needed to follow their husband's advice and indications dutifully when it came to deciding how to have children, in terms of when to have children and how to space out the treatments. This was sometimes at the cost of their own wellbeing and mental health.

From women's stories it appeared sometimes husbands unintentionally became a source of pressure for the women. Some women in this study reported to have felt some pressures from their husband's to continue treatments and to start new IVF cycles even when at times they did not feel ready for this. Despite these pressures women accepted to go along with their husband's directions. We could argue that this is because Orthodox women believe it to be a religious honour '*mitzvah'* for a wife to help her husband to fulfil the obligation of having children.

Rina was an example of this. She got married at the age of 23 and after a few years of trying to conceive and not being successful she decided to seek help. After a few tests she was diagnosed with unexplained infertility. Rina had a few IVF cycles that resulted in pregnancies but ended in miscarriages. On her third cycle she conceived and then gave birth to a girl. A couple of years later she decided to start trying for her second child. She had an IVF cycle but this did not go well as there was a complication. This delayed her next cycle as she

needed to recover. Nevertheless, her husband was eager to continue trying for a second child:

> *"I got pregnant with IVF and I miscarried again. Then I waited. It was back to back so it was a bit too much for me so I thought I would wait a year and not do anything and so we waited a year and then my husband pushed me to use the frozen cycles." (Rina)*

Having children for Rina was important as a Jewish Orthodox woman but in some ways it was her husband who pushed her to continue treatments. It seems that she did not want to continue treatments especially as she did not feel ready for this physically yet she went along with what her husband wanted. This could have been out of duty or obligation towards her husband to give him children. But in any case, she went along with what her husband wanted against her will. Here she obeys him and put's his desires first, rendering herself as a vessel of procreation.

Jessica, after undergoing multiple complications decided perhaps it was time to stop and start thinking about adopting. She felt physically tired and emotionally drained. But her husband suggested for them to have one more IVF treatment.

> *"I remember him saying to me I understand you want to adopt and I will go along with it and the whole time actually through this whole process it had always been me pushing. He wanted children but I would have said to him, look it is not happening, let's just live our life and you focus on your business and I will focus on my career. He would have gone with it, it was always really me pushing so, he said to me let's just give the IVF one more go." (Jessica)*

Jessica's husband who up until now had just tagged along because of Jessica's desire to be a mum, now asked her to consider IVF one more time. Jessica decides to listen to her husband despite her need for a break. Similarly to Rina's case, she lets herself be persuaded to continue. When Jessica tells me about complying with her husband's wishes she sounds happy. She later mentions

that thanks to that treatment she then went on to have another child. The same was true for Sophie. After nearly 15 years of fertility treatment the couple adopted a girl but before that her husband wanted to try and have as many IVF cycles as possible. It was only towards the last two years that they decided to go for adoption:

> *"We had not been able to have a child and at this point, I was ready to consider adoption but my husband, he was not. I would have happily adopted much sooner than we did." (Sophie)*

Sophie wanted a child and she did not care how this happened. Whether it was via IVF or adoption it did not matter. Sophie, like Jessica and Rina, did listen to her husband and kept trying to conceive with IVF. This leads her down a path of more unsuccessful IVF cycles which only add to her feelings of hopelessness and failure.

Sophie put her husband first and followed his intuition on the way to continue. This is interesting because cycles, procedures and treatments are mostly taking place in the woman's body. Sophie, like the other women, appear to be sacrificing their bodies in physical pain to attain the children they desire with a push "pressure" from their husbands. Despite the pain and readiness to move on they listen and dutifully continue with treatments.

In Andrea's case, the desire to have children though from her husband was rooted on his religious practice:

> *"My desire to be a mother was not that strong…I could have seen myself somewhere else… but living in a religious community and living with a religious husband." (Andrea)*

As Andrea describes her infertility experience the feelings of stress anxiety and needing to belong are what come to the surface. Her husband had a child with his previous wife but for some reason together they could not get pregnant.

When Andrea got married she was not as religious as her husband and over time this changed. She became more religious to please him and be able to be with him. Along with this came the pressure to have children. Something which she says she was not “desperate” about. But as her husband was religious she knew he wanted to have more children and she wanted to be able to belong to his community so she took it upon herself to do anything in order to have children. Consequently, as she goes on, it becomes clear that this decision gave her two children, but it cost her a lot emotionally, psychologically and physically.

Karen similarly mentions that she was not desperate to have children but her husband wanted a big family:

> *“I was never desperate to have kids so when it did not happen I was not like oh my gosh why is it not happening. But my husband, he always wanted to have a big family and he always wanted to start straight away.” (Karen)*

At the time of the study Karen was one of the women who had not managed to have a successful pregnancy. She was not totally devasted when she did not get pregnant straight away but in the way she describes what her husband wants it suggests he did get upset when conception did not occur. It seems that this “hit” him harder and in some ways his desires for a large family are what keeps her going in her journey into IVF. Karen further adds:

> *“I just have this feeling that I know it will happen and when it does I am fine with it and it is more the physical toll it takes on me. The emotional toll that it takes on my relationship with my husband, that I resent the most.” (Karen)*

She is confident that she will have children and this helps her to let go of stress. As she mentioned she is not desperate to have children but on the other hand it seems that her husband is, so she has treatment after treatment. They face multiple IVF cycles yet none result in pregnancy. For her this is not a stress but

for him this means he is further away from the large family of his dreams. At the time of the interview Karen was getting ready to embark on another cycle of IVF. She wanted to please her husband and give him the children he desired.

Dalia, who similarly wanted to please her husband, only wanted to continue having IVF because she wanted to give him a biological child:

> *"My husband is a Levy. I could not do egg donation because egg donation applies conversion, conversion so that the child would be Jewish but then the child would not be a Levy and for us it was problem. I wanted my husband to have children that would be Levy like him. If it is a boy to be like his father and if it is a girl the Jewish laws for a daughter of a Levy is different." (Dalia)*

Dalia got married later than usual and expected in the Orthodox Jewish community. She was aware that her chances of IVF were less than if she was a woman of 20 years of age. Nevertheless, egg donation was an option that she refuses to consider because as she explains above her husband belongs to a special Jewish kinship. Here Dalia is the one that inflicts on herself pressure to please and honour her husband. She wanted to help him fulfil his obligation of parentage and of continuity in the 'Levy' Jewish lineage.

For some women whose husbands were the reason for their infertility, their relationship became one about protecting their husband's maleness, ego and appearance to the outside world. Some women did this at their own expense.

This is what happened to Ana. For five years she did not realise there was a problem and only after multiple tests was it discovered that her inability to conceive was directly linked to her husband's low sperm mobility. In the interview, she was asked if she would share her infertility journey and open up about her treatments. Ana straight away mentioned that this was not her experience to share and to protect her husband she would not say anything:

> *"When I was going through it I did not tell anyone anything. Also I felt really that it was not my secret to tell, that it was more my husband's thing and you don't want to undermine him or anything and if he wasn't comfortable saying it, then I am not going to tell his secret." (Ana)*

Throughout the interview Ana said how hard it was for her to go out and be out in the community as people would ask her questions and look at her stomach inquisitively. Nevertheless, she did not tell anyone about her journey and about her struggle. For her it was more important to protect her husband and respect his privacy than her own difficulty. Ana found it hard to go through the treatments and the struggle was only more difficult because people started to look at her and ask questions. Her family and her mother specifically wanted to know why after five years of marriage she still had not had a child. When she discovered that it was her husband who was limiting her chances to motherhood, she did not share it with anyone. Ana felt that if she protected her husband's privacy it would help to bring her closer to her husband.

In Shternie's case although she does not admit that she carries the blame on an external perspective her narrations indicate that emotionally and psychologically she feels like it could be her fault. She feels bad for her husband because: "As a man he was ashamed and embarrassed". In her compassion for her husband's feelings, as a man, she seems to be forgetting about her own feelings as a woman and a human being. Living through the treatments, pressures and miscarriages led Shternie to "deep depression":

> *"Then a week and a half later I started bleeding and I went into quite deep depression… For all the miscarriages, I got very ill and mentally too. I got very low and then I started to get a phobia of sex because for me sex equated miscarriage and failure. It was just horrible… I am petrified of ever having another child again." (Shternie)*

Shternie is not the one to blame for her infertility yet she takes on the miscarriages and the unsuccessful treatments as her fault or so it seems from the severe depression that results from the failed attempts. After multiple attempts they manage to have a baby. Yet after all the failed treatments and miscarriages her depression develops into phobia of having sex and having more children. She carried a view of herself being the one to blame. This was also discussed in the previous chapter with her interaction with the counsellor that suggested that she would never be a mother because of her confused sexuality. At the time of the interview Shternie had just come out of hospital and she presented herself with large plasters in her arms that covered the places where she had self-harmed. When we spoke about her depression she pointed at these plasters and said she did not consider herself strong at all. Shternie is not the reason why the couple needs infertility treatment but in her mind she sees herself as so and in doing so she protects her husband maleness.

Other situations included occasions where husbands were present at the time of the interviews. This happened for Rebecca and Dina. In Rebecca's case this was because her husband was a specialist in the field of fertility. For Dina, it was because it was the male partner that could not produce viable sperm therefore the couple opted to use sperm donation and the husband wanted to be part of the infertility interview. Both Dina and Rebecca, seemed to be happy to have their husbands present at the time of the interview. Nevertheless, this could have affected the way they answered several questions and this in itself could have put pressure on them when it came to answering and really being able to open up about what it was like for them to have undergone ART.

Some women talked about how their relationships were strengthened due to the infertility challenge. For some this experience was an important step in their marital relationships. Some women were grateful for their husbands because they made the experience lighter for them. For some, who in the end had children, this experience brought them closer together.

Yael was grateful for her husband's strength and willingness to go through anything in order for them to have children. She felt blessed by this:

> *"I have a husband that says this is what we need then that is what we will do. Who says we will pay for it as many times as we can. Who is with me so, that is another blessing." (Yael)*

Yael had so many difficulties with her gynaecological problems that having her husband by her side and having him support her emotionally and financially was such a positive experience in her difficult journey to motherhood. Yael's husband understood that she wanted to become a mother and it was important for her to carry the baby. She knew that she could not have a child that was biologically related to her because her eggs were no longer viable. Yael struggled to accept this but when looking at the brighter side she saw that one option for her to be involved in the pregnancy process was for her to use an egg donor. Her husband understood this and the above quote narrates her husband's answer. He was willing to do anything for her and help her in any way he could, whether this was financially or emotionally. For Yael this was a blessing amidst her undesired infertility.

In Leah's case, her husband was the best companion to have for this challenge. She knew from the age of 16 that she had Rokitansky syndrome (she was born without a uterus), therefore, she knew that she would need a surrogate in order to have children. During the interview, she mentioned that she accepted this diagnosis and did not pay it much attention growing up. When it came to the time of finding someone suitable to get married, she mentioned it to her husband and he had a very positive reaction and was very supportive:

> *"I told my husband. He went off and did research into it and he came back and asked questions and I kind of knew that he was ready for it which sounds crazy… but I knew. We must have been engaged and he came to the doctor with me to find out what it was going to be like because I didn't want to get married and then have him say my gosh I cannot do this, like that was my route and that was what I was going to have to do, this is part of me but he is amazing and we just did it together." (Leah)*

Leah was straight forward with her then fiancé and now husband. In the interview she mentions how this was something she had made peace with while growing up. Nevertheless, for any potential husband this could be a problem. This could be a problem as according to Jewish law there are no clear instructions as to who establishes Jewish identity when a surrogate or egg donor is used. Leah knew that these were issues she was going to have to face in order to have children. For her they were not a problem, it was her only way to motherhood. As it can be read above once she told him, she was pleasantly surprised. He accepted the challenge and joined her on the journey as she said "we just did it together". These words suggest a relief in having someone on her side, someone to hold on to and someone to be there for her as her infertility was very public. She needed someone and this someone was her husband who became a pillar of support for her.

Dalia similarly uses this notion of doing the infertility challenge together:

> *"Thank God I have a husband who is fantastic. We were together in it. Some husbands are ok like I will supply the sperm and that is it, it was not the same. All this way my husband lived it with me completely." (Dalia)*

Dalia truly felt that her husband was by her side and he helped her to go through this difficult time. For them both infertility was a shared journey. As it has been mentioned in the previous section Dalia was happy to do anything in order to give her husband a biological child. Her husband's support could have given her more wishes to please him and to continue the IVF journey in order to thank him and appreciate him for his support.

In Gail's case, she explains that this experience helped her understand and appreciate her life through a different perspective and more importantly, it helped her to get closer to her husband.

> *"In a way, I thought it was not fair that you know this was happening to us… Life is not always good and sometimes you need a reminder of who runs the world but this experience, it brought me and my husband closer together." (Gail)*

Gail went to religious seminary, got married earlier on in life, had her flat and living arrangement sorted and then had her first child all smoothly. In her mind nothing was wrong until she had two miscarriages when trying to have a second child. Despite the way she felt about her unfair condition she recognises that this challenge was important. She refers to this challenge as a reminder, to appreciate what she has, a reminder that took her away from the smooth and positive cycle that she started when she was young. Gail took this experience and appreciated her husband and built a stronger relationship with him.

My parents

From the discussions with the women it became apparent that the relationships women had with their parents were also affected by and changed as a result of experiencing infertility. Family has a central role in the Jewish religion. It has the purpose to both nurture tradition and to ensure continuity of Jewish faith by transmitting commitment and Jewish values to the next generations.

Women specifically felt that their relationships with their mothers deteriorated because of the pressures they felt to have children. In the Jewish religion a mother holds a very special and important place. The mother, the matriarch, ensures that her children will grow in Jewish knowledge and practice. This job is important to ensure that Jewish religion propagates and continues through the generations. It is also through mothers that young Jewish women learn about what married life entails and what it means to be a wife. Fertility, alongside other delicate topics such as intimate relations and family purity, are topics that are not usually discussed openly amongst Orthodox families. These topics usually are only discussed with a teacher that women meet with a couple of times before getting married and occasionally between mothers and daughters. This explains why for some women it was their mothers who

approached their daughters with regards to having children and perhaps seeking help to understand why the couple was not getting pregnant.

Some women in this study stated that their relationships with their mothers changed drastically as they were unable to have children and fulfil their mothers expectations. These women felt like they could not speak and share their difficulties with their mothers because they either felt judged, hurt or distant from those women whom they once used to be close to. This change in their relationship pushed some women to want to have more treatments to please their mothers in their desires to be grandmothers or to just accomplish what their mothers had educated them and expected of them.

Ana got married when she was 19 years old. For five years, she did not think or try to get pregnant. During those years she had unprotected sexual intercourse and it never crossed her mind to wonder or question why she had not gotten pregnant. But her mother which knew and expected her to have children would ask her questions frequently:

> *"My mother would sort of ask me… I should go and check it out… we were actually approached from a religious neighbourhood. (Ana)*

At the time, Ana wanted to just enjoy married life with her husband and enjoy the money that she worked so hard to earn. During the interview she talked about her work as her baby. She enjoyed the corporate life and she wanted to enjoy some good holidays with the money she made from her work. But her mother persisted on her finding out why she was not getting pregnant. Eventually, she was contacted by a Jewish organisation. The organisation approached her and when she spoke about this she sounded surprised as she had not made a direct approach to them. This leaves one to wonder how the organisation knew. Could it have been her mother who contacted them to try to help her daughter? In any case, after that Ana started having tests that proceeded to IVF.

Other women in the study found that their mothers were less delicate about their lack of children. Some of these women received pushy and pressurising comments from their mothers to have children.

Maya got married at the age of 18 and was 23 years old and childless at the time of the interview. She felt immense pressure to have children because she is the eldest daughter and the only one who is married and therefore can make her mother a grandmother:

> *"I am the oldest and I do not have any married siblings. It is not the same, but definitely for my parents, all my mum's friends are grandmothers already and she wishes she would be a grandmother already. She keeps pushing me and asking why do not do this or that and why I do not go private." (Maya)*

Maya's mother wanted to belong to her community. Maya discusses the way her mother suggested things and activities trivially. Her discussion of what is expected of her seems almost natural and normal in how she describes this. She had tried for a few years to have children and this was not happening, therefore it was normal for her to try, keep going and not stop in her pursuit of motherhood. Everyone expected a baby from her and so did she.

Maya also talks about her husband's side of the family and the pressure and expectation on their side:

> *"My husband has four siblings that have gotten married since we got married and three of them have kids and the one that got married last year has also had a baby since then and this is quite pressuring and they all live here as well. So, when we get together every Shabbat at my in laws, for Hannukah or this or that party, it's always about the kids and you feel a bit left out. (Maya)*

Maya and her husband found it hard to celebrate every Jewish holiday and *Shabbat* with her husband's family as for them children took centrality in these celebrations. This in some ways took away from the joy of celebrating family gatherings for Maya. She could not belong in her own family. The way these

relationships to her mother and husband's family starts to change because of the pressure that Maya feels. This is worsened because Maya wants to belong, she wants to be part of those she loves so much. She wants to join in the conversations and be part of the Jewish celebrations that she loves.

Sophie had a similar case to Maya. Her mother also cared about becoming a grandmother. To her mother, being a grandmother was more important than being there for her daughter and helping her through her infertility. Sophie's situation was made worse when her brother, who knew that she had been struggling with infertility for a little while, announced that he was expecting a baby. His announcement was a brutal shock. Sophie had been trying to conceive for a long time but nothing really worked for her and now these news hurt her. Her family was no support and this just 'pushed her to a corner'. As a result she mentions that she felt isolated from her family and her community.

> *"Through all of this I did not have any family support whatsoever. The closest support I ever got from my mother was one day when she said to me "when are you going to have a baby? You know all my friends want to know when am I going to be a grandmother" and I said to her you know what if your friends are so concerned with my welfare how about you get them to phone me up and they can have a little chat with me. She went ballistic but it was all about her and in that time my brother, who had been married five or seven years less than us, also announced in a very insensitive way that they were expecting. Then we all fell out because apparently my first thought should have been for my mother rather than for myself. I was supposed to run to her." (Sophie)*

It was difficult for Sophie to accept that her mother cared about her community and all that surrounded her more than she cared about her own daughter. Sophie struggled for 15 years due to her inability to have children. Through her narration above it is clear that she needed support, understanding and warmth from her mother. She needed sensitivity from her brother. This is something she states later on in the interview. She focuses on how little sensitivity exists towards women who face infertility. Sophie struggled with this first hand due to her mother's insensitive comments and lack of emotional and moral support.

Later on in the interview, Sophie highlights why she so desperately wanted to have her own children. She had to endure her infertility challenge without having support from her mother and this was very difficult for her to accept. She wanted to be taken seriously by her mother, she wanted her mother to be there for her during treatment but what her mother wanted was grandchildren so she could belong in her community. Sophie's needs were not considered and looked after. Her desire to be a mother was fuelled by these negative feelings she had from her relationship with her parents; especially which she held with her mother. She wanted to be a better mother to her child, she wanted to mend the hurt she felt towards the woman who was her mother but did not act like it. These feelings could perhaps explain why Sophie continued treatments for 15 years.

> *"I have my biological mother and father and to say that we are not close would be a massive understatement. I have my own biological mother and I have no connection with her at all whatsoever and she always put my needs to the bottom of the pile and I always just wanted to have a child and I thought that having a child was basically about loving that child and giving them everything that you can because I have my own biological mother and I didn't have that I felt that." (Sophie)*

Nevertheless, for Sophie this was not just one sided. Negative comments also appeared from her husband's side of the family. After nearly ten years of trying to conceive with IVF, Sophie and her husband had agreed to pursuit adoption. They made a deal with a couple in the USA to adopt their baby once it would be born. This 'contract' came to a halt when the parents changed their mind. This was devasting for Sophie and her husband who were desperate to become parents.

Below is a quote from a scene that occurred just after Sophie discovered that the adoption deal had been broken:

> *"I went into a very severe depression. I could not talk to anybody for weeks. I only texted people, I did not speak to anyone for weeks. Eventually we decided that we would go see them (parents in law) and it was a foggy day and it took us ages to get there and we had missed our turn. We finally go there with all our food and she (mother-in-law) just started telling me off for not answering the phone to her for weeks and I told her after all that happened to me, I was just not really able to speak to even my closest friends. So, she said to me "what happened to you? Nothing happened to you, it's not like you were f… pregnant or anything" She actually said the full f word. I was just so shocked at her. My husband just "said grab your bags, we are going" and we did not speak for weeks. So, then I had no mother in my life or mother in law and it was approaching my 40th birthday and I was just in a really bad place for a few months." (Sophie)*

Above we can read about Sophie's deep pain and loneliness. On the positive side of her struggle she knew that her husband was with her emotionally. This was Sophie's only support. Yet Sophie struggled emotionally and physically. Her physical pain was understandable by the amount of IVF cycles she endured over the long years of treatments. Her emotional pain, unlike her physical pain, did not heal. It got worse as the years went by and her infertility continued. This was made worse by the comments she received from her family and from those around her. Sophie needed her mother, she wanted her support and we can note this from the amount of times she mentioned the lack of love and support she had from her mother. She goes as far as to add that "I had no mother in my life". The distance between them was so big and so was the damage done that she considered herself motherless. Her mother was not existent in her challenging life. This was hard for her because she wanted her mother, she craved support and stability from her family. Her family extended to her husband's family too. His family were also no support for them. Her mother in law could not understand that for Sophie this was again a failed attempt at becoming a mother. A failed attempt that only prolonged her feelings of pain, emptiness and loneliness.

Rachel similarly received unpleasant comments from her mother:

> *"When I had my miscarriage, my mother said, no it was not a miscarriage, that I was not pregnant that it was a false alarm." (Rachel)*

The fact that Rachel was pregnant in the first place was already a miracle for her. Now she had been pregnant and she had lost the baby. This episode is what came to her mind when describing her journey through fertility treatments. For Rachel when she thought about her mother that is what she remembered. She thought of the time that her mother dismissed her first miscarriage. After that episode, Rachel mentions that she did not discuss her infertility or any of the treatments and procedures she underwent when trying to conceive.

These women felt irrelevant to their mothers; instead of being able to connect to their mothers when trying to get pregnant and therefore open up about the hardship of treatment and the emotional difficulty of treatment failure, they felt that all their mothers cared about and wanted to know was when the baby was going to arrive. It was almost like they did not care about how it would happen or all the pain that their daughters would have to endure. They just wanted the grandchildren and more than anything they just wanted to belong. This need their mothers experienced was something that was passed on to these women struggling with infertility. Some women in this study mentioned that they too desperately wanted to belong; desperately wanted to make others around them happy and fulfilled. It could be that this feeling of belonging was created in the women by feeling the pressure that their mothers felt to belong in their communities.

Dina's mother did not have any knowledge about fertility treatments and how harsh these are on women undergoing them.

> *"There is a complete lack of knowledge about what is involved in IVF even from someone like my mum who knew what was going on and she knew to be sympathetic or whatever but she had no idea what the process was. She had heard about it on the paper. She is not an uneducated lady but she did not appreciate anything of*

what it was. It is not something that is discussed in the community, like what it is or what it actually involves or how does it affect someone and how it works. It is complicated." (Dina)

Her mother was supportive and this was great for Dina but still it was not enough for her. Dina thought that her mother could not understand her physical pain and that she really did not appreciate what she was going through. For Dina that was what impacted her. In her own way, she felt that she was not understood.

The paternal relationship, in contrast with the maternal one, is one that requires respect, admiration and often obligation. The father has an important place in family life. He establishes the kinship and Jewish lineage. The father, men in general, have many more obligations according to Jewish law. This can at times increase their Jewish faith and their level of stringency.

In this study some women saw their relationships with their fathers deteriorate because of their infertility. Victoria's case was an example.

Victoria tried to do things her own way and so decided not to share her infertility challenge with anyone in her family. She explains that this is because they have different views on Jewish life. But this changed when her father found out by accident that she was seeking treatment.

"I had to tell him, you know you think that we are just messing around and that we do not want children actually we have been trying and it's not working, of course as parents do, all along they are going "Nu, well so?" I think because of the experience with my sisters, they were not in tune with the possibility that someone could want children and not be able to have them. It really did not occur to them and then… After my daughter, they never said anything and to this day they probably do not know if my second my boy was natural or not. I only told them at that stage because I felt I needed to because my dad had heard it." (Victoria)

In Victoria's family, her sisters had gotten married and had multiple children easily and because of that her parents assumed that she did not want to have children as she had been married for multiple years and did not have any. It was a surprise to her parents that she had been trying to have children but had not succeeded. Victoria had to share her troubles with her father. This was an eye-opening experience for him and for Victoria in some ways weight lifting as in the family's eye she was no longer the selfish person who was just 'cruising' through life and not trying to bring children into this world.

Nevertheless, at some point her father started suggesting possibilities that could help her achieve what she wanted:

> *"My father has this thing about things happening for a reason. So, if someone gets ill, they should be thinking what did they do to deserve that and I do not like that. I do not like that at all especially when it applies to children and there was a time, I cannot remember well when it was, and he said I think you should think about things that you can do to improve and in my head I was thinking he wants me to cover my hair and I am not going to do it, but I always went to mikveh and I remember instead of only dipping twice I started to dip a third time maybe to be a bit more strict during Niddah, I just felt that if I wanted something from God, that I had to give a little bit." (Victoria)*

Victoria disagreed with her father's perspective of people's destinies and life occurrences. She did not think that she deserved her infertility. Vitoria was already doing as much as she could to make sure that she was getting "God on board" and for her to deserve the children she wanted. Her father wanted her to change to become more religious because he believed that this challenge was sent to make her more religious, to change her and bring her closer to God. If she wanted God to give her children she needed to change too. So, in the end despite her not sharing her father's aggressive view of people deserving all the bad things in their lives she did believe that God was ultimately in charge.

My family

Women reported to feel under pressure to procreate from their own family and from their husband's families too. These relationships appeared to deteriorate over time because women were still not getting pregnant.

Sarah struggled with her family. They would only support her choice to have children with her friend if she would seek approval from the London Beth Din's (Court of Jewish law in London). Their approval meant to her family that everything would be carried out under strictest Jewish law:

> *"My mum was shocked. She spoke to my brother and I don't know, somehow… well I never spoke about marriage, and just spoke about having children. For me there was no sex, there was no contact so we were just having a kid together. So, my brother told her and then they spoke to me "if you are going to do this, then whatever the Dayan says you have to do, if he says it is ok and if you follow his instructions we will support fully so long as you do what he says it is ok." (Sarah)*

Sarah knew what she wanted and she was going to do it. She needed the financial support from her family and wanted to make sure that they would be aware of how she would have children. Sarah's father had passed away a few years ago so, her brother helped her mother decide if she was for or against her route to parenthood. The family then decided that they would only support her if the London Beth Din backed up her choice. The Beth Din then decided that she had to marry her friend, a man she later describes as "a disgusting character". Sarah was forced to marry a man she had no physical or intimate interest in just in order to have her family's emotional and financial support and for her child to be fully recognized as Jewish in her community and all other Orthodox Jewish communities.

In Rachel's case, her husband's family was the problem:

> *"My husband's family knows because of my husband. He tells everything to everyone but sometimes they said stupid comments to me like if you do not know how to make a child, then I can show you how to make a child and I just thought ok thank you very much." (Rachel)*

These comments from her husband's family were hurtful. They were much more open to discuss fertility issues and other more delicate and private topics. This was difficult for Rachel to accept because she thought this was such a delicate time in her life that she did not want to share this with anyone but her husband. Comments like these hurt Rachel as they implied that she was not trying her hardest, that she was not having tests or undergoing invasive explorations of her body in order to understand why she was not able to conceive. Unfortunately for Rachel that was not the only comment that she received from people trying to 'help her'. Rachel also received unwanted help from a friend on the street:

> *"Even when sometimes people tried to help, I remember a friend she still is a dear friend to me I have known her for 21 years. She said to me- you know now they have wonderful treatments- and I thought we were in a shop and I nearly slapped her. I thought she has a child what does she know what I am going through." (Rachel)*

Rachel did not want to share her infertility journey with anyone and this explains why her friend did not know about her challenge and the treatments that she already endured. The comment Rachel got from her friend frustrated her as she knew the treatments she had tried herself and all the tests she had done. Rachel felt that these comments she got from her family and her friend were not helpful. These just stressed her and frustrated her more. These comments underestimated her stress. The treatments she had already undergone and the struggles she had already faced, just in order to try to have a child.

Things were made harder for some women in this study as other members in the family were having children easily. This was the case for both Jessica and Andrea.

> *"My cousins were having babies and my brother and everyone around me seemed to be having babies and for me it just did not seem to be happening." (Jessica)*

Jessica felt that everyone around her was able to conceive. She felt that she was the only one who could not have a child and this just reminded her of her misery and her misfortune.

In Andrea's case, it was about her husband's ex-wife who was having children without any problems. This was made worse by the presence of her step-son who was a constant reminder that her husband had had a child with his previous wife but that this had not worked for her.

> *"My husband's son was living with us and there was a lot of tension and the fact that his mother had gone on to have two other children. So, his mother had him and when she got remarried she had another two children before I started or just at the time when I was starting my IVF… there was all this pressure with my step son and him going away to his mother and being able to talk about his new baby brother and sister and how cute they were." (Andrea)*

Andrea found it very hard to see her husband's son every day. This for her a constant reminder of her infertility and her bad luck. This was made worst by the fact that the child spoke of his siblings that he had from his mother. Andrea struggled with this knowledge and this just increased the pressure she felt in order to have children to belong to her community and in order to please her husband, who was religious.

My community

Orthodox Jewish communities are known for their very tight knit communities, where everyone knows each other, families have been friends for over decades and they usually tend to live very close to one another and attend the same schools, shops and restaurants.

As Miriam describes "*my family and the community, it is everything*". Being part of the community is everything for some of the women interviewed in this study. Belonging to their community is what allows them to feel good, accomplished and to an extent their community is their family.

One can expect that this could be an advantage because it creates good connections and a secure neighbourhood for children and adolescents to grow up and develop themselves as young adults. Nevertheless, this is not so positive for couples who are struggling with infertility and at the same time are trying to conceal this from their friends and community members.

There is another factor that impacts couples undergoing ART. This is the pressure that Jewish religion puts on having children and how obediently all congregants try to follow the *Mitzvah to procreate.* The pressure is not to just have children but to have numerous children. This is something that most couples do. Some women in this study were bothered by this fact in the community. These women felt that all their life revolved around children, having children, getting pregnant and seeing more children all around them.

Throughout the interview, Rachel made it very clear how important it was for her to have children and how infertility was a challenge sent to her by God. She knew she was going to become a mother someday but nonetheless the infertility journey was made harder as the community she lived in was a constant reminder that she did not have children and that she was missing something in her life in order to belong.

> *"In the community when everyone is having children right left and centre and everyone is pregnant around you and you want a child you want to nurture that little being you want to express your love and it is not there. It is very tough." (Rachel)*

For Rachel, being part of an Orthodox community was a difficult task she had to endure. In the community, she saw people she knew having children easily all the time and this just emphasized her desire to become a mother. Her surroundings and her society increased her internal need to have a child. Rachel also mentions how this made it harder for her to forget about her misfortune and to stay positive when things did not go as she wanted or work as fast as she wanted.

In Joana's case:

> *"Lack of fertility, lost dreams, lost purpose. All I ever wanted to be was a mum. It just meant getting isolated and alone. I am sorry I am getting emotional. I have very strong tears." (Joana)*

Her infertility isolated her from the community which she loved so much. She wanted to belong, to be like everyone else but her infertility did not let her. As a result she was at a loss. Her infertility emphasised her lost dream of being a mother.

Ana did not worry about being childless for five years but she mentions that this is not normal in the Jewish community. Ana says how in the community one is expected to have children as soon as they get married and this is something that everyone abides by:

> *"We got married when I was 19 years old… I was not taking any preventative measures to not get pregnant so after a year we pretty much figured that something is wrong, but I am the most laid back person… we then decided that we were going to enjoy our time. We did not make any doctor's appointments we did not go and sort ourselves out. We did not do that for five years so, for five*

> *years we just had fun. But I am not the norm, for people usually it gets them down and specially in the Jewish community I find there is much more peer pressure because everyone around you is having kids." (Ana)*

Ana mentions that in her opinion the community pressures people into wanting to have children as soon as you get married. She mentions that this is something that everyone feels and that is something that for her was not a big pressure. Ana figured that something must be wrong as they were not getting pregnant but still she decided not to fall into the pressure, into the expectations set on her by the community. She wanted to have 'fun', to enjoy her relationship with her husband. She wanted to do things 'her way'.

At the time of the interview Ana had a three years old daughter and was undergoing treatments to conceive a second time. She mentions that the pressure people receive from the community also impacts second-time parents. The pressure to have children goes beyond just having one child.

> *"In the Jewish community, specifically where we are, there is such a pressure to have kids that people want to have many more kids… some people would feel pressured to have more kids… as much as you try not to focus on it all the time and when you are going through it everywhere you look there is someone with a buggy or someone pregnant or some other event." (Ana)*

Ana saw how everyone had large families and as much as she wanted to ignore this, she could not let go of the idea that for her to belong to her community she needed to have a large family. Ana did not want her infertility to take over her life as she really did not want to worry about it all the time but living in the community made it hard for her as it was all she saw, even if she did not want to see it.

But as Ana mentions, she was not the norm in the study. Most women were negatively affected by the community's pressures to have children. Ana

describes what most women in this study felt, even if she initially described herself as someone that is laid back and does not worry about things.

Some women found it hard to be part of the community and to go out and just be able to belong in the society they were living in. Sandra had her first child naturally at the age of 32. A few years later she started taking note of the pressure that Ana mentions. In the community she lived in, it was not enough to just have one child. Sandra needed to have more children if she wanted to belong. This impacted her and in certain ways pushed her in her desire to have more children.

> *"There is an assumption I think that if people chose to have a family in the Jewish community it is very likely that it will not just be one child… I felt there was an expectation that we should have more than once child, I felt other people were expecting it of us." (Sandra)*

Sandra also thought that this pressure to have children in the community was directly based on the Jewish mentality. In her opinion, she thought that Judaism is alive because of the way families keep it alive. Judaism is based on family life and this was hard for Sandra to accept.

> *"I think it is a shame that in Judaism because it is all based around families and homes and communities, that does mean children… for people who are struggling to do that, there needs to be better understanding and better support." (Sandra)*

Both Ana and Sandra mention the community and how it pressured them to continue having children. This notion could be an underlying motivation for both Sandra and Ana when it came to keep seeking treatments and looking for help when trying to conceive.

Andrea explains why it is difficult in the community she lives in to have just one child:

> *"I had a hard time … I was told at least you have one child but they don't understand that having one makes you…*

> *you just stick out so much in a religious community even if you are modern and it doesn't matter how modern you are, without children you stick out." (Andrea)*

In some Orthodox communities couples are only seen as having fulfilled the commandment of being fruitful and multiply if they have more than two children. According to the *house of Hilel,* a couple must have boy and a girl and by the *house Shammai* the couple must have two boys in order to fulfil the commandment. This along with her surrounding made Andrea feel like an outsider. She could not belong to her community and this deteriorated her relationship with those around her.

Couples are expected to keep having children until they have reached a certain age or until they mentally, physically or emotionally cannot have any more. Usually couples will seek out Rabbinical advice to certify when they will stop having children, as taking contraception without Rabbinical advice is usually not permitted for Orthodox couples (Tarragin-Zeller 2019; Birenbaum-Carmeli 2008).

Shosh found it hard to agree with the expectations from the community as she did not think children should be everything in life:

> *"Societies expectations of how we are supposed to be and you know, in our circles people get married and have kids so that is what you are supposed to do… we are happy to or try to live life without kids, but they kind of expect us to always be sad and upset but the kids cannot be the be all and end all… it gives a label in the community not to have children." (Shosh)*

Shosh wanted to be able to live and try to be happy without being a mother but she felt that this happiness would be judged by her community which expected her to be devasted by her infertility. At the time of the interview Shosh was still childless and she strongly felt that this pressure from the community only made the infertility struggle worse. It emphasized her isolation from the community and it forced her to think of how behind she was in the chapters of life in comparison to her friends and those around her.

For Miriam, the problem came from having to attend functions in the community and having to face people:

> *"It is very difficult and Jewish home life is based around family, so every time that there is a Jewish festival and every Shabbat, you feel it and everyone else is moving on and it is horrible because you want to be happy for other people when they are pregnant but you know every time someone else would tell me that they are having a baby I would actually feel physical pain inside of me that is just like someone stabbing me and that is really hard." (Miriam)*

Miriam not only found pressure from the way others were "producing" children easily but also from the way others were moving on with their lives. She wanted to be happy for them and she tried but this, made her feel 'physical' pain. This hurt her deeply and not only because she could not have children herself but because she wanted to be happy for her friends, for those she had around her but her own misery prevented her from feeling joy for others' good news.

Naomi also mentions how hard it was to see close family members go on to have families swiftly whilst she was still struggling. She also mentions that this was only made worse by having to attend birthday parties or other functions:

> *"It is funny because in the group of friends that I have, a lot of girls are not married and are not going to have children. We are friends with people who have children and specially my nieces and nephews are of a similar age you know… for example, my sister in law she got married about six months after we did and they sort of struggled a little a bit but they got married and they had children fairly soon and yes to think that we had been married and we were struggling and we were not getting anywhere and they had had two children in the space of the time that we only had one… so, yes birthday parties were hard to go to and you want to be happy and enthusiastic for them but it is very difficult when you are feeling that." (Naomi)*

This was also true for Jessica:

> *"My cousins were having babies and my brother and everyone around me seemed to be having babies and for me it just did not seem to be happening… Emotionally I started to find things quite hard… There were family events where cousins and brothers had babies there and for me that was quite hard. Just simply going into the shopping centre and everyone is walking around there with babies became quite hard for me. So, it was quite a tough period so there was a physical side and an emotional side." (Jessica)*

Jessica had emotional pain that transformed into physical pain. She was struggling physically because of treatments and emotionally because her dreams and hopes were being torn apart. Jessica just wanted to have a baby and be able to walk around with her baby and be happy. This was something that later on Jessica mentions when she describes how much she loves her two boys.

Leah and Dina similarly mention how hard it is in the Jewish community when one does not have a child straight after marriage:

> *"If you do not have children, in the Jewish community I think it is harder in a way. Once you are married and after a certain stage, I think it is in a way the Jewish network kind of expects you to have kids." (Leah)*

> *"It was pretty awful, especially as when you get married the first thing people say to you is when is the baby coming and I am like it is not." (Dina)*

Leah knew from a young age that she would need surrogacy to have children. The need for surrogacy it made it very hard for her to conceal her infertility from those around her, therefore her infertility became very public.

For Dina, the problem was the intrusive questions she received from people. Dina was married for a few years before she realised that they were having problems trying to conceive. Soon after she had this realisation it became apparent that her husband did not have viable sperm. She felt pressured by people's questions and at the time she did not want to share the private reasons for her lack of children and she felt that this was just not possible in the community, as people constantly asked her questions.

Rina also agrees that the pressure and the extra struggle women feel is derived from what the community expects of its congregants:

> *"Fault of the community we live in. People who get married are expected to get pregnant in their first year… people start looking at your stomach, thinking that you have something in there." (Rina)*

Rina highlights the way she was constantly reminded of her infertility. The way the community behaved towards her and other newly married couples made her feel like she was not the 'norm' not what was expected.

Andrea also mentions how people were always looking at her stomach. This, alongside comments from family members was, what drove her to think that yes perhaps something was not working right for her in terms of her reproductive system:

> *"I did not think I would fall pregnant so quickly because it had taken my sister quite a while even though she did not have fertility treatments. But for myself I just thought oh ok it will take a while, so I do not need to worry. Fast forward to like three-four years, people are always looking at your stomach and people are always saying things… Even my sister started to say something to me and it was only then, after the external pressure became a lot that, I started to think. It was very strange I am a midwife, I know about fertility, and in all those three years I never thought there was a problem." (Andrea)*

Andrea was influenced by her external surroundings; the external pressure actually changed her internal perspective and her peace of mind. This changed her character drastically. These comments lead her down a path of numerous IVF cycles that were not successful at first and the lack of success drove her into a severe depression. Andrea specifically remembered a few episodes that were the worst.

> *"It was really bad to the point that I was suicidal after the cycles that did not work… I remember after the one cycle before my first daughter was born. They could not get the correct blood test that they needed for me, and they gave me a result and I faxed it to the other clinic and they said to me, what is this number, they cannot write less than 0.2. I want a number, and so they said to go to a specialist hospital and do it so I had to go to another place to get the test and we knew that it had not worked but we were still in the midst of it because the doctor wanted to know what had happened … So, I drove. I was so angry and upset and I drove to the nearest city at 170 the whole way and I thought to myself, if something happens, it happens." (Andrea)*

Andrea did not care what would happen to her at this point. She had had a few cycles and these had not been successful. Now the preparation for the next cycle and investigating her hormonal level was proving to be hard and again the fear of another failed cycle roamed in her life. It is obvious to see the change from her first years of marriage and how she did not stress about her lack of children or worry about how she was not getting pregnant. After peoples' comments got to her and she started to think and started discovering her infertility, her outlook of life changed. She became obsessed with having children and so devastated every time treatment failed. She could not cope with the failed treatments. She felt each failed treatment physically and emotionally.

This did not end here for Andrea, after another failed treatment she mentions how things just got harder with the community:

> *"The pressure was immense and I came back after a failed cycle and the marriage was very difficult and people in the community, because I was still so swollen and I was comfort eating… people would look at me and*

wish me an easy birth and I was just … that was a killer… people need to be educated better, that when a woman gains weight, a lot of it is the infertility treatment." (Andrea)

Later on in the interview Andrea mentions that the hardest part of undergoing fertility treatments is having to live with peoples' expectations, their judgements and intrusive, insensitive comments.

"For me, the women looking at me, and women who really should have known better. They were themselves almost grandmothers. By that stage, we were not talking about 25 years old women, they knew that we had been married a long time and maybe not trying but married and the well wishes and looking at my stomach, that was appalling and I wish I could change the community's sensitivity because there is such a lack of sensitivity… You know people constantly ask you to be the person who walks in with the baby when others have children on the day of the circumcision and it is supposed to bring you luck and even though I understood that it was all meant for the good, it is such a sensitive topic and it is so hard. I look at women and I did it once I think, but this was after my girls were born because before I just refused and I know they meant extremely well but I just could not. If there was anything, I would want to or wish I could change I wish it was the sensitivity for the women who are going through this in the community." (Andrea)

There are certain superstitious acts that people within the Jewish community do in order to get pregnant and have children. An example of these acts includes what Andrea mentions above. Andrea found this so hard the constant questions and demands made her feel uneasy. Even now after having her two daughters she still held on to this memory. She still remembered how painful it was to be asked to be part in those celebrations. Andrea wished this would have been different but, as she cannot change the past, she hopes at least that it will be different for the women trying to conceive now.

In Sophie's case, people's comments were not about how she should get pregnant, they were comments about how she should not complain about

physical exhaustion and how she should be enjoying her life so much because of her lack of motherhood.

> *"I had people say to me even at 10.30 at night when I was yawning one day years and years ago, in the midst of all the treatments -you are tired, you have got no right to be tired, it's not like you have children or anything. Or people say that it is ok that my husband can have a sports car because we do not have children when we so desperately wanted one. Its ok for us to do our house extension but why would we bother. A whole range of things that people said to us that frankly are just shocking. Another thing a counsellor once told me was, if you just laugh everything off and never put people in their place how will they ever know that they have hurt you? I always put on a hard exterior and then I would come home and sob into my pillow and I did that for years and years." (Sophie)*

Sophie felt a mixture of stress and pain from not being able to conceive and this was constantly brought back to her every time someone said something. Sophie took peoples' comments to heart and these had a great impact on her. For years, she struggled with depression and feelings of isolation just because she did not have a child. Sophie's sadness and desperation became obvious as the interview went on. The constant failed treatments, community events, derogatory comments, created for her a personal hell that followed her for 14 years.

Contrary to all other women mentioned above, Dalia did not let others have an impact on her life and on her mental health. She knew how the community worked and she was aware of the pressure that exists for couples to have children.

> *"This is a normal cycle in the Jewish community, to have so many children but because I am who I am, I did not let people comment or get to me. I protected myself, I really did. I protected my couple." (Dalia)*

What a contrast Dalia's quote is to that of the other women mentioned previously. Dalia was older when she got married and started trying to have children. Dalia was much older than most of the women in this study and as such she was more mature and stronger mentally when it came to letting other people's comments and expectations slide away.

Shternie felt pressure also from her work environment:

> *"I work with children in a nursery. That is my background and at the time all the teachers were pregnant, all the mums were pregnant. The kids were always talking about babies." (Shternie)*

Shternie struggled mentally throughout all her failed treatments and even after she had her child her struggled continued as she still lived with her past struggles.

Shternie mentions another episode that happened at work:

> *"I remember sitting in the staff room one day and a teacher was saying that she was getting married. She was not religious, and she was saying -I have worked it all out. I am going to get married on the Tuesday, I am going to get pregnant then I am going to start my maternity leave from here and there. I was thinking what a stupid woman, it does not just happen like that. Then I found out later in a staff meeting that this teacher was going on maternity leave and I just run out of the meeting in front of 45 members of staff crying hysterically." (Shternie)*

Shternie gives us an example of pain and struggle. She had struggled so much with her failed treatments and now observing how someone so easily planned their life and the structure of their pregnancies and how things worked out just as she wanted. Shternie struggled and her struggle pushed her into depression and isolation from the community and her friends and those from her work.

CHAPTER 7: MY IDENTITY

This theme emerged as women expressed their thoughts on motherhood, womanhood and infertility.

Accepting their infertility was a very difficult challenge for these women. Women reluctantly accepted that infertility was “God given”. They tried their best to navigate through the pressures and difficulties they faced with their families. But this did not prevent them from at times internalizing the blame and the responsibility for their infertility.

The internalization of infertility came mostly as a result of the pressure some women felt from their communities to procreate. The women observed how families around them grew and multiplied. This had a negative impact on the women and while they tried to be happy for their families and friends it was getting harder and harder for them to be active participants of their communities and their social events. The women slowly started to detach themselves from those that they were closest to. This was also observed when it came to women disclosing their difficulties when trying to conceive. Due to the pressures women felt from their families and communities they decided against disclosing their difficult experiences of infertility.

This led to a deep Internalisation of infertility. For some of the women this meant an identity crisis as they were not able to function as women are expected to. Furthermore, some women could not separate motherhood from womanhood and for many both words meant the same thing. Therefore their identity as women was compromised and they felt less worthy when compared to all other women who had children around them.

Our family did not know

The internalisation of infertility for many women begun with keeping their challenges from their families. Women in general felt that they did not want to

hurt their families or attain pity from them because of their infertility and difficulty to conceive naturally. These women felt like they had enough from their own internal pressures and desires to be mothers. Therefore they did not share their journeys through infertility with anyone, not even their families.

For example, Shosh mentioned that for her it was hard to open up about having treatments:

> *"I feel like they will be upset for us and I just find that I do not need more people being upset and looking into it. I just want to be treated normally and the less people who know the better… being excluded from situations just because you do not have kids and stuff is more upsetting than not having kids themselves." (Shosh)*

In some ways Shosh felt that people pitied her or worried about her and her inability to conceive. This was pressure that she felt as people wanted to know everything about her life. Shosh mentions how at times people saw her as being ill just because she did not have any children. In certain ways people treated her differently as if she was not well and this was something that Shosh could not live with. She felt that there were enough people involved in her infertility challenge.

For Shosh, the pressure of her surroundings and the isolation that resulted from being childless was more painful and emotionally harder than having no children at all. Shosh felt excluded and this she still felt now. These negative feelings only increased her internal pressure and ill feelings about herself. In Shosh's case this isolated her from her family, and friends. The way she lived her life changed as a result of her infertility. Now she felt like she was hiding things from those she loved and more importantly she felt that she did not belong anymore.

Vicky and Sandra offer a different perspective as to why they did not want to share their infertility experience.

> *"My mum does not even know to this day. Funnily enough I felt much more comfortable telling friends or just complete strangers about it once we were actually on the IVF. The two years we were trying, as I said I did not talk to anyone about it except for my husband. My mother is a nurse and she has a background in gynaecology. She is a midwife as well so I would talk to her about the gynaecological problems I was having and she obviously knew that we were trying to have a baby but once we actually knew we were having IVF it was such a pressure of it not working and I knew how excited my parents and in-laws would be that you know if there is a chance. I almost could not handle the pressure of letting them down. My disappointment I could just about handle but, their disappointment it just put so much pressure on us that we just decided not to tell anyone or family." (Vicky)*

Vicky looks back and thinks about who she would share her experience with:

> *"If there was anyone who I knew who was interested themselves to have it and if they happen to open up to me, then I would definitely say I went through it and what it was like to help anyone and talk to them and say how it worked. I found that a lot easier." (Vicky)*

Vicky knew that undergoing fertility treatments in the Orthodox Jewish community is hard on many accounts. Some of these being Jewish laws and other pressures from community and friends. Now that she had her child and she 'crossed' to the other side of the line, she felt happy and ready to face those who might be at the starting point of their journey. She wanted to "help anyone" in ways she was not helped.

Sandra, who is a mother of three, initially became a mother naturally. This was all she wanted and things had worked just as they usually do for everyone around her and everyone she was aware of. Nevertheless, as the years went by after her first child, her fertility suddenly changed and she was not able to get pregnant. After multiple tests and no concrete reason for her inability to conceive, she started having treatments. This led her down a spiral of tests, miscarriages and pressure upon pressure to augment her family. She mentions

how she did not share this experience with her family or friends and how ultimately this left her feeling isolated and miserable.

> *"I am not the kind of person who normally opens up and shares to a lot of people. Looking around me I did not see more than one or two people in a similar situation to me. At the beginning, I did not tell my family or my mum or anything because we are not close like that and so I guess from that point of view it is what I mean when I say I found it lonely… It was very soul destroying it was a very lonely experience, it was very upsetting and very distressing." (Sandra)*

Sandra makes one think of her struggle to first have to endure the discovery of one's infertility, even after her case where she had a daughter naturally. Then to think of the physicality of tests and treatments and whilst undergoing all of this to have to stay quiet and not share this with those she loved the most. Sandra felt that she was not close to her family and her mother specially, so she did not really have who to share this with apart from her husband. When she was asked why she did not try to open up about her experience, she replied that she did not want to burden her family:

> *"I think already by then we knew that my husband's brother was going through IVF so we would not have shared it with them. We would not have wanted to burden them with anything else." (Sandra)*

Sandra sacrifices her need for support and guidance from her family to protect her brother-in-law and her family from suffering more. This which she thought was an act of love towards her family led her down a path that isolated her from those she loved the most.

Sam, like some women mentioned before, felt that in retrospect she should have been more transparent, she should have opened up about her struggle more:

> *"I did not tell my parents and now I think about it and I do not understand just why I was not open about it, so that friends and family could know what I was going through. It is just the stigma and this is too much, but I think it is slowly changing like that was 15 years ago and it has changed I hope." (Sam)*

She later adds:

> *"I do not know, God forbid, if my kids ever need this. I just think it is such a private and emotional roller-coaster that is why would you not tell people? Why do we not just say this is what we are going through? But maybe I can say that because at the end of it now, I have four kids and that was relatively un-traumatic now and there was no drama. I mean at the time there was drama but now it is like I have my family, so maybe I can think about it with less emotion. But it is really a shame people do not talk about it." (Sam)*

At the time of the interview Sam reflected about her journey to parenthood. She recognised that she should have opened up more about her struggle. Sam felt that this would have changed her experience completely as people would have understood her better.

The feelings of isolation were also felt by other women in this study. Other women felt that they were left out and not invited to multiple occasions and this in turn isolated them from their communities and form their friends more than the actual infertility itself. Participants felt that they lost many friends through the challenge of infertility.

Joana and Maya simply stated:

> *"You are not included if you don't have children." (Joana)*

> *"You feel a bit left out." (Maya)*

Both women felt in some ways that their infertility pushed them away from their social circles as they could no longer belong or share any life circumstances with their closes friends.

Participants also mentioned that their lives changed and their relationships were never the same. In Joana's case, she mentions how her best friend had a big family and this made it hard for her to see her friend and feel good about it. Joana says "Even my best friend has 12 children". For her this was hard. She had to see her friend whom she loved and was deeply happy for, but seeing her friend and seeing her 12 children was very hard as Joana could not even have one child.

In Rebecca's case her isolation stemmed from the way her friends saw her:

> *"Some of our friends would say you are so lucky that you can go on holiday so many times together but they do not realize what each month is and that you cannot invite people over for Shabbat meals. We did not have kids and everyone else did… it was awkward to invite people and it was hard for them too… it was hard for them to invite us too." (Rebecca)*

For Rebecca and her husband, it was easier to run away from the town during Jewish festivities than to face the children that they did not have and that they wanted to have and were expected to have if they wanted to belong. This was made harder for Rebecca as she felt isolated from her friends as they moved on and went along their lives to have children. Suddenly there was a gap in most of Rebecca's relationships and this was something that Rebecca could not change.

Our friends knew

There were some women that thought that disclosing their infertility struggle was the best way for them to cope and face their difficulties. Not holding infertility as a secret allowed women to have better relationships with those in

their lives. For some women, in particular, Shabbats became easier when their friends knew that they were trying but failing to conceive.

Some women were able to talk about their experiences of infertility openly and these women were able to see the benefits of doing so. These women felt that this is what allowed hem to connect to the community and find a common ground between themselves and other couples undergoing ART.

Leah's narration shows the positive side of being in a close community:

> *"We tried to be as open as we can to help others and I quite like that people can ask us and we must have met at least ten couples who have and have not done. It is nice that people have asked us. I really like that people can approach us." (Leah)*

Leah was born without a uterus and as such her inability to carry a baby implied that everyone around her knew that she needed some form of fertility treatment. This made her infertility very public. Apart from it being an additional challenge and something that she had to deal in the public's eye, for Leah this was not just all about the pressure that the Jewish community places on couples when trying to conceive. For her it was important to be open and transparent about the treatments she had and more importantly about her experience and journey to motherhood. Leah enjoyed having questions from people and this gave her strength to live her daily challenges. For her it was important to hear other people's stories too, for example when she was preparing for egg collection. She wanted to have someone to ask some questions to. Being able to help others also gave Leah meaning in terms of her life and her infertility experience. Her difficulty in becoming a mother was important to her because with this experience she was able to help other women who were struggling like her with some form of infertility.

In Lisa's case, she was happy that her infertility challenge was not a secret. She mentions how she shared this with her family and her husband's family:

> *"We were quite open. We were never really secretive about it. Our parents they knew, and my husband's parents knew." (Lisa)*

Lisa takes this notion further and mentions how much better it was that people knew that she was undergoing fertility treatment. This was so that they would be sensitive to her circumstance. This made her life easier in certain aspects.

> *"Another friend who knew, we were supposed to go around to her house for dinner. She called me up in advance to let me know that she was pregnant again and she said I understand if you do not want to come and I did not cancel dinner. It was really good that she had told me because then I had the time to process it at home and cry about it and when I went to her house it was ok. Whereas if she had just told me at the dinner-party, with other people, it would have been awful. I do not know what I would have done. So, I am pleased that we were not so secretive about it and our good friends knew." (Lisa)*

The fact that Lisa's friends knew about her challenges and her difficult journey through infertility meant that they could also help her navigate through some potentially difficult situations. This was very helpful for Lisa; she was happy and grateful that her friends were there to support her and to help her rejoice in their happy moments by giving her time to process her condition and their opposite situation. Lisa's attitude was different to what has been previously mentioned by Miriam, Naomi and Jessica who struggled to be happy for those around them who could have children easily. Lisa also had this problem but the fact that her family and friends knew of her struggle helped her to deal with the negative emotions before having to face their happiness and accomplishment.

To be a fulfilled woman

As a result of their infertility some women in this study saw their identity as women questioned. Their challenges extended and expanded as their infertility journey continued. The pressures and struggles women felt as a result of being isolated from their loved ones and their communities lead women into internalising their infertility to the point where women questioned what it meant to be a woman who cannot reproduce.

Women in this study had very strong views on motherhood. For some motherhood was everything in their life, the sole reason why they are alive in this world. Other women related fertility and having children to having a 'happy ending' and the lack of children a nightmare that constantly loomed over them. Many of the women in this study also saw motherhood as the primary duty of a Jewish woman. Furthermore, they also saw it as the most important obligation towards their husbands and family. Something which has also been noted in other studies (Birenbaum-Carmeli, 2008). Their inability to conceive and the nightmare of infertility constantly challenged what women thought normal and expected from them. This left many participants feeling angry with themselves and their reproductive system. This then made them feel upset, empty, lonely or even lacking purpose in life.

The ultimate impact of their infertility was that of confusion in their identity as women. Some did not know how to separate motherhood from womanhood and their own desires to procreate. As I have explored before, women's relationships with those they loved changed due to the pressures the women felt because of their infertility. Women had fertility treatments to please their husbands, their families and to belong to their communities. But what did this mean for them? What did this mean about their desire to be mothers? Was motherhood a pursuit just to belong to the community? How did they feel about being childless women?

Rachel struggled with multiple gynaecological complications and surgeries before she could seriously start looking into having treatments. She knew very well what it meant for her to have a child:

> *"For me not to have a child is not to be fulfilled as a woman, right or wrong that is how I felt… you want a child, you want to nurture that little being, you want to express your love and if it is not there, it is very tough." (Rachel)*

Rachel directly links being a woman to being a mother. If she was not able to produce children Rachel would feel that her duty as a woman was not accomplished and that all that love she has would go unshared. The idea of not sharing and expressing her love with her future children deeply saddened her.

Throughout the interview Rachel says that she did not have the best relationship with her parents and further mentions that she did not get along very well with her siblings. Having her own children could be a way for her to rectify this negative aspect of her life. She almost wanted a new chance to fix her family life. In other words, to give the love she was not given or perhaps fix her relationship with her family by creating her own family. In the meaning she gives us of motherhood, we also see that to her motherhood was not just about giving birth and having children, it was about nurturing and loving the children that are born to an individual.

Rachel's idea of motherhood further extended to conceiving naturally:

> *"Personally, I was petrified of IVF not because of the injections but because I had a psychological hang out that if the baby is fertilised outside my body, what kind of mother can I be? How can I say that, it was an emotional and psychological distress, I am not a mother if I cannot conceive naturally basically, it is not my baby, it is a fictional baby." (Rachel)*

After having had two miscarriages and an ectopic pregnancy that resulted in the removal of one of her fallopian tubes, Rachel found it difficult to accept that her only option might be IVF. Rachel's reflections make one think that for her not being able to 'produce' the child naturally would mean that she as a woman was not good enough.

Later on in the interview Rachel tells me how she became a mother of two children naturally to her relief. Though she knew that IVF was such a great help for couples she felt that she would only be a fulfilled woman if she could conceive her children naturally. Rachel was fortunate enough to be able to accomplish this. For her this was a blessing from God.

At the time of the interview, Lisa was a mother of three. When asked what fertility means to her:

> *"Defines being a woman, if you are not fertile you are not complete." (Lisa)*

Lisa struggled with reproductive health issues from a young age. She endured multiple surgeries, interventions and fertility treatments. A connection can be made between what Lisa says fertility means to her and her inability to conceive due to her reproductive health problems. For her fertility defines a woman and this is taken further by Lisa's idea that as a woman you are not complete if you cannot produce a child "not fertile". Her reproductive problems only reminded her of what one needs to be fertile which in her case were not working fully.

Jessica, who had a prominent job in the city, only cared about becoming a mother:

> *"I was an account manager and an account director in a big advertising agency and I used to earn a lot but really all my money was going on trying to become pregnant so really my career was incidental, like I was not interested in my career. All I wanted was a pram. I wanted to be in a shopping centre with my baby." (Jessica)*

In the interview, Jessica mentions important projects that she was involved in throughout her career. None of those important steps in her career mattered as much as having children.

She also added:

> *"You know as a woman wanting a baby is just… you know if someone would have said to me at that point, look you are going to be run over by a bus but you will have a baby I would have said ok, let's just try it, let's see how painful it is going to be to be run over by a bus because the baby is just so great." (Jessica)*

Jessica underwent fertility treatment for almost ten years until she was successful in having two boys. With the above quote, her desperation, struggle and pain are obvious. Jessica's pain was inflicted by her desire to be a mother, her need to have children, have them and look after them. Her life had no meaning if she did not have someone to care for, her life was no life. Jessica was desperate to have children and this she made clear throughout her interview. She said that she tried most variations of IVF and also holistic treatments, Chinese medicine and other stress relieving treatments such as acupuncture; none worked. Her career was not half as important as her desire to have children. She did not feel good without a pram and a baby to hold.

Jessica waited a long time for her two boys to be born. All her life revolved around the need to become a mother and when this was achieved she did not have eyes or hopes for anything else. Jessica entirely devoted her life to her two boys. She says that having her boys changed her life, made her feel complete and ultimately how this was her 'happy ending':

> *"I have one 16 years old and one 18-year-old. I never fell pregnant after that but I am very lucky to have my two boys, really lucky. I know people always appreciate their children but I still do to this day. Do you know that as a mum I never went back to work after my first one? I just could not as a mother. I still look at my kids and think wow. I used to stand at the school gates thinking wow I am so lucky, thinking, I am with these mums and I have a child to collect as well. It was nearly ten years, it was a*

very long time. I still look at my kids and think I am lucky, but I am very lucky and I do spoil them too much. Not necessarily with things because I do not have lots of spare money but I spoil them with love and doing things and cooking for them. I just absolutely adore them and I still see them looking down the street and I think wow how lucky I am that they are my kids, that I have these two boys." (Jessica)

Jessica's happiness and joy for having become a mother is still what it was when she first gave birth 16 years ago. For Jessica her boys, though now teenagers, were still her babies. These boys were what she desperately wanted and what she accomplished with much devotion and dedication. She became a mother and that was the only thing she cared about.

These women mentioned above had become mothers, some with the help of IVF and others naturally. Despite their success at accomplishing what they wanted most, their feelings of desperation, pain and struggle remained. These women still linked womanhood to motherhood. For them womanhood was only complete if they were fertile and produced their children naturally.

Pregnancy my dream

The idea that motherhood is everything was further corroborated by the idealization of pregnancy as a dream state and infertility a nightmare. For a lot of women in this study pregnancy and having children was a dream that they held on to for hope and happiness. For other women once pregnant they felt good, complete and like everyone else. The opposite was true for infertility and lack of pregnancy. That which for some women in this study was their constant nightmare.

Miriam thought:

"I am very lucky that I had a happy ending, at the time of going through it felt like for ever and really hard." (Miriam)

After many years of struggle and failed attempts of IVF Miriam became a mother of four achieving what she refers to as a "happy ending". Miriam strongly believed that this was a blessing from God. He blessed her so that she could fulfil her dreams of motherhood. Miriam's recognition of her luck also reflects how she knows that there are other women who are less fortunate and do not have the happy ending she was so lucky to have.

Lisa's second treatment was a successful one. When discussing her pregnancy, she states:

> *"That was lovely and obviously I was thrilled and over the moon and of course I complained like everyone else about being pregnant but I loved it, I really enjoyed being pregnant." (Lisa)*

Lisa felt that a woman was only complete if she could conceive. When she was pregnant, she felt happy, she felt complete. She felt able to do what she was meant to do as a woman, as a female with female reproductive organs. This happiness at being pregnant could also be understood as having reached her happy ending. Having reached the ultimate female completion. If to her being a mother is what completes a woman, then pregnancy is another step to the final destination.

After many failed cycles of IUI and IVF Sam found out that she had conceived naturally. She went on to have another three naturally conceived children. When I asked Sam what she thought about fertility and reproduction she answered:

> *"When I think of fertility, I think of all the people that struggle and do not get the happy ending and they have to go down different roads or people who chose not to and then don't have a family so yes, I think it really is something. Maybe I can say that because at the end of it now I have four kids and that was relatively un-traumatic now and there was no drama. I mean at the time there was drama but now it is like I have my family." (Sam)*

Her initial thoughts about fertility are those of infertility. Sam acknowledges that she was lucky to have had her four children naturally and that even though she had treatments and stressful cycles and tests she managed to go on in her life and have her children relatively easily. Her pains and traumas were healed because “I have my family”. Her family healed the drama and struggle she had to face in order to become a mother.

Dalia also describes pregnancy as the most amazing experience that a woman can experience and enjoy in her life-time:

> *“You know giving birth is a fantastic experience. I had a sister who had eight children, all natural births. It is a wonderful experience, you are holding your baby and there is a feeling during those first few weeks when the baby is still a new born baby those weeks.” (Dalia)*

Dalia takes it further:

> *“I got pregnant, a miraculous pregnancy completely... that month I got pregnant and for me it is an experience where I was very lucky.” (Dalia)*

Not only does she emphasize the great feeling of motherhood but she also explains why pregnancy could potentially be so important to her and perhaps to other women. Dalia describes the special connection that occurs between mother and child, specifically with one’s own child. By saying:

> *“I am sorry for the men. They do not know what that means to have this creature hanging and completely yours. The connection between you and the baby and the trust the baby has on you.” (Dalia)*

Dalia was one of the women who were of the opinion that if she could not conceive her child naturally without the need of donated gametes, she would

not be able to have children, as her husband, who is Levy, could not have either donations in order to continue the family lineage. Dalia's natural conception to her was a "miracle", a fulfilment of her dreams and the reassurance that God himself was looking after her needs.

Despite her appreciation of pregnancy and her daughter, Dalia firmly believed that having children was not the sole purpose and the meaning of life:

> *"We enjoy life because having children is not an aim in life, the aim is to do the best we can do with our own person, children are a wonderful gift but it is also a lot of responsibility." (Dalia)*

She wanted to have a child because she wanted to love them, look after the child and have continuity. For her being a mother was about the experience and a new stage in life. Dalia continued on to say:

> *"A child changes your life, but did I think that my life was worthless before? God forbid, I had a full life, I just wanted to be a mother, there are steps in your life you cannot have them all." (Dalia)*

After having had her daughter Dalia can reflect on the importance and the impact that having a child has on ones' life. Dalia is proud that she had a successful career and an accomplished engineering business. Despite her great desire to have children, to love them nurture them and give them everything she has, she says, that having children is not everything in life. She thinks that being a good person is more important. There are other missions in life and Dalia believes that having children does not take more importance than other life accomplishments.

> *"I really believe that children change your life and fertility is very important. To be fertile is very important but if I did not have children this way I would have adopted a child. There was no question for me. I wanted a child in my life and my husband was the same way. It is wonderful to have a child from you, you recognise yourself you*

recognise your husband, you reconnect your faces, their ways, their little fingers it is all yours. But I wanted a child. I would have loved any child. A child is a child." (Dalia)

Dalia was one the women who understood the value of motherhood but still appreciated that it did not have to be all in life. The majority of women did not even question or think of a life without having children or without being mothers. Dalia was different, she thought life could go on if she was not a mother. She had her job, her business and other commitments that still helped her fulfil her life.

My body failed me

Some women in this study felt that they were incomplete as women if they were not able to be mothers. This idea was taken further by some participants as for them their failed treatment cycles left them feeling negative about themselves, their reproductive organs, bodies and their health in general.

For Rachel motherhood was vital; it was all she wanted. Her body did not get the message:

"The pregnancy is not where it should be. They made a test and they found that the pregnancy was in the tube rather than in the uterus and they said I had to have an operation to have probably a tube removed… that was the end of that particular pregnancy and I was a bit distraught. I thought I am already 38 or more 39 and I am not getting pregnant easily, and when I do there are problems and now I am going to lose a tube on top of it all." (Rachel)

Above we can sense Rachel's desperation and frustration towards her body. Rachel seems almost upset at herself. She cannot get pregnant and when she does it does not work and it ends in more medical complications. The way in which she describes these events makes us think of someone who is upset and who feels that their body is the limiting factor between them and motherhood. After multiple gynaecological complications, her body and female organs are

not responding to their primordial task and this in itself made Rachel feel upset and desperate.

Rachel firmly believed, that a woman was only complete if she could have a children. This view that she held was based on her level of Orthodoxy. She also thought that her journey to motherhood should not be too easy, just like it was not easy for the Jewish matriarchs to have children. Even though she has this opinion, the quote above shows us the opposite. She gets frustrated and upset at her body for not helping her in the process of becoming a mother. She seems upset because of the ectopic pregnancy, because it ended her current pregnancy and it took away some chances of getting pregnant again.

One cannot blame Rachel for what seems to be a paradox. She believes that she will be a mother and that the process will not be an easy one, but she still gets upset and frustrated at her difficulties when pregnancy does not result. Rachel is an example, like some women in this study, who had great faith in God when it came to understating their infertility but this still did not entirely help her to understand the physical complications. Her infertility made her feel less of a woman. Her reproductive problems further emphasized her inappropriateness when it came to belonging to her community.

Yael shares this predicament:

> *"I have two ovaries and two fallopian tubes, so the right side of the system works but on the other side, the ovary is very far detached and there is no connection. Now I do not remember if there is a fallopian tube there and even if there is, it would not work for anything because it is on the other side, like the kidney is in the middle." (Yael)*

This was Yael's first medical discovery. It was followed by the discovery of an unicornuate uterus:

> *"I have this unicornuate uterus. Possibly the best- case scenario would be to have a premature baby. We do not know how premature and if the baby would survive." (Yael)*

She adds:

> *"I was in premature menopause. I am like I have half a uterus and I have no eggs. Menopause in terms of like we are going to start you on hormone replacement therapy and we are not even going in because if we find one old egg let's not even think about it. I remember my doctor here saying, your results are so bad that they are actually good because we know what we need to do- we go for egg donation." (Yael)*

Initially we can see the almost trivial way in which Yael describes her predicament. She talks about it in an almost matter of fact kind of way. It could be that she already adapted to the idea that she was going to have to deal with this reproductive impairment in order to be a mother. As the quotes continue we see a slight change in the way she talks about the complications. She tries to find solutions and practical options that will be positive and will help her in her path to becoming a parent. Like with her discussion of her chances to carry a child to term with a unicornuate uterus. She looks for chances, positive solutions that will allow her to have a child. She tries to keep going and keep her head up when facing all her reproductive compilations.

In Yael's case, her reproductive complications are a constant reminder that her chances at motherhood are limited and that she might actually never be a mother. She struggles with all possible complications, a small uterus, no viable eggs, advanced age and to top it off she has Jewish restrictions to treatments.

> *"So, there I was with half a uterus and no chance of having a genetically linked child ever." (Yael)*

The way in which she describes herself seems almost as if she finds herself in total reproductive misery, with no chance of her own naturally conceived or biological child. Her body failed her; it did not produce or fulfil what it was created for.

Surprisingly Yael choses to focus on the possible meaning of her complications:

> *"The situation in my uterus had never been picked up before… what would I have done with that information at the age of say 23? Nothing. It would have made me a completely different person to have that knowledge that I might not be able to carry a baby at the age of 23, I thought I had a perfect reproductive system that would work whenever I wanted. So I grew up like that and that could have influenced my choices in life." (Yael)*

Yael reflects on the idea of how her decisions in life could have changed if she would have known this sooner. This idea of her seeking out positive meaning behind the occurrences in her life were little sparks of hope for her who at the time of the interview was pregnant for the first time after a treatment with donated eggs and her husband's sperm.

Miriam had a similar view about herself and her reproductive system. She did not start her period until she was 16 years old. This was something that she did not worry about as she thought it was normal as both her mother and sister also started late. After she got married and she did not get pregnant straight away, she started to worry:

> *"We got married and after a couple of years and nothing was happening… so my sister had been diagnosed with polycystic ovaries and she had also been married for a few years for longer than me and she had not had any children… she had a minor operation that fixed it and then she actually went on and had children, so she has three children now… So, I thought maybe I had PCOS and that was the problem. I was convinced that was the problem with me too." (Miriam)*

At this point, Miriam did not have any medical tests done or any concrete diagnosis as to why she was not getting pregnant. Perhaps it was easier for Miriam to self-diagnose than to face a doctor or the intrusive medical tests that were to follow. At this point it also seems that Miriam was still positive and still

thought lightly about what PCOS might be or one could even say her reproductive system. She was positive about her body and had hope that she too was going to be fine.

Miriam then seeks medical help. In her description of the tests and scans she mentions one particular episode that left her feeling vulnerable about her body and more confused than that which she already was before trying to understand why she could not get pregnant.

> *"Literally after 30 seconds of starting the internal scan they said they could not proceed anymore because I had huge cysts and they could not see anything else and that I had to come back in a couple of months when that had gone and they can see what they could do. Obviously at this point I was so upset. We had gotten this far and it took so long to get to this point and them just sending me away again without being diagnosed or anything it was quite difficult to take that day and I was really upset about it." (Miriam)*

In Orthodox Jewish circles, it takes a lot of courage to firstly admit that you cannot conceive naturally, second that you are not like everyone else in your community who just have babies non–stop and third that you now need to tell someone else about your misery because, you need professional help. One can imagine the courage that these women need to be able to recognise they need help and to then find the right help. For Miriam, after much research, she found a doctor who could help her with tests and scans. She prepared for these tests with eagerness and relief as finally she would be able to understand some part of her body that was not responding accordingly. But this was not the case. This delay upset Miriam and extended her uncertainty due to lack of diagnosis and information about her inability conceive.

Miriam is now a mother of four. When discussing her journey to motherhood she remembers:

> *"The nights that I used to spend crying in bed." (Miriam)*

Miriam holds on to the feelings and emotions that she felt due to her infertility even after having her desired family.

Shternie is another participant who feels negatively about herself, her body and in particular her reproductive system. Upon discussion, she mentioned fertility treatments had been very negative for her mental health. She had many fears around sex, treatments and pregnancies. She feared having intercourse as it always led to miscarriage, she feared the Rabbis around her because she was afraid they would judge her, and she feared the doctors because they would promise her children she never saw.

> *"My blood is very thick so it clots a lot when I am pregnant. So, it causes clots in the placenta which kills the babies but all these pregnancies they thought they were ectopic as I was in a lot of pain. For all the miscarriages, I got very ill and mentally too. I got very low and then I started to get a phobia of sex because for me sex equated miscarriage and failure. It was just horrible." (Shternie)*

The way Shternie describes her journey seems almost like she is talking about someone else's' experience. It feels superficial and it sounds almost as a matter of fact. This is what is happening to me and this is why I am having miscarriage after miscarriage.

Shternie is another example of the women in this study who did not feel happy with their body. She felt that she was not strong and the stress from the miscarriages and failed IVF cycles left her strong emotional trauma. She had multiple fears that she expressed by hurting herself physically. Her pain needed to be shown on her body. One could speculate that her pain for not being able to be a mother had to be shown in some way. For her these marks could be reminders of what she has not been able to accomplish.

After many attempts finally Shternie became a mother. At the time of the interview her child was almost three. Now that she had accomplished her desire to be a mother she talks about what it would mean to try to have a second child:

> *"I am petrified of ever having another child again … I know I cannot imagine never having another child and I have not been in the hospital for three and half months but I was there yesterday and I had the police and the ambulance take me to hospital. All the nurses in the hospital know me by name." (Shternie)*

Shternie mentions her fear of becoming a mother again and this raises a question. If she does not want to be a mother again, or if she is not ready to be, then why would she start trying again? Her fear of becoming a mother again, is a fear of having to undergo treatments again, a fear of falling into the cycle of tests, injections, scans, tests, pregnancies, miscarriages repeat – the fertility treadmill. Shternie was afraid, as she said previously, miscarriages only left her feeling depressed and this led to self-harm. She wanted to be away from hospitals and unfortunately for her pregnancy could only result from treatments.

Naomi got married at the age of 36. She knew that her advanced age would make it harder for her to get pregnant. Nevertheless, Naomi also found it hard to accept her reproductive misfortune:

> *"Physically I was very healthy so it should not have really been an issue as such but I think age did play a part but you know we had all the tests done through a private gynaecologist and everything seemed ok and when they did a test to test your egg count, AMH, they said that was on the lowest side and our gynaecologist referred us to a clinic and we saw a doctor there and they did again all the thyroid tests and it all seemed to be fine… they said start with the less invasive process and to try IUI, so we did a couple of rounds of IUI and that did not work because every time we tried that or we went through that nothing was really at its optimum level, the egg was not good enough or the wall lining was not thick enough so we never really did it with optimum circumstances." (Naomi)*

She accepts her infertility and recognises that there was nothing she could do about that. Again, in a similar way to Shternie, Naomi sees the need to find reasons for her inability to conceive. She needs to have meaning and reasons for her failed IUI. Naomi wants to understand why her body is not responding and not behaving in the way that it should. One can understand this from the quote as she explains this is by referring to the age of her eggs and the way in which she explains the procedures she had done. Naomi refers to this as being done in less optimal circumstances.

Her reflection also suggests that she mostly blames herself for the failed treatment. She brings it back to her age and her eggs. She feels solely responsible for not being able to conceive and she blames her age and her lateness in getting married. This could explain her general feelings of guilty and feeling like she is the sole responsible person in her story of infertility.

These negative feelings continue to appear throughout the interview as Naomi continues to describe her medical problems. Through her description, it becomes apparent that she felt limited and controlled by her ill health.

> *"In the middle of doing two cycles of IUI I had issues with my back. I experience chronic back issues and so for three years we stopped. There was nothing I could do I was in constant pain and I was on anti-inflammatory drugs and it was really strong medication and muscle relaxers and we could not do anything." (Naomi)*

Her body is not helping her fulfil her dreams of motherhood; this is something she cannot change. This struggle leaves Naomi feeling powerless and at times feeling sorry for herself. Naomi is another example of a participant who felt betrayed by her body, not just her reproductive organs but her general health. These occurrences add to her general feelings of powerlessness and lack of reproductive control.

Once Naomi felt better and her back pain subsided she was able to resume her treatment. For her this was an exciting time as it meant that she would be able to remain hopeful in achieving motherhood. Much to her disappointment it was not so simple:

> *"When I got there to have the process the day I had the first scan they found I had a lesion on my uterus and they refused to actually do the treatment… they discovered I had endometriosis and that basically said I had to wait for that to clear up and I had to go into menopause so they induced menopause and ironically it turned out that I was going through natural menopause anyway so I had to wait another six months to have the process done." (Naomi)*

Her medical complications were not simple and were not easy ones to solve or go through. From Naomi's interview, it was clear that her physical health very much impacted her morale, the way she spoke about herself and most importantly how she let her medical complications rule her life. During the interview, Naomi seemed like a shy woman who was not very happy and confident. Naomi's desire to become a mother was more important than her health.

Vicky, mentions how lost and upset she felt due to her failed attempts of fertility treatments:

> *"The first year it was like ok, and then the second year you start to get really stressed out about it and then it becomes really predominant in your life and by the third year they were finding medical issues and it just felt like I was getting more ill each time which sounds crazy because I was going to work every day." (Vicky)*

Vicky wanted her body to reply to her commands but instead she was failing at trying to get pregnant and this just increased her stress. Vicky looked for

medical help and she found that once she started having analytical tests she opened Pandora's Box.

> *"I felt like every time they investigate something, they found something wrong and I had never been ill at all before, like I was not ill. I clearly had gynaecological problems. It was something I found difficult to absorb, like I had to take medication for prolactin and I have to have an operation and I need to take this thing and this blood test and this and that is wrong and it was all very difficult, those 18 months were really hard." (Vicky)*

It seems from her narrative that Vicky took pregnancy for granted. She had never considered potential gynaecological complications and when she thought about getting pregnant she thought that it would be easy and straightforward. As this vision started to dissolve, Vicky faced a few crushes. Initially her inability to conceive naturally later on, her medical complications. As Vicky plainly describes "it was all very difficult". She had to endure all these 'bullets' alongside her desire to become a mother. It is clear that fertility treatments are hard enough to undergo. This is made harder when, like in the case of Vicky and many other women mentioned in this study, there are further gynaecological complications present. In Vicky's case this came as a surprise to her. One can deduce, from her quote that she had to change her lifestyle and adapt to the complications and the strict path that would lead her to motherhood. What seems to be most shocking for Vicky is that all her life she thought herself healthy and she mentions "I had never been ill before". Her gynaecological problems, which are not phenotypically obvious, deem her ill and incapable to have children.

For Victoria, who openly admitted to take fertility and the ability to get pregnant completely for granted, the repeated failed cycles, the stress of not being able to get pregnant and her period every month were as she called it "bad news".

> *"We were trying and really putting in the effort and month after month. I was getting upset when I got my period and I would say to my husband maybe we need to look for help… I feel like every month I am getting bad news." (Victoria)*

Like Victoria, Jessica also saw her period as a bearer of bad news. A constant reminder that she had failed and she had again not managed to get pregnant.

> *"My period was a whole massive big, dark cloud that would be coming towards me every month. It would be a really depressive time." (Jessica)*

In Jessica's case, there were almost ten years of failed attempts and endless cycles of treatments and recurring menstruation. This was a cocktail for sadness and depression as she mentions above. Jessica struggled for nearly ten years trying to overcome her inability to conceive. Her feelings of desperation are palpable from her experience and this comes along with her negative feelings towards herself and her health. Jessica did not see her reproductive system as hers. It was something that was external to her, almost like someone who decided to fail her and not help her in her adventure to motherhood.

One and a half years after her daughter was born Gail started trying to conceive again. Unfortunately, she was not able to get pregnant and therefore looked for medical help. For Gail, the ability to have children and women's reproductive health go hand in hand. Yet this is exactly what failed her:

> *"I went to the doctor after of 13 months of trying and so we had all these tests and stuff and then they did a test to check my tubes to see if they were blocked and that was a painful test and again because I was so young I didn't really think twice about it. I went alone, my husband was working. This was just before Passover, so I had that done and that was all ok and then we met with the specialist consultant and he said that they looked at my results and they said that I had 99% chance of not*

conceiving naturally. That is why we would need IVF or IUI… He said, well it is a bit of a mystery, because I have low eggs, but I was only 22 at the time so I don't know and I didn't have any problems conceiving with my first child so we were in a bit of a shock." (Gail)

This was surprising to Gail. In certain ways, this made Gail feel like she was not normal and her own body had suddenly become a stranger to her. These negative feelings suddenly changed as Gail decided to try naturally monitored cycles. Thanks to this change, at the time of the interview Gail was pregnant with her sixth child. Gail did not have to endure any other complex treatments and for that she seemed to be very grateful for.

In Sophie's case her negative feelings towards herself were more obvious. She underwent 14 IVF cycles, none of which worked and resulted in the child she so much wanted to have. After multiple complications, changing doctor between three and four times, having multiple tests and investigations, nothing could explain her and infertility and this only just complicated things for Sophie. She was desperate to understand why she could not get pregnant, why treatments would not work in her case, why it was that other women could conceive easily and for her it was a big problem? This goes along with the notion that Sophie had such a negative view of herself, of her female organs and her reproductive system. She had lost hope in her body in her health and unfortunately all this had a negative impact on her mental health too.

"I feel like I have got shrivelled female body parts that is how I see it. I have a very negative view of my ovaries, and my cervix and the rest of it, my womb as it never really served me." (Sophie)

The way in which Sophie describes her womb gives us a notion that the whole purpose of one's body is to serve oneself and for Sophie her body failed her terribly. She has negative views about all reproductive organs that make her a woman and essentially all that in her opinion would make her a good Jewish

woman. These feelings were further emphasized as a gynaecologist makes this even more painfully obvious for Sophie:

> *"One gynaecologist said to me, your womb never really served you , I had terrible problems with my period and I never managed to have a child and I was perimenopausal for a couple of years and just a few years ago, I thought it is enough already." (Sophie)*

Sophie expressed her difficulties and throughout the interview she recurrently mentioned how hard it was for her to have to undergo multiple tests and have to meet new doctors every now and again. In her case, she started to have to separate herself from her body in order to be able to undergo treatments. She needed to detach herself from all the physicality and technical side of treatments in order to just be able to continue. This was sadly true as she was on the metaphorical fertility treadmill for nearly ten years. After many failed attempts, Sophie was able to adopt a girl. With this child, many of her dreams of motherhood were fulfilled and this finally meant that she could share all the love she had to give. Nevertheless, Sophie felt that she had to accept that her treatments had not resulted in any fruitful pregnancy.

Sophie further emphasises that the first thing she would do differently now would be:

> *"The first thing I would change is being kinder to myself instead of pretending everything is normal and just fitting in a treatment here and a treatment there and just carrying on life as normal, accepting life as normal, when I know that actually it is not normal and it is extremely painfully emotionally." (Sophie)*

Sophie pushed through years of treatments whilst working in an important firm in the city centre. She mentions that she had to have treatments and on occasions she had miscarriages and failed treatments in the toilets of her office and had to continue working that day. One can understand Sophie's struggle,

her negative feelings towards herself. Her need to push herself to try to make up for her bodies failed response to all the treatments she underwent. In Sophie's case, she can look back and admit that she was very hard on herself and this was painful emotionally and psychologically. Sophie was harsh on her body and forced herself to undergo treatments even when she could not physically.

This is followed through by Andrea. She was not extremely religious when she got married and she did not want to have children straight away. After moving to a more religious neighbourhood and starting to see everyone around her having children this changed her view towards motherhood. Her husband had a son from his previous marriage and in her mind, everything would be ok and straight forward. Nevertheless, things did not quite turn out as she would have expected. Her initial treatment did not work and she ends up seeking treatments in America in order to try to find better doctors.

In the quote below Andrea describes one of her first IVF treatments. In this cycle she had a strong reaction to the ovarian stimulation and she was feeling quite miserable with herself. She hated the way her body had reacted. Now she was not just a woman who needed treatment but one who had had failed the treatment cycle:

> *"You feel as sick as dog at least I reacted to the medication and I was not able to eat, my stomach was so bloated I really felt so ill, and in fact physically I got quite ill." (Andrea)*

She then goes on to describe the way the doctor spoke to her during one of her first IVF treatments. The treatment did not work and the doctor blamed her stress and inability to relax during the procedure. This also emphasised her feelings of self-blame. This can be deducted by the way in which she blames herself for the treatments not working and for the 'wasting' of thousands of pounds. Andrea seemed to be anxious at the way in which the doctor spoke to her and this only increased the pressure she felt and therefore only made her more nervous.

“His bedside manner was appalling but he was angry with me because for the IVF I was not relaxed enough and he could not get the catheter in and so they gave me sedation and after the second time that it did not work he said it is not working because you are too tense, and you feel awful you feel so blamed you feel like you are spending thousands of pounds not even of my own money and it is not working because I am too tense of course you are going to be tense.” (Andrea)

CHAPTER 8: DISCUSSION

In this chapter I combine the themes I identified from the interviews carried out with women in order to expand and relate these themes to other scholarship in the field (see Chapter2). The themes included: my destiny, my Rabbi, my relationships and my identity. These themes explored the pressures, struggles and difficulties some Orthodox Jewish women face when dealing with infertility.

For the women in this study infertility was a challenge on many levels. These women saw their lives and relationships challenged and changed. Some women found solace in God's control over their lives while others felt the need to bargain with God in order to deserve his favour. Most women found reassurance in having a Rabbi to guide and support them. There were various levels of trust that developed between these women facing infertility and their Rabbis. Yet this was not the case for all other relationships. Some women struggled to maintain good relationships with their husbands, mothers, fathers and other family members. These relationships were sources of pressure for some of these women. The ultimate change for these women was the acceptance of their infertility as part of their identity. This change started as the acceptance of infertility as their destiny and path in life. Thus an individual challenge but as the challenge went on it became apparent that their infertility was a challenge that changed their relationships with themselves, their Rabbis, husbands, parents, friends and communities.

My Destiny

Some women in this study understood infertility as their destiny. A destiny that was set and controlled by God. God was seen as the ultimate giver of fertility and infertility. The one who controls everyone's lives and destinies, who blesses and the one who punishes according to a code of judgment, only he understands. For some women these were unsettling realities. At times some women felt that God was being unfair with them and that he was punishing them. These feelings and notions were also true in Teman's work (Teman *et*

al., 2011). Teman's work provides proof that some Orthodox Jewish women believe that God is who controls their ability to have healthy children and who directs their life (Teman *et al*., 2011).

For example, in Yael's case from this study, she accepted that her infertility was God given and this was a test and challenge to make her stronger as a person but yet despite disliking the idea of being tested there was nothing she could do about it. Chavi from Teman's study shares a similar perspective. She sees these tests as tests of *Emuna* (faith) (Teman *et al*., 2011).

On the other hand, some women who accepted their infertility as God given saw this a blessing. These women felt they were in God's hands and this allowed them to relax and let things happen as they should. Ivry *et al*, (2011) reported similar relationships between women and God in mothers of disabled children. Women in their study also believed that God controlled their destiny. God made their challenges and sent them tests according to their capabilities. Likewise, women in my study also thought that some of these tests are challenges of faith and tests that are sent to people to challenge them and make them grow as people. The same was found in Teman's study; women believed that it was God who was in charge of the "reproductive factory" therefore any challenges with reproduction are a direct challenge sent by God (Teman *et al*., 2011).

On another level women understood and accepted that God controlled their lives but they thought that they had a duty to seek medical or Rabbinical help. This level of action is something that Teman describes as *Hishtadlut (Teman* et al*., 2016)*. Only God controls the outcome of the pregnancy but by seeking help and trying to overcome their infertility women "do their part".

The way these women accepted their infertility as "God given" paralleled the stories of the Jewish matriarchs and prophetesses in the Bible. These women also saw their infertility as "God given" (Moss & Baden, 2015). Both sets of women understood the infinite power that God holds over their reproductive abilities. In the present time this is taken further by the deep Jewish belief that

God is the third partner in the conception of baby (*Guemara Niddah* 30a). On another level Rabbis emphasise that only God has the power to "open" a woman's womb (Gen. Rab 73.4; Deut Rab 7.6; Tanh. B. Vyyera 35; Pes. Rab 42.7;b Ta'an 2a). These principles along with the stories in the bible were constantly visited by women in this study. Therefore a link can be made between these views and women's opinions about their destinies.

The acceptance that God gives infertility and fertility led some women to want to gain proximity to God and thus bargain their chances of becoming fertile. As such some women prayed, others became more observant in *Halacha* or *Niddah* or observing the *Sabbath* or eating *Kosher*. Most women mentioned that what they took on was praying. Praying offered them a connection to God that allowed them to express their stresses, worries and fears. This connection to God gave women a way to ask God for what they wanted and what they believed that only He could grant. Again this act of praying is something that resembles the women mentioned from the Bible. The matriarchs and prophetesses used their infertility to gain proximity to God, more importantly they did this by praying (Moss & Baden, 2015). For example, in Hannah from the Bible we learnt the huge importance her prayer had in answering her fertility request. (Moss & Baden, 2015).

Similarly in Kahn's study (2000) women held on to prayer as a form of connection to God and a means to ask for motherhood. In Teman *et al.,* (2010) women were also determined to pray. Women resorted to prayer in order to communicate with God. Prayer was the outlet that connected women to God and also allowed them to ask for things they wanted and needed throughout their journey through infertility. Through prayer some women in my research were able to connect to God in conversation and in hope to understand why they were chosen with the difficult task of experiencing infertility.

My Rabbi

Another means of connection to God was the Rabbi. The Rabbi for these women was a multi-dynamic pillar of support.

In their study Benjamin & Ha'elyon (2002) found that women felt closer to God if they held a stronger relationship with their Rabbi. This was exactly what was noted in this study. The faith and trust in their Rabbi gave women positivity and hope that treatments would be successful. This notion could explain the need women had to contact their Rabbis and always have them present in the discussions of their treatments and medical steps. These women believed that having the Rabbi on their side meant that they were following Jewish law and that their treatment would be 'blessed' and this gave them more chances of their treatments being successful.

On occasions, women felt that they trusted their Rabbis more than they trusted the medical personal. Nevertheless, as Ivry mentions this relationship should not threaten doctors but rather be viewed as a positive link between patients and doctors (Ivry, 2010). Doctors should use this link to their advantage. When at times it is difficult to treat patients because of their complicated cultural requirements, here we are faced with a potential solution. The strong link between the Rabbi and the patient could provide the Doctor with any information he might lack, especially in the realm of Jewish law to any medical treatment. Rabbis though at times not fully medically qualified, are familiar with medical jargon and have faced many situations where couples have needed help trying to conceive; to some extent these Rabbis have broad knowledge about science and medical situations. So, here the Rabbis provide a solution to *Halachic* questions and complications. Additionally, they give IVF patients the stability that they need from their religion to know that what they are about to do does not go against their beliefs. This stability could help these women face treatments in a more calmed manner.

Benjamin & Ha'elyon (2002) also found that women in their study who had a good relationship with their Rabbis often had a better relationship with clinicians and in turn this also meant that women had a better outlook for their challenge and struggle. This was not always the case in this present study; some women such as Sophie, Andrea and Lisa, found that they got closer to their Rabbi and this distanced them more from their doctors as they felt that they could not trust them on the same level that they trusted their Rabbi. It seemed almost that the women placed their trust on their Rabbi over their doctor because they were Rabbis and therefore representatives of God.

It is important to mention in this study women had a stronger and deeper faith in their Rabbis than they did in their doctors. The way women in Benjamin and Ha'elyon describe their "blind faith" in their doctors was not replicated in my study. The Rabbi for these was the sole pillar of total support (Benjamin and Ha'elyon, 2002). To take this notion further, some women in my study felt closer to their Rabbis than they did to their family and close friends. Women did not just seek out Rabbis to know about laws, they sought out Rabbinical support for emotional guidance and guidance in terms of how to deal with their relationship with their husbands and having to go through fertility treatments.

On the other hand, some women in the study disliked the close proximity that the Rabbi had with them and the constant reminder and obligation to observe Jewish law. Some women focused on the difficulty they faced when accepting that Rabbis, which according to Jewish Orthodox law have to be male, could control their counting of the *Niddah* period.

Hartman & Marmon (2004) have tried to shed some light into the *Niddah* practice and fertility treatments. Some of their participants mentioned this as being "dehumanizing" in the fact that it disregarded their emotions and their physical need of contact with their husbands. Like Joana from this study, women disliked the way they felt about *Niddah* but still they felt "bound inextricably" to this ritual that caused them so much "personal torment". This reflects the importance that following Jewish law has on some Orthodox Jewish

women. Other women mentioned the difficulty of performing the ritual bath every month because it reminded them that they did not have children.

There is no doubt that the Rabbi plays a vital role in emotionally, medically and spiritually helping infertile women face their reproductive challenges. The women's connection the Rabbi allowed them to have a support mechanism to cope, face their challenge and find answers to their *Halachic* and occasionally medical questions. The Rabbi is a crucial pillar of support to these women.

My relationships

Many women spoke about how their relationships changed due to their infertility struggles. This was an experience that affected most women in this study. For these women this included changes in their relationships with their husbands, parents, families and communities.

Participants of Remennick's (2000) study and some women from Benjamin & Ha'elyon (2002) just like Ana, Shternie and Dina, from this thesis, decided to protect their husbands and to look after their husband's masculinity. This need to protect their husbands could add to the pressure and the outlook people have on these women and their inability to conceive. The protection of their husbands adds to the existing stigma that surrounds women and infertility (Lorber 1989; Greil 1991; Cousineau & Domar 2007; Dyer *et al*., 2005 & Greil *et al.,* 2010).

Infertility can negatively impact marital relationships (Greil *et al*., 2010 & Wirtberg *et al*., 2007). In Jessica's case her marriage crumbled and resulted in divorce due to her infertility. As treatment cycles proceeded her partner was less involved and she had to go to more appointments and interventions on her own. She felt that he was not as involved as he should have been and she felt alone. This was also true for women in Berger *et al*., (2013). The women in their study also had marital difficulties: romantically and financially speaking. For one of their participants infertility similarly ended her marriage. This is also what other studies have documented; infertility turns marital relationships into

“medicalized” relationships and this in turn makes partners feel like reproductive machines (Battaglia *et al*., 1983; Mazor, 1984; Reed, 1987).

Other disagreements that women in my study had with their husbands was when to stop treatments. On the majority of occasions women wanted to stop having treatments because physically they felt unwell but the husbands pushed for more cycles. This is the opposite of what Throsby and Gill have found. In their study it was the women who wanted to keep going with treatments but the men encouraged the women to stop (Throsby and Gill 2004). Could we argue that in this case the commandment to procreate sits heavy on Jewish men, hence the desperation to continue treatments.

Nevertheless, some couples might feel that infertility brings them closer together (Greil 1991 & 1997). Some women in Benasutti’s (2003) research felt that undergoing fertility treatments strengthened their relationships with their husbands as the experience created closeness between couples. Yael, Leah, Gail and Dalia, from this study, felt the same way. For them facing the challenges of infertility brought them closer to their partners and it allowed them to grow in their marital relationships.

Changes in familial relationships were for some women the hardest to bare. As several studies have predicted, women who experience rejection from family and spouses due to infertility experience higher levels of stress during this challenge (Gulseren *et al*., 2006 & Guz *et al*., 2003). Women talked about their families as sources of pressure to for them to seek help and medical treatments to overcome their infertility. This to some came as shock. Due to their Orthodox upbringing, some women expected to have a tight support group in their families. Instead women were faced with negative comments from their mothers. The mothers wanted to be grandmothers and belong with their friends’ circles. These comments hurt some women as they were looking for support but instead found more pressures to have children.

In Remennick’s study we find one participant, Karin, that similarly describes how conversations with her mother suddenly became superficial. Karin could

not open up and truthfully discuss her difficulties to get pregnant and have children with her mother (Remennick 2000). Women in my study felt deeply saddened by their negative relationships with their mothers. In some cases, these delicate relationships encouraged women to want to have children to build better mother-child relationships.

As Kahn noted infertility and childlessness can be seen as pitiable states (Kahn, 2000). Women in my study often chose not to share their infertility because they did not want to be pitied or a burden to their families. These women wanted to "Normal", being normal to some meant having four or more children, therefore, they omitted their infertility. Other reasons included, the prevention of further intrusion and the wish women had to protect themselves from feeling failed. For many the decision to keep their infertility a secret resulted in feelings of isolation and loneliness as women were not able to belong in their families and communities.

Women in this study were very selective with the people they shared their infertility with. This was mostly shared with their Rabbi, doctors. Parents and friends for very few women. This was also noted in the study Beger carried out (Beger *et al*., 2013). The women in their study reported that they were very selective with whom they shared their situation with in order to minimize uncomfortable situations and pressuring occasions. These women chose to share their experience with only a selected few. This course of action has also been recorded by Remennick (2000). Nevertheless, this course of action further causes women pain (Greene *et al*., 2006). It increases their emotional distance from their next-of-kin and other people they are usually most close to

Remennick (2000) found that women only share their experience with other women in a similar position to them. Some women in this study were of similar opinion. They were readily open to sharing their experiences with other women who might be facing infertility or who might need ART instead of sharing these with their families. The feelings that come up to the surface are those of isolation and loneliness. In the interviews Williams carried out with infertile

women this was also picked up alongside other feelings of worthlessness, inadequacy, anger and resentment (Williams 1997).

Other pressures women felt were from their communities and what they thought religion expected from them. Women in Benjamin and Ha'elyon (2002) felt immense pressure from the country they lived in, Israel. Though the pressure is slightly different to that which women of my study felt it is still based on the pro-natalist view that Israel has. This pro-natalist view of fertility and procreation is parallel to that Orthodox Jews have from a religious perspective. Some women in Benjamin and Ha'elyon mention how having children became an intrinsic and extrinsic priority as Jewish Israelis. Similarly women in my study also felt the pressure to procreate because their communities expected this from them. This was true from the comments and questions women received. This delicate climate of continuous and expected procreation only made women feel more vulnerable and less fulfilled due to their infertility.

In my study some women also faced difficulty when having to attend public places such as Synagogues or when needing to go to their families for *Shabbat*. As a result of the struggle of going to Synagogue and other gatherings with friends and other community members, some of the women started to use "strategic avoidance" (Riessman 2000). Women mentioned how they planned in advance where they would rather go in order to avoid possible difficult situations where they could be faced with lots of babies or questions and enquiries into their private lives. As some women in this study mentioned the need to travel outside the country every time there was a religious holiday.

Ayelet from Remennick (2000), had several miscarriages, she mentions how hard it was for her to keep going to community events and to try to be happy for other people who she saw getting on with their life. Some women in this study similarly found it hard to go out to community gatherings and be able to be a part of events and celebrations without feeling negative about themselves and those that have children and are able to move on with their lives. Yet as a whole, with regards to the community it appeared that women in this study were divided. Despite the negative pressures and intrusive questions they received

from other community members and friends women, still loved and appreciated the community life that Judaism as a religion offers.

These feelings of pressure also extended to the place of work. Nirit, another participant from Remennicks' (2000) study, also focused on how hard it was for her to work in a school environment. Shternie, a woman from my study, also spoke about the difficulty of working with children. In Andrea's case, from my study, the problem was that she was a midwife. Her job, put her everyday face-to-face with her dreams and unfulfillment.

My identity

This research uncovered the importance and the deep meaning that some Orthodox Jewish women give to motherhood. This was taken further as for the women this blurred the lines between motherhood and womanhood and thus changed what they understood as their identity and role in life. The majority of women thought that a woman is only complete when she has had children. Haelyon's (2006) study also found that women related femininity and womanhood to being pregnant and having children. Some of their participants mentioned that to be feminine a woman needs to pregnant and be able to give birth. This was also seen in Remennick's (2010) study. In her study, motherhood was interpreted as a primordial intrinsic feminine task and a basic instinct that is determined was a fulfilled woman.

Sophie, Miriam, Andrea, Jessica, Vicky and Naomi, were open about the fact that they had taken fertility for granted before their challenges. They firmly believed that they would never have any problems trying to conceive and that pregnancy would come on its own time. Much to their surprise and sadness this was not the case. Motherhood for them seemed like a basic function, something that should happen when you want it to and something that intuitively each woman is in charge of. When reality did not meet their expectations, the depth and meaning of motherhood became apparent. This realisation can for some women create an identity crisis (Thompson 2005; Bergart, 2000).

The inability to have children generally creates a disruption in a woman's life; in all that she views as her identity, important relationships, structures of meaning in her life and personal and general expectations of her life and that of her marriage (Ireland, 1993; Becker, 1990; Bassin, 1989; Greil *et al.,* 1989; Glazer & Cooper, 1988). These notions were true for the likes of Jessica, Rachel, Andrea and Sarah. These women were forced to question what womanhood meant for them. How could they be a good Jewish woman if they could not conceive as easily as they wished to? Some women in this study like Sophie had an identity crisis when it came to accepting the fact that she could not become a mother naturally or even with fertility treatments. This crushed Sophie's idea of who she was and more importantly the view she had of what it meant to be a woman. For her being a woman meant that you had reproductive organs that 'served you' that responded to her desire to become a mother. The same was true for Naomi, Jessica and Gail.

Naomi and Gail further felt like they were patients. All the medical visits and physical difficulties made them feel like they were patients and to some extent victims of the misfortune of a female physique that does not respond in the way that is expected. This notion gives one the idea that these women could potentially see themselves as pathologized. They did not have any serious medical conditions yet they still had to endure several rounds of treatment and medication in order to get pregnant. One could use the analogy of a person who is not feeling well, in this case not having children is the illness.

In Jessica and Sophie's case they were saddened and stressed by their period and the meaning behind their monthly bleed. These negative feelings, have previously been documented by Glazer & Cooper who describe menstrual cycles as an emotional roller coaster of two weeks of positive hope followed by two weeks of grave depression and affliction (Glazer & Cooper, 1988). The emotional rollercoaster has also been documented in Berger's (2013) study. Berger's women reported feelings of: sadness, helplessness, misery and depression. One participant described her experience as "I went from disappointed to unhappy to depressed to devastated as each negative test

result came through" (Berger, 2013). Some women in my study had to deal with their periods every month. Their menstrual bleed came with the negative reminder of another failed attempt. This was made harder for the women as they then had to go to the *Mikveh* and spend two weeks of total sexual and physical abstinence. The practice of *Niddah* and the family purity laws was difficult for some women. For one participant in my study this was hard because she knew that she was struggling with *Halachic* infertility. She knew that she was missing her ovulation window and due to this restrictive practice she could not have sexual relations with her husband. Despite this restriction set up by the practice of *Halacha* this participant went along with *Niddah*. Here we see the importance that Jewish law had for this woman.

Pregnancy and the ability to have children gave these women meaning and purpose in their life. Esti from Remennick's study firmly believed that a woman was only fulfilled if she was able to have children (Remennick 2000). Shira another participant form Remennick, stated that infertility would make her feel empty and lost as a woman (Remennick 2000). The same was true for the majority of women in my study. To take this idea further, women in my study felt that by having children they could contribute to the world and the Jewish community. This notion was picked up by Birenbuam-Carmeli. In her study childbearing was the ultimate life goal and most important self-realization (Birenbuam-Carmeli, 2008).

For most participants, the intrinsic need to be a mother was also important as it gave women a sense of continuity. For example, in Naomi's case, fertility was important for continuation. Having children for Naomi allowed her to guarantee a future generation, to let go of their losses and to some extent find replacement for all those loved ones she had lost.

In this study only Dalia recognised that motherhood did not define her identity. Dalia was happy with her life and for her motherhood was the "cherry on top". Most women in the study worked and had full time jobs, but this was not something they were proud of or something they did because they loved and were passionate about. For instance, Ana loved her job but when she '*hopped*'

on the IVF treadmill this changed. Jessica mentions, she only worked so she could pay for more treatments. Their work is what allowed them to have endless cycles of IVF. The same was found for Dalit a participant in Remennick's study. Dalit was willing to sacrifice every aspect of her life to have the children she desired (Remennick 2000).

For Sarah, the desire to become a mother, made her think of things which she would have never considered if she would have not been desperate to have children. Her late age, poor reproductive health and lack of partner, meant she needed a sperm and egg donor to fulfil her dreams of motherhood. Her family reluctantly only agreed to her reproductive choices if the Jewish Beth Din allowed it. According to Jewish law and Jewish Jewish Beth Din Sarah had to marry her friend, the "sperm donor". As seen in Kahn's study of solo mothers, some women will go to any extent in order to have children (Kahn 2000). For Sarah this was about marrying someone she did not love. For Rita a participant of Kahn's research it was about becoming a mother on her own using IUI. Both forms of procreation contested Jewish law yet both women went along with their treatments to become mothers.

For the majority of women in my study, like for Naomi, having children was their ideal happy ending. Just as Ruth and Jessica discussed in their interviews, being pregnant was the dream goal even with its difficulties. These positive feelings of pregnancy went along the idea that to be fulfilled as women they needed to be mothers. At the time of the interviews the majority of women had reached their desired dreams of overcoming infertility. Only Sosh, Karen and Maya were still childless. Nevertheless, as Sundby stated despite having their "happy ending", most women, when talking about fertility, focus on the negative feelings they had felt at the time of infertility (Sundby *et al.,* 2007).

CHAPTER 9: CONCLUSION, REFLECTIONS AND FUTURE WORK

My study has explored the way 26 Orthodox Jewish women living in London experienced infertility. These women as a whole saw their lives change in many aspects. In general there was a sort of break-down of everything they thought was normal. This started simply with accepting their destiny and path through infertility as it being “God given”. Followed by accepting and embracing the Rabbi as a vital support pillar in their life. The Rabbi, who in many cases was also in a privileged position, as he was the only other person to know about the infertility outside the married couple. Women also faced drastic changes in their relationships with their husbands, their mothers, fathers and other family members. This in many cases distanced them from their families as they continued in their life cycles without any complications and the women faced infertility.

Another difficulty included being part of a community that centralizes and embraces having children. Orthodox Jewish couples are expected to have children as soon as they marry. When this does not occur, couples start to feel excluded and isolated from their communities. Women in my study loved being part of the community. For them this was the essence and the standing ground of their religious belief. These women lived a life of Jewish practice and for this they needed to belong to the community. Being outside the community was a difficult challenge. This separation from the community added more pressure and further increased women’s desire to have children.

This is taken further by the slow but challenging internal battle that takes place inside these women. Some women started wondering what defines and fulfils a woman. These ideas are linked to having children. Without the ability to have children some women in my study felt incomplete and unfulfilled. This idea sits along the extreme pressure that these women feel from their families, communities and societies to have children. All they know, all they see around them is children. Children become a centrality in their lives and thus this made

their infertility their defining characteristic. The majority of women in my study were able to achieve a 'happy ending' and have the children they always dreamt of. Yet, their feelings of desperation and sadness resurfaced when sharing their stories with me.

In light of this research, there is a great need to implement changes in the way Orthodox Jewish women learn and perceive reproduction and fertility. Orthodox Jewish schools teach selective information about reproduction and women's health in fear of advocating sex before marriage, as discussed with the Ma'ayan women. It then comes as no surprise why women would not know or understand why they are not getting pregnant naturally once they get married and are sexually active. Targeted information in a sensitive and appropriate manner should be delivered to these schools and be available for this community.

On another level, there needs to be greater support mechanisms for women undergoing infertility in the Jewish community. These changes could include having open discussions about infertility in circles where women feel at ease to talk about their experiences. Orthodox Jewish women would benefit from having other women to talk to who are facing similar challenges to them. A conversation about motherhood, womanhood and infertility must be started so that women who cannot conceive as quickly as expected do not feel 'abnormal' or excluded.

Some sources of support and information already exist in the community, such as Chana and the women who graduated from the Ma'ayan programme. These organisations could take on board the findings of my thesis in order to better the service and help they provide to these women. Women in my thesis were lacking basic support mechanisms. They felt like they could not trust their families, friends and at times even their doctors. Having this support, from other women figures could tremendously change the feelings of loneliness and isolation some these women felt. Having someone to talk to who understands the Jewish laws and restrictions and is also a woman could help women accept and readily take on the information they are being given.

These findings also show the immense value Rabbis have in the life of infertile Jewish women. Rabbis provide spiritual guidance, emotional support, and psychological support, advice on Jewish practice and more importantly clinical advice. Rabbis are key sources of information for these women. They connect women to the medical knowledge they do not know or understand. These Rabbis are a trusted source therefore, for medical professionals Rabbis become key in the process of helping Orthodox Jewish women understand and navigate through infertility. It would be important to better the knowledge Rabbis have of infertility, ART and infertility counselling. The Rabbi for many women could be the only trusted source of information.

It is important for medical professionals to understand and accept the relationship that exists between Orthodox Jewish women and their Rabbi. In some cases the Rabbis could be the leading authority when it comes to the Rabbi-patient-doctor relationship. Instead of working against them, Rabbis and doctors should learn to co-operate in medical and clinical scenarios in order to improve and increase the chances of successful treatments for Orthodox Jewish women.

The findings of my thesis have changed my perspective on how Orthodox Jewish women experience infertility. Upon reading the literature available on this matter I found that women could be pressured to have children due to the strongly pro-natalist nature of Judaism. From my interviews I learnt that this was not just based on old Jewish traditions. Procreation for these women is a basic need settled deep within them. They were willing to undergo any kind of treatment for as long as it took in order for them to become mothers. Speaking to the women further allowed me to see the connection between their stories. Most of them were facing similar challenges but yet always individually and separately: these women hardly opened up about their experiences. Connecting these women could be beneficial to their infertility journeys. As such it is my aim to take the stories shared by these brave 26 women and compile them into a book. This book will aim to connect women and simultaneously try

to be a source of hope for other women struggling with infertility and more importantly to remind them that they are not alone in their infertility struggle.

As a descriptive qualitative study I recognise that a lot of interpretation and further evaluation of the women's stories could have been missed. I greatly focused and was guided exactly by what the women said and therefore felt was important to them. I wanted to share their experiences as they shared them with me. This was important to me because I wanted to ensure that their stories, which had been silenced for so long, finally appeared as they themselves had shared them. In addition, I further recognise that as a starting qualitative scientist my analysis of the interviews could have been weak as I lacked experience in this field of research. In any case, I tried to respect women's stories and express them in the most correct and complete way. As such, I tried my hardest to lower my voice through this thesis in hope to highlight the women's voices.

I further recognise that my position as a Modern Orthodox Jewish woman could have changed the way women expressed themselves. Furthermore, women could have also omitted some parts of their journey due to the fear of me knowing people they might know. Despite these limitations, I tried to always ensure the women and remind them that their participation in my study would be anonymous and confidential.

Many aspects uncovered in the women's interviews would be worth developing further. Some of these topics include the relationship women have with their Rabbis. This relationship has been explored in several studies yet it would be valuable to further try to understand exactly the relationship women have with their Rabbis when facing infertility. For example, would women need to be accompanied by their Rabbis to medical appointments? Would women feel more comfortable if it was the Rabbi instead of a counsellor or a doctor explaining clinical and medical implications? This information would be very useful for medical professionals when dealing with Orthodox couples.

Another aspect worth developing would include the relationship that Orthodox Jewish women have with their mothers. Many women in this study felt pressurised by their mothers to have children. Some women mentioned that they wanted to have children to build better mother-child relationships. It would be valuable to explore these relationships further in order to try to understand how this impacts women's desires to become mothers themselves. Understanding this relationship could bring light into some of the reasons why women want to have children. This research would be beneficial when counselling women and when trying to understand the reasoning behind women's use of ART when facing infertility.

Lastly, it would be worthwhile to understand how Orthodox Jewish women negotiate disclosing their infertility. Upon completing my research I realised that these women suffer greatly, not only because of their inability to have children but because of the heavy weight of their secret infertility. These women deliberately chose to not share their infertility challenges, this at times leaves them feeling isolated, misunderstood and outside their communities. It would be extremely valuable to try to understand deeper their reasoning behind them not sharing their challenges and attempt to change this so that their burdens lighten.

BIBLIOGRAPHY

Biblical resources

Book of Judges 4-5
Book of Judges 13:23-25
Deut Rab 7.6
Exodus 20:2
Exodus 21:1
Ezekile 23:37
Genesis 1:28
Genesis 2:18
Genesis 2:24
Genesis 3:16
Genesis 5:2
Genesis 11:30
Genesis 15:5
Genesis 17:6
Genesis 17:20
Genesis 18:12
Genesis 20:9
Genesis 21:6
Genesis 22:17
Genesis 24
Genesis 25:21
Genesis 25:23 Rashi
Genesis 28:3
Genesis 29:31
Genesis 29:35
Genesis 30:2
Genesis 30:9
Genesis 30:18
Genesis 30:20
Genesis 30:22
Genesis 31:1-2
Genesis 34:14
Genesis 34:31
Genesis 35:11
Genesis 48:3-4

Gen. Rab 73.4
Gittin 41b
Isaia 45:18
Kiddushin 30b
Leviticus 15
Leviticus 17-26
Megila 14a
Micah 6:4
Mishna Yevamot 6:6
Nehemiah 2:17
Niddah (Gemara) 30a
Pes. Rab 42.7
Psalm 128:3-4
1 Samuel 1:18
1 Samuel 1:10-16
1 Samuel 1:20
1 Samuel 2:21
1 Samuel 11:2
1 Samuel 13:13
1 Samuel 14:49
1 Samuel 17:26
1 Samuel 18:20
1 Samuel 18:28
2 Samuel 6:16, 20, 23
Songs of songs Rabbah 2:14:8
B Ta'an 2a
Talmud Bavilon
Talmud Niddah 13a
Talmud Niddah 31a
Talmud Yevamot 62a
Talmud Yevamot 63b
Talmud Yevamot 64a
Talmud Yevamot 65a
Talmud Yevamot 65b
Tanh. B. Vyyera 35

Websites

ATime (https://www.atime.org/)

Bord of deputies of British Jews: Advocacy for the community. Jews in numbers. Article:https://www.bod.org.uk/jewish-facts-info/jews-in-numbers/.

Chana website: https://www.chana.org.uk/

Dor Yeshorim (https://doryeshorim.org/)

European Society of Human Reproduction and Embriology, 2014. ART fact sheet. http://www.eshre.eu/Guidelinesand-Legal/ART-fact-sheet.aspx.

European Society of Human Reproduction and Embryology (2018) "More than 8 million babies born from IVF since the world's first in 1978: European IVF pregnancy rates now steady at around 36 percent, according to ESHRE monitoring."ScienceDaily: www.sciencedaily.com/releases/2018/07/180703084127.htm

International Committee for Monitoring Assisted Reproductive Technologies (ICMART) Access: https://www.icmartivf.org/.

Pew Research Center, 2012. “The Global Religious Landscape”. Available at: https://www.pewforum.org/2012/12/18/global-religious-landscape-exec/.

Pew Research Center, 2015. “The Future of World Religions: Population Growth Projections, 2010-2050”.
Available at: https://www.pewforum.org/2015/04/02/religious-projections-2010-2050/

Puah (https://www.puahfertility.org/)

Ma’ayan Programme: https://chiefrabbi.org/maayan-programme/

My Jewish Learning, How to Pray Through Infertility,
article: https://www.myjewishlearning.com/article/how-to-pray-to-have-a-child/

Tahareinu (https://www.tahareinu.com/)

World Health Organisation, “Infertility defintions and terminology”, Available at: https://www.who.int/teams/sexual-and-reproductive-health-and-research/areas-of-work/fertility-care/infertility-definitions-and-terminology.

World Health Organisation, “World report on disability 2011” Available at: https://www.who.int/teams/noncommunicable-diseases/disability-and-rehabilitation/world-report-on-disability.

Journals & Articles

Abraham, S.A. (1984) Medical Halachah for Everyone. Feldheim Publishers Ltd, Jerusalem, 172-174.

Ahmed, S., Atkin, K., Hewison, J. & Green, J. M (2006) The influence of faith and religion and the role of religious and community leaders in prenatal decisions for sickle cell disorders and thalassaemia major. *Prenat Diagn* **26**:801–809.

Al-Bar M., Chamsi-Pasha H. (2015) Assisted Reproductive Technology: Islamic Perspective. In: Contemporary Bioethics. Springer, Cham pp173-186.

Ames, H., Glenton, C. & Lewin, S. (2019) Purposive sampling in a qualitative evidence synthesis: a worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology*, **19**(26):1-9.

Ardakani, Z. B., Navabakhsh, M., Treymane, S., Akhondi, M., A., Ranjbar, F. & Tabrizi, A. M. (2021) The impact of Third Party Reproduction on Family and Kinship. *Journal of Reproduction & Infertility*, **22**(1):3-15.

Atieno, P. O. (2009) An analysis of the strengths and limitations of qualitative and quantitative research paradigms. *Problems of education in the 21st century* 13: 13-18.

Attride-Stirling, J. (2001) Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, **1**:385-405.

Balasch, J. & Gratacós E. (2011) Delayed Childbearing: Effects on Fertility and the Outcome of Pregnancy. *Fetal Diagn Ther,* **29**:263–273.

Balde, D. M., Bnagoura, A., Diallo, B. A., Sall, O., Balde, H., Niakate, A. S., Vogel, J. P. & Bohren, M. A. (2017) A qualitative study of women's and health providers' attitudes and acceptability of mistreatment during childbirth in health facilities in Guinea. *Reproductive health*, 14:4.

Baldwin, K. (2018) Conceptualising women's motivations for social egg freezing and experience of reproductive delay. *Sociology of Health and Ilness,* **40**(5):859-873.

Baldwin, K., Culley, L., Hudson, N. & Mitchell, H. (2018)Running out of time: exploring women's motivations for social egg freezing. *Journal of psychosomatic Ostretics and Gynaecology*, **40**(2):166-173.

Bamford, S. C. (2019) The Cambridge Handbook of kinship. 1st ed. Cambridge: Cambridge university press; 750p.

Battaglia, A. R., Graziano, M. R. & Fonti, S. (1983). Experimental research into the changes in the way sexuality is experienced by the infertile woman. *Acta Europaea Fertilitatis 14*:67-73.

Becher, H., Waterman, S., Kosmin, B. & Thomson, K. (2002) A Portrait of Jews in London and the South-East: A Community Study (Institute for Jewish Policy Research, May 2003), Available at: http://www.jpr.org.uk/publications/publication.php?id=177&sid=178.

Becker, G. (2000). *The Elusive Embryo: How Men and Women Approach New Reproductive Technologies*. Berkeley, CA: University of California Press.
Benasutti, R. D.(2003) Infertility: experiences and meanings. *Journal of Couple & Relationship Therapy*, **2**(4):51-71.

Behjati-Ardakani, Z., Navabakhsh, M. & Hosseeini, S. H. (2017) Sociological study on the transformation of fertility and childbearing concept in Iran. *J Reprod Infertil,* **18**(1):153-61.

Benoot, C., Hannes, K. & Bilsen, J. (2016) The use of purposeful sampling in a qualitative evidence synthesis: a worked example on sexual adjustment to a cancer trajectory. *BMC Med Res Methodol,* **16**(1):21.

Benor S. B. (1975) Becoming Frum, How Newcomers Learn the Language and Culture of Orthodox Judaism. Rutgers University Press.

Berg, B. (1995) Listening to voices of the infertile in joan calla med reproduction, ethics and the law (Bloomington: Indiana university press, 1995)pp80-109

Berger, R. (2013) Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, **0**(0):1–16.

Berger, R., Paul, M. S. & Henshaw, L. A. (2013) Women's Experience of Infertility: A Multi- systemic Perspective. *Journal of International Women's Studies*, **14**(1): 54-68.

Bermant, C (1970) Troubled Eden: An Anatomy of British Jewry (London: Valentine Mitchell, 1969).

Berkowitch, N. (1997) Motherhood as a National Mission: The Construction of Womanhood in the Legal Discourse in Israel." *Women's Studies International Forum* **20**(5-6): 605–19.

Bick, E. (1993) Ovum donations: A Rabbinic Conceptual Model of Maternity A *Journal of Orthodox Jewish Thought*, **28**(1):28-45.

Birenbaum-Carmeli**,** D. (1997) "Pioneering Procreation: Israel's First Test-Tube Baby." *Science as Culture*, 6:525-540.

(a)Birenbaum-Carmeli**,** D. (2003). Reproductive policy in context: Implications on the rights of Jewish women in Israel, 1945-2000. *Policy Studies*, **24**(2):101-114.

(b)Birenbaum-Carmeli, D. (2003) Contextualizing a medical breakthrough: An Overview of the case of IVF. *Health Care for Women International*, **24**(7):591-607.

Birenbaum-Carmeli, D. (2007) Contested Surrogacy and the Gender Order: An Israeli Case Study. *Journal of Middle East Women Studies,* **3**(3):21-44.

Birenbaum-Carmeli, D. **(**2008) Your faith or mine - Family planning intervention in an ultra-orthodox Jewish community in Israel. *Reproductive Health Matters*, **16**(32):185–191.

Birenbaum-Carmeli, D. (2009) The politics of 'The Natural Family' in Israel: State policy and kinship ideologies. *Social Science and Medicine,* 69:1018-1024.

Birenbaum-Carmeli, D**.** (2010) Genetic relatedness and family formation in Israel: Lay perceptions in the light of State policy. *New Genetics and Society,* **29**(1):73-85.

Birenbaum-Carmeli, D. & Carmeli, Y. S. (2010) Kin, Gene, Community: Reproductive Technologies among Jewish Israelis. Berghahn Books, New York, USA.

Birenbaum-Carmeli, D. & Dirnfeld, M. (2008) The more the better? IVF policy in Israel and women's views**.** *Reproductive Health matters,* **16**(31):1–10.

Birenbaum-Carmeli, D., Carmeli, Y. S. & Cohen. R. (2000) 'Our first 'IVF baby': Israel's and Canada's Press coverage of procreative technology. *International Journal of Sociology and Social Policy,* **20**(7):1-38.

Birenbaum-Carmeli, D**.** & Haimov-Kochman, R. (2010) Fertility treatments under semi/occupation: The case of East Jerusalem. *Facts, Views and Vision in Ob/Gyn,* 35-42.

Birenbaum-Carmeli, D**.** & Inhorn, M. (2009) Assisting Reproduction, Testing Genes: Global Encounters with New Biotechnologies. *Berghahn books publishing.*

Birenbaum-Carmeli**,** D. & Soffer, Y. (2010) Le don de sperme en Israël ; son secret et son anonymat, *Andrologie: Journal officiel de la Société d'andrologie de langue Française* Reprinted in P. Jouannet and R. Mieusset (eds.) *Donner et après… La procréation par don de spermatozoïdes avec ou sans anonymat? Springer*, 17-30.

Birt, L., Scott, S., Cavers, D., Campbell, C. & Walter, F. (2016) Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qual Health Res*, **26:**1802–1811.

Bleich D. J. (1991) Survey of Recent Halakhic periodical literature: In Vitro Fertilization: Questions of Maternal Identity and Conversion. *Tradition: A Journal of Orthodox Jewish Thought*, **25**(4)82-102.

Bleich, D. J. (1979) "The Obligation to Heal in the Judaic Tradition: A Comparative Analysis." *Proceedings of the Associations of Orthodox Jewish Scientists,* **6**:11-64.

Blutinger, J. C. (2007) '"So-called Orthodoxy": The History of an Unwanted Label', *Modern Judaism*, **27**: 310-28.

Blyth, E. & Landau R. (2004) Third party assisted conception across cultures: Social, legal and ethical perspectives. Jessica Kingsley Publishers, UK.

Blyth, E. & Landau R. (2009) Faith and fertility: Attitudes towards reproductive practices in different religions from ancient to modern times. Jessica Kingsley Publishers, UK.

Bowen, G. (2008) Naturalistic inquiry and the saturation concept: a research note. *Qual Res*, 8(1):137-152.

Bowden, J.A. & Walsh, E. (2000) Phenomenography. Melbourne: RMIT University Press.

Boyarin, J. (1991) "Jewish Ethnography and the Question of the Book", *Anthropological Quarterly,* **64**(1):14–29.

Boyatzis, R. E. (1998) Transforming qualitative information: thematic analysis and code development. Sage publications Inc.

Brand, Y. (2010) Essays: Religious medical ethics: A study of the rulings of Rabbi Waldenberg. *Journal of Religious Ethics* **38**(3):495-520.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology,* **3**:77-101.

Brinkmann, S. & Kvale, S. (2005) Confronting the ethics of qualitative research. *J Constr Psychol,* **18:**157–181.

Brinkmann, S. (2014) Interview. In Teo T, editor. Encyclopedia of Critical Psychology. New York (NY): Springer.

Broad, T. (2017) Dear You: A letter to my unborn children. Red Door publishing, Denmark.

Brook, S. (1990) The Club: The Jews of Modern Britain (London).

Browner, C., Preloran, H. & Cox, S. (1999) Ethnicity, bioethics, and prenatal diagnosis: The amniocentesis decisions of Mexican-origin women and their partners. *Am J Public Health **89***:1658–1666.

Budds, K., Locke, A. & Burr,V. (2013) 'Risky business'. Constructing the 'choice' to 'delay' motherhood in the British press. *Feminist Media Studies*, **13**(1):132-47.

Bundren, M. (2007). Influence of Catholicism, Islam and Judaism on the assisted reproductive technologies (art) bioethical and legal debate: comparative survey of art in Italy, Egypt and Israel. *University of Detroit Mercy Law Review*, **84**(5):715-746.

Burstein, M. (2006) Doctor Rosenak, ask for forgiveness! [In Hebrew.] *Hatsofe,* Page 498.

Caelli, K., Ray, L., & Mill, J. (2003). "Clear as mud": Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, **2**(2):1–23.

Cannon, E. (2017) Fertile: Nourish and balance, your body ready for baby making. Penguin Random House UK.

Cardin, N. B. (2007) Tears of sorrow, seeds of hope: A Jewish spiritual companion for infertility and pregnancy loss (2nd Ed). Jewish lights publishing, Vermont.

Carmeli, Y. S. & Birenbaum-Carmeli, D. (2000) Ritualizing the 'Natural Family': Secrecy in Israeli Donor Insemination. *Science as Culture*, **9**(3):301-325.

Carter, S. M, Ritchie, J. E & Sainsbury, P. (2009) Doing qualitative research in public health: not as easy as it looks. *NSW Public Health Bulletin*, 20:7-8.

Cates, W., Farley, T. M. & Rowe, P. J. (1985) Worldwide patterns of infertility: is Africa different? *Lancet* **2**: 596–598.

Chana, creating lives together (2019) Un-expecting: personal stories of resilience. Chana Charity Ltd, UK

Chiseri-Strater, E. (1996). Turning in upon ourselves: Positionality, subjectivity, and reflexivity in case study and ethnographic research. In P. Mortensen & G.

E. Kirsch (Eds.), Ethics and responsibility in qualitative studies of literacy (pp. 115-133). Urbana, IL: NCTE.

Clarke, M. (2008). New kinship, Islam, and the liberal tradition: sexual morality and new reproductive technology in Lebanon. *Journal of the Royal Anthropological Institute*, 14, 143–169.

Cohen, A. P.(1985) The Symbolic Construction of Community (London: Routledge).

Cohen, A. S (1987) Artificial Insemination. *Journal of Halacha and Contemporary Society,* **13:**43–59.

Collet, M., Reniers, J., Frost, E., Gass, R., Yvert, F., et al. (1988) Infertility in Central Africa: infection is the cause. *Int J Gynaecol Obstet* **26**: 423–428.

Collins, J. A. (2002). An international survey of the health economics of IVF and ICSI. *Human Reproductive Update*, **8**:265–277.

Conrad, P. & Schneider, J. W. (1980) The medicalisation of deviance: From badness to sickness. St Louis, Mo: Mosby.

Cote, L. & Turgeon, J. (2005) Appraising qualitative research articles in medicine and medical education. *Med Teach,* **27**:71–75.

Cousineau, T. M. & Domar, A. D. (2007) Psychological impact of infertility. *Best practice & research clinical obstetrics and gynaecology*, **21**(2):293-2007.

Creswell, J.W. (2013) Qualitative Inquiry and Research Design. Thousand Oaks: Sage Publications.

Cui ,W. (2010) Mother or nothing: the agony of infertility. Available at: https://www.scielosp.org/pdf/bwho/2010.v88n12/881-882/en.

Dahan, M. H., Coffler, M. S. & Patel, K. S. (2005) Oral contraceptives for inducing ovulation delay in Orthodox Jewish women. *J Reprod Med,* **50**:284-6.

(a)Dahan, M. H., Goldstein, J., Ratts, V. & Odem, R. (2005) Programming ovulation using estrogens for patients to time intercourse. *Obstet Gynecol,* **105**(5):1209–1210.

(b)Dahan, M. H., Coffler, M. S. & Patel, K. S. (2005) Oral contraceptives for inducing ovulation delay in orthodox Jewish women: a report of 2 cases. *J Reprod Med,* **50**:284–6.

Davis, H. (1997) *Be Fruitful and Get Fertility Treatment* Theological Essay Manna, number 58 (Winter 1997) Sternberg Centre for Judaism, London.

De Lacey, S. T., Peterson, K. & McMillian, J. (2015) Child interests in assisted reproductive technology: how is the welfare principle applied in practice? *Human Reproduction*, **30:**616-624.

DellaPergola, (2018) Global Jewish population: Available on the Jerusalem Post article: https://www.jpost.com/Diaspora/Global-Jewish-population-reaches-147-million-566880

Denton, J., Monach, J. & Pacey, A. (2013) Infertility and assisted reproduction: counselling and psychosocial aspects. *Human fertility,* **16**(1):1.

De Tona, C. (2006) But what is interesting is the story of why and how migration happened. *Qualitative Social Research,* 7:(13).

Dixon-Woods, M., Shaw, R. L., Agarwal, S. & Smith, A. J. (2004) The problem of appraising qualitative research. *Developing research,* **13**:223-225.

Dorff, E. N (1996) Artificial insemination, egg donation and adoption. *Conservative Judaism,* **49:**3–60.

Dorff, Elliot. (1999) "A Jewish Approach to Assisted Reproductive Technologies." *Whittier Law Review*, **21**(2):391-400.

Dutney, A. (2007) Religion, infertility and assisted reproductive technology. *Best practice & Research Clinical Obstetrics & Gynaecology* **21**(1):169-180.

Dryer, S. J., Abrahams, N., Mokoena, N. E., Lombard, C. J. & van der Spuy, Z. M. (2005) Psychological distress among women suffering from infertility in South Africa: a quantitative assessment. *Human Reproduction,* **20**(7):1938-1943.

Dyer, S., Chambers, G. M., de Mouzon, J., Nygren, K. G., Zegers-Hochschild, F. Mansour, R., Ishihara, O., Banker, M. & Adamson, G. D. (2016) International Committee for Monitoring Assisted Reproductive Technologies world report: Assisted Reproductive Technology 2008, 2009 and 2010. *Human Reproduction*, **31**(7): 1588–1609.

Egbunikee, J. N., Shaw, C., Porter, A., Button, L. A., Kinnersley, P. Hood., Bowden, S., Bale, S., Snooks, H. & Edwards, A. (2010) Streamline triage and manage user expectations: lessons from qualitative study of GP out-of-hours services. *BR J Gen Pract* 60:83-97.

Eisner, E. (1991) The enlightened eye: Qualitative inquiry and enhancement of educational practices. New York: Macmillan.

Emden, C. & Sandelowski, M (1999) The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. International *Journal of Nursing practice*, **4**:206-212.

Ericksen, K. & Brunette, T. (1996) Patterns and predictors of infertility among African women: a cross-national survey of twenty-seven nations. *Soc Sci Med,* **42**:209–220.

Feldman, E. & Wolowelsky, J. B. (1997) Jewish law and The new reproductive technologies. Katav Publishing house, USA.

Fertig, A. (2007) Bridging the Gap: Clarifying the Eternal Foundations of Mussar and Emunah for Today. Jerusalem: Feldheim Publishers.

Feuer, J. (2011). Relatively speaking: Halachic and legal issues of gamete donation. *Medicine and Law*, **30**(2), 239-266.

Finkler, K., Skrzynia, C. & Evans, J. P. (2003) The new genetics and its consequences for family, kinship, medicine and medical genetics. *Soc Sci Med* **57**:403–412.

Finlay, L. (2002) 'Outing' the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research,* **12**:531-545.

Flick, U. (2007) editor Managing quality in qualitative research. London: Sage Publications.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S. & Aboagye-Sarfo, P. (2018) Application of four-dimension criteria to assess rigor of qualitative research in emergency medicine. *BMC Health Services Research*, **18**:120.

Franklin, S. (1997). *Embodied Progress: A Cultural Account of Assisted Conception.* London: Routledge.

Franklin, S. (2006). Origin stories revisited: IVF as an anthropological project. *Culture, Medicine and Psychiatry*, **30**:547–555.

Friedlander, D. & Feldmann, C.(1993).The modern shift to below-replacement fertility: has Israel's population joined the process? *Population Studies*, **47**(2): 295-306.

Gardin, S. K. (1988) The laws of Taharat Hamishpacha: potential effects on fertility. *J Biosoc Sc,i* **20**:9-17.

Gatens, M. (1992). Power bodies and difference. Cambridge: Polity Press.

Giger, J. N. (2017) Transcultural nursing: assessment and intervention. 7th ed. St. Louis, Toronto: Mosby.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs,

Gold, M. (1988) And Hannah Wept. The Jewish Publication Society, Philadelphia.

Gordon, J. A., Amelar, R. D., Dubin, L. & Tendler, M. D. (1975) Infertility practice and orthodox Jewish law. *Fertility and Sterility,* **26**:480–484.

Graham, D. & Vulkan, D. (2010) Synagogue Membership in the United Kingdom in 2010, Institute for Jewish Policy Research Available at: http://www.jpr.org.uk/publications/publication.php?id=233.

Graham, D., Boyd, J. & Vulkan, D. (2011) Census Results (England and Wales): Initial Insights about the UK Jewish Population (London: Institute for Jewish Policy Research, 12 Dec. 2012), Available at: http://www.jpr.org.uk/downloads/2011%20Census%20Initial%20findings%.

Greene, K., Derlega, V. L., & Mathews, A. (2006). Self-disclosure in personal relationships. In A. Vangelisti & D. Perlman (Eds.), Cambridge handbook of personal relationships (pp. 409–427). Cambridge, UK: Cambridge University Press.

Greil, A. L. (1991) A secret stigma: the analogy between infertility and chronic illness and disability. *Advances in Medical Sociology*, 2:17-38.

Greil, A. L. (1997) Infertility and psychological distress: a critical review of the literature. *Social science and medicine,* **45**(11):1679-1704.

Greil, A. L., Slauson-Blevins, K. & Mcquillan, J. (2010) The experience of infertility: a review of recent literature. *Sociology of health & Illness,* **32**(1):140-162.

Gruenbaum, B. F., Pinchover, Z. S., Lunenfeld, E. & Jotkowitz, A. (2011) Ovum donation: examining the new Israeli law. *European Journal of Obstetrics & Gynecology and Reproductive Biology,* **159**(1):40-42.

Guba E. G. (1981) Criteria for assessing trustworthiness of naturalistic enquiries. *Educational Communication and Technology Journal,* **29**:75-91.

Guba, E. G. & Lincoln, Y. S. (1989) Fourth generation evaluation. Newburry Park, CA: Sage.

Gulseren, L., Cetinay, P., Tokatlioglu, B., Sarikaya, O. O., Gulseren, S. & Kurt, S. (2006) Depression and anxiety levels infertile Turkish women. *Journal of Reproductive Medicine*, **51**(5):421-426.

Gürtin, Z. B. The ART of Making Babies: Turkish IVF Patients' Experiences of Childlessness, Infertility and Tüp Bebek. (PhD Thesis, Cambridge) (2013).

Gürtin, Z. B. (2011). Banning reproductive travel? Turkey's ART legislation and third-party assisted reproduction. *Reproductive Biomedicine Online,* 23:555–565.

Guz, H., Ozkan, A., Sarisov, G. & Yanik, F. (2003) Psychiatric symptoms of Turkish infertile women. *Journal of Psychosomatic Obstetrics and Gynaecology,* **24**(4):267-271.

Hackett, C., Stonawski, M., Potančoková, M., Grim, B. J. & Skirbekk, V. (2015) The future size of religiously affiliated and unaffiliated populations. *Demographic Research*, **32**:829-842.

Haelyon, H. (2006) "Longing for a Child: Perceptions of Motherhood among Israeli-Jewish Women undergoing *InVitro* Fertilization Treaments." *Nashim,* **12**:177–202.

Haimov-Kochman, R. & Hurwitz, A. (2009) Religious Halachic infertility. *Harefuah,* **148**(4):271-4.

Haimov-Kochman, R., Rosenak, D., Orvieto, R. & Hurvitz, A. (2010) Infertility counselling for orthodox Jewish couples. *Fertility and Sterility,* **93**(6):1816–1819.

Halcomb, E. J. & Davidson, P. M. (2006) Is verbatim transcription of interview data always necessary? *Appl Nurs Res,* **19**:38–42.

Halperin, M. (1988) In vitro fertilization, embryo transfer, and embryo freezing. *Jewish Medical Ethics,* **1**:25–30.

Hammarber, K., Kirkman, M. & de Lacey, S. (2016) Qualitative research methods: when to use them and how to judge them. *Human reproduction,* **31**(3):498-501.

Hellawell, D. (2006) Inside-out: Analysis of the insider-outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. *Teaching in Higher Education*, **11**:483-494.

Hetzroni, A. (2009) Stop giving birth to poor children. *Maariv*, NRG.

Hirsh, A. V. (1996) Post-coital sperm retrieval could lead to the wider approval of assisted conception by some religions. *Human Reproduction,* **11**:245–247.

Hirsh, A. V. (1997) Advances in the management of male infertility may concur with Jewish. *London Jewish Medical Society, Law Menora,* 5–8.

Hirsh, A. V. (1998) Infertility in Jewish couples, biblical and rabbinic law. *Human Fertility,* **1**(1):14-19.

Hollos, M. 2003. 'Profiles of Infertility in Southern Nigeria: Women's Voices from Amakiri.' *African Journal of Reproductive Health/La Revue Africaine de la Sante´ Reproductive* **7**(2): 46–56.

Inhorn, M. C. (1994). *Quest for Conception: Gender, Infertility and Egyptian Medical Traditions.* Philadelphia, PA: University of Pennsylvania Press.

Inhorn, M. C. (1996). *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt.* Philadelphia, PA: University of Pennsylvania Press.

Inhorn, M. C. (2002) 'Sexuality, Masculinity, and Infertility in Egypt: Potent Troubles in the Marital and Medical Encounters.' *The Journal of Men's Studies* **10**(3): 343–59.

Inhorn, M. C. (2003). *Local Babies, Global Science: Gender, Religion, and In Vitro Fertilization in Egypt.* New York, NY: Routledge.

Inhorn, M. C. (2006). *Fatwa*s and ARTS: IVF and gamete donation in Sunni v. Shi'a Islam. *Journal of Gender, Race and Justice*, **9**: 291–317.

Inhorn, M. C. (2012). *The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East*. Princeton, NJ: Princeton University Press.

Inhorn, M. & Birenbaum-Carmeli**,** D. (2008) Assisted reproductive technologies and cultural change. *Annual Review of Anthropolgy,* **37**:177-196.

Inhorn, M. C. & Tremayne, S. (Eds.) (2012). *Islam and Assisted Reproductive Technologies: Sunni and Shi'ite Perspectives*. New York, NY: Berghahn.

Inhorn, M. C. & Van Balen, F. (Eds.) (2002). Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies. Berkeley, CA: University of California Press.

Inhorn, M. C., Birenbaum-Carmeli, D., Tremayne, S. & Gürtin, Z. B. (2017) Assisted reproduction and Middle East kinship: a regional and religious comparison. *Reproducitve Biomedicine and Society Online*, **4**: 41-5.

Irshai, R. (2012) Fertility and Jewish Law: Feminist Perspectives on Orthodox Responsa Literature. Brandeis University Press, Waltham Massachusetts, USA.

Israel's Ministry of Health (2013). In Vitro Fertilization (IVF) Treatments: Absolute Numbers, Percentages, Rates. (http://www.health.gov.il/PublicationsFiles/IVF1986_2012.pdf)

Ivry, T. (2010) Kosher Medicine and Medicalized Halacha; An exploration of triadic relations among Israeli Rabbis, Doctors and infertility Patients. *American Ethnologist*, **37**(4):662-680.

Ivry, T., Teman, E. & Frumkin, A. (2011) God-sent ordeals and their discontents: Ultra-orthodox Jewish women negotiate prenatal testing. *Social Science & Medicine,* **72**:1527- 1533.

Jakobovits, I. (1975) Jewish Medical Ethics 4th Edn. Bloch, New York.

Jakobovits, I. (1984) Human Fertilisation and Embryology – A Jewish View Submissions to the Warnock Committee of Inquiry and the Department of Health and Social Security Office of the Chief Rabbi, London.

Jakobovits, Y. (1993) Male infertility: Halakhic issues in investigation and management. *Tradition* **27**:4–21.

Jafar., A. J. N. (2018) What is positionality and should it be expressed in quantitative studies? *Emerg Med J,* **35**:323–324.

Jenkins, G. L. (2002) 'Childlessness, Adoption, and Milagros de Dios in Costa Rica.' Pp. 171–89 in Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies: A View from the Social Sciences, edited by M. C. Inhorn and F. van Balen. Berkeley: University of California Press.

Jenkins, G. L. & Inhorn, M. C. (2003). Reproduction gone awry: medical anthropological perspectives. *Social Science and Medicine,* 56:1831–1836.

Jewish agency, (2019) Number of Jews worldwide. Available at: https://www.jpost.com/Israel-News/Number-of-Jews-in-Israel-and-worldwide-on-the-rise-reports-603033.

Jewish Agency, Aliyah Statistics from 2018 (2018) Available at: http://archive.jewishagency.org/news/aliyah-statistics-%E2%80%93-2018.

Judd, I. (2017) Dare to dream. Bantam Press, Penguin Random House UK.

Kacen, L. & Chaitin, J. (2006) The times are a changing: understanding qualitative research in ambiguous, conflictual and changing contexts. *Qualitative Report,* **11:**209–228.

Kahn, S. M. (2000) Reproducing Jews: A cultural account of assisted conception in Israel. Duke University Press, Durham and London, USA.

Kahn, S. (2006) Making Technology Familiar: Orthodox Jews and Infertility Support, Advice, and Inspiration. *Culture, Medicine, and Psychiatry,* **30**:467–480.

Kasstan, B. (2019) '*Making bodies Kosher. The politics of reproduction among Haredi Jews in England'.* Fertility, Reproduction and Sexuality. Berghahn Books, New York and Oxford Publishing.

Kahn-Harris, K. (2020) Social research on European Jewish populations The state of the field. *Institute for Jewish Policy Research,* 1-58.

Kitto, S. C.Chesters, J. & Grbich, C. (2008) Quality in qualitative research: Criteria for authors and assessors in the submission and assessment of qualitative research articles for the medical journals of Australia. *Med J Aus,* **188**(4):243-246.

Kochman-Haimov, R., Adler, C., Ein-Mor., E., Rosenak, D. & Hurwitz A. (2012) Infertility associated with Ovulation Precoital ovulation in Observant Jewish couples; Prevalence, Treatment, Efficacy and Side Effects. *IMAJ,* **14**.

Kol, S. 2018 Ultra-Orthodox Jews and infertility diagnosis and treatment. *Andrology,* **6**:662–664.

Koropatnick, S., Danilukm J. & Pattinson, H. A (1993) Infertility: a non-event transition. *Fertility and sterility,* **59**(1):163-171.

Kuper, A., Lingard, L. & Levinson, W. (2008) Qualitative research: critically appraising qualitative research. *BMJ,* 337:1035.

Landau, R. (2003) Religiosity, Nationalism and human reproduction: The case of Israel. International Journal of Sociology and Social Policy 23: 64–80.

Landsman, G. (2008) Reconstructing motherhood and disability in the age of "Perfect" babies. New York: Routledge.

Larsen, U. (2000) Primary and secondary infertility in sub-Saharan Africa. *Int J Epidemiol* **29**:285–291.

Leung, L. (2015) Validity, reliability and generalizability in qualitative research. *J Family Med Prim Care*, **4**(3):324-327.

Lincoln, Y. S. & Guba, E. (1985). Naturalistic Enquiry. Beverly Hills, CA: Sage.

Lincoln, Y. S. & Guba, E. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *N Dir Eval,* (30:73-84.

Lingard, L. & Kennedy, T. J. (2010) Qualitative research methods in medical education. In Swanwick T, editor. Understanding medical education: evidence, theory and practice. West Sussex: Wiley-Blackwell; 323–335.

Lorber, J. (1988). IVF and gender politics. *Women and Health*, ***13***:117–133.

Lunenfeld, B. & Birenbaum, N. (1970) Treatment of infertility originating from mismatch between the date of the Mikveh and the fertile window. *Moria,* **13-14**:48-52.

Lunenfeld, B. & Birnbaum, N. (1970) Treatment of infertility due to mismatch between fertile days and time of immersion. *Moriah,* **13–14**:48–52.

Mackler, A. L. (1997) An Expanded Partnership with God? In Vitro Fertilization in Jewish Ethics . *The Journal of Religious Ethics*, **25**(2):277-304.

Maheshwari, A., Porter, M., Shetty, A & Bhattacharya, S. (2008) Women's awareness and perceptions of delay in childbearing. *Fertility and Sterility*, **90**(4): 1036-1042.

Marshall, C. (1990) Goodness criteria: Are they objective or judgment calls? In E. G. Guba (Ed), The paradigm (p188-197). Newburry Park, CA: Sage.

Marteau T, Kidd J, Cook R, Michie S, Johnston M, Slack J, Shaw R. 1991. Perceived risk not actual risk predicts uptake of amniocentesis. Br J Obstet Gynaecol 98:282–286.

Maxwell, J. A. (2005) Qualitative research design: An interactive approach. 2nd ed. Thousand Oaks, CA: Sage Publications.

Mazor, M.D. (1984) 'Emotional Reactions to Infertility', in M.D. Mazor and H.F. Simons (eds), *Infertility: Medical, Emotional and Social Considerations* (New York: Human Sciences Press).

Maya N. Mascarenhas, M. N., Flaxman, S. R., Boerman, T., Vanderpoel, S. & Stevens G. A. (2012) National, Regional, and Global Trends in Infertility Prevalence Since 1990: A Systematic Analysis of 277 Health Surveys. *PLOS Medicine* **9**,12.

Mayaud, P. (2001) The role of reproductive tract infections. In: Boerma, J.T., Mgalla, Z., editors. Women and infertility in sub-Saharan Africa: a multidisciplinary perspective. *Amsterdam: Royal Tropical Institute Press*, 71–108.

Mays, N. & Pope, C. (2000) Qualitative research in health care: assessing quality in qualitative research. *BMJ*, **320**(7226):50-2.

McGrath, C., Palmgren, P. J. & Liljedahl, M. (2019) Twelve tips for conducting qualitative research interviews, Medical Teacher, 41(9):1002-1006.

Melender, H. L. & Lauri, S. (2002) Experiences of security associated with pregnancy and childbirth: A study of pregnant women. *Int J Nurs Pract* **8**:289–296.

Merriam, S. B. (1998). Qualitative research and case study applications in education. San Francisco: Jossey-Bass.

Miall, C. F. (1986). The stigma of involuntary childlessness. *Social Problems*, ***33***:268–282.

Mitchell, M. (2010) Risk, pregnancy and complementary and alternative medicine. *Complement Ther Clin Pract* **16**:109–113.

Mittman, I. S. (2005) Most Studied Yet Least Understood: Perceptions Related to Genetic Risk and Reproductive Genetic Screening in Orthodox Jews [Ph.D. dissertation]. Baltimore, MD: Johns Hopkins University.

Morse, J. M. (1995) The significance of saturation. *Qual health Res*, **5**(2):147-149.

Mor-Yosef, S. & Schenker, J.G (1995) Sperm donation in Israel. *Human Reproduction,* **10**(4):965-7.

Moss, C. R. & Baden, J. S. (2015) Reconceiving infertility: biblical perspectives on procreation and childlessness. Princeton University Press, UK.

Nahar, P., A. Sharma, K., Sabin, L., Begum, S., Ahsan, K. &. Baqui, A. H (2000) 'Living with Infertility: Experiences among Urban Slum Populations in Bangladesh.' *Reproductive Health Matters,* **8(**15): 33–44.

Nahman, M. (2013). *Extractions: An Ethnography of Reproductive Tourism*. London: Palgrave Macmillan.

Nahman., M. (2011) Reverse traffic: intersecting inequalities in human egg donation. *Reproductive BioMedicine Online*, **23**:626–633.

Nahman., M. (2006) Materializing Israeliness: Difference and mixture in transnational ova donation. *Science as Culture,* **15**(3):199–213.

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description–the poor cousin of health research? *BMC Medical Research Methodology*, **9**(1): 52.

Nyboe Andersen, A., Goossens, V., Gianaroli, L., Felberbaum, R. de Mouzon, J. & Nygren K.G. (2007) Assisted reproductive technology in Europe, 2003. Results generated from European registers by ESHRE. *Human Reproduction,* **22**(6):1513–1525.

ONS(2015) Births by Parents' Characteristics in England and Wales: 2014. London: Officee for National Statistics.

ONS (2017) Births in England and Wales: 2016 Live births, stillbirths, and thee intensity of childbearing measured by the total fertility rate. London: Office for National Statistics.

Paxson, H. (2004) *Making Modern Mothers: Ethics and Family Planning in Urban Greece.* Berkeley, CA: University of California Press.

Pfeffer, N. (1987). Artificial insemination, in-vitro fertilization and the stigma of infertility. In M. Stanworth (Ed.), *Reproductive Technologies: Gender, Motherhood and Medicine* (pp. 81-97). Cambridge: Polity Press.

Pfeffer, N. (1985) The hidden pathology of the male reproductive system. In Hilary Homans (Ed.), The sexual politics of reproduction: Feminist approaches to the so- ciology of human reproduction (30–44). Aldershot, England: Gower.

Pillow, W. S. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education*, **16**(2):175-196.

Philipp, E. (1994) The Jewish ethical approach to infertility. *Menora,* 3–5.

Phoenix, A., & Woollett, A. (1991). Introduction. In Ann Phoenix, Anne Woollett & Eva Lloyd (Eds.), Motherhood: Meanings, practices and deologies (1 – 12). London: Sage Publications.

Popovsky, M. (2007) Jewish perspectives on the use of Preimplantation Genet Diagnosis. *Journal of law medicine & ethics,* **35**(4):699–711.

Poland, B. (1995) Transcription quality as an aspect of rigor in qualitative research. *Qual Inq*, **1**:290–310.

Pope, C. & Mays, N. (2006) Qualitative research in health care. 3rd ed. London: Blackwell Publishing: 2006.

Portuguese, J. (1998) Fertility Policy in Israel: The Politics of Religion, Gender and Nation. Westport, CT: Greenwood.

Rabinson, J. & Katan, C. (2005) Endometriosis: Halakhic aspects as indications for treatment. *Isr Med Assoc J,* **7**:107108.

Rapp, R. (1999) Testing women, testing the fetus: The social impact of amniocentesis in America. New York: Routledge.

Raucher, M. (2016) Ethnography and Jewish Ethics; Lessons from a Case Study. *Reproductive Ethics Journal of Religious Ethics*, **44**(4)636-658.

Reed, K. (1987) 'The Effect of Infertility on Female Sexuality', *Pre- and Peri-natal Psychology*, 57–62.

Reeves, S., McMillan, S. E., Kachan, N., Paradis, E., Leslie, M. & Kitto, S. (2015) Interprofessional collaboration and family member involvement in intensive care units: emerging themes from a multi-sited ethnography. *J Interprof Care,* **29:**230–237.

Remennick, L. (2000) "Childless in the Land of Imperative Motherhood: Stigma and Coping Among Israeli Women". *Sex Roles*, **47**(11-12):821-841.

Remennick, L. (2009) Between reproductive citizenship and consumerism: Attitudes towards Assisted Reproductive technologies among Jewish and Arab Israeli women. Chapter 13 in Kin, Gene, Community: Reproductive Technologies Among Jewish Israelis**.** Edited by Daphna Birenbaum-Carmeli, Yoram S. Carmeli**.** Berghahn Books New York, USA.

Riessman, C. K. (2000). Stigma and everyday resistance practices: Childless women in South India. *Gender and Society*, **14**(1):111–135.

Rocker, S. (2008) 'Expat and Excluded, Israelis in the UK' Available at: https://www.thejc.com/news/uk/expat-and-excluded-israelis-in-the-uk-1.1798 .

Rosenak, D. & Shimon, R. (2006) Time to rethink the stringency of Rabbi Zera? [In Hebrew.] *Hatsofe*.

Rosenblum, I. (2013). Being fruitful and multiplying: Legal, philosophical, religious, and medical perspectives on assisted reproductive technologies in israel and internationally. *Suffolk Transnational Law Review*, **36**(3)627-648.

Ross, D. (1998) Identifies the only other published rabbinic opinion on this issue. Rabbi Ben Zion Ferrer in Noam, book 6 Responsa of Va'ad Halacha of the Rabbinical Assembly of Israel, **3**:574-5749.

Rothman, B. K. (1994). *The tentative pregnancy: Amniocentesis and the sexual politics of motherhood*. (Rev. ed.) London: Pandora.

Sallam, H. N. & Sallam, N. H. (2016) Religious aspects of assisted reproduction. *Facts Views Vis Obgyn,* **8**(1): 33-48.

Samet, M. (1988) 'The Beginnings of Orthodoxy', Modern Judaism, 8:249-69.

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description? *Research in Nursing and Health*, **23**(4):334–340.
a)Sandelowski, M. (1993) Rigor or rigor mortis: The problem or rigor in qualitative research revisited. *Advances in Nursing Science*, 16:1-8.

b)Sandelowski, M. (1993). *With Child In Mind: Studies of the Personal Encounter with Infertility.* Philadelphia, PA: University of Pennsylvania Press.

Sandelowski, M. (1986) The problem of rigor in qualitative research. *Advances in Nursing Science* **8**:27-37.

Schenker, J. G. (1997) Infertility evaluation and treatment according to Jewish law. *European Journal of Obstetrics, Gynecology and Reproductive Biology* **71**:113–123.

Schenker, J. G (1996) Religious views regarding gamete donation. In: Seibel MM, Crockin SL (eds) Family Building Through Egg and Sperm Donation. Jones and Bartlett, Boston, pp. 238–250.

Schenker, J. G. & Halperin, M. (1995) Jewish family practice and their evolution. *Global Bioethics*, **1**:35–47.

Schenker, J. G. (1999) In-vitro fertilization in Israel. *Lancet,* **353**(9170):2163.

Schenker, J. G. (2002) Gender selection. *Journal of Assisted Reproduction and Genetics* **19**:400–410.

Schenker, J. G. (2007) Assisted Reproductive Technology in Israel. *J Obstet Gynaecol Res,* **33**(1):51-5.

Schenker, J. G. (2013) Human Reproduction: Jewish perspectives. *Gynecol Endocrino*l, **29**(11):945-8.

Schenker, J. G. (2008) Assisted reproductive technology: perspectives in Halakha (Jewish religious law). *Reproductive Biomedicine Online,* **17**(3):17-24.

Schumaker, J. F. (1992) Religion and Mental Health. Oxford: Oxford University Press.

Seale, C. (1999) The quality of qualitative research. *London Sage publications.*

Seeman, D. (2010) "Ethnography, Exegesis and Jewish Ethical Reflection." In Kin, Gene, Community: Reproductive Technologies among Jewish Israelis, edited by Daphna Birenbaum- Carmeli and Yoram Carmeli, 340–362. New York: Berghan Books.

Seidman, I. (2013) Interviewing as qualitative research: a guide for researchers in education and the social sciences. New York (NY): Teachers College Press.

Serour, G. I., Rizk, B., Abdallah, A. & Silber, S. J. (2005) Religious perspectives of ethical issues in ART. *Middle East Fertility Society Journal*, **10**(3)185-204.

Shalev, C. (1998) Halakha and patriarchal motherhood- an anatomy of the New Israeli surrogacy law. *Israel Law Review*, **32**(1):51-80.

Shalev, C. & Golding, S. (2006) the uses and miuses of invitro fertilisation (IVF) in Israel: Some sociological and ethical considerations" *Nashim:A journal of Jewish women's studies and gender* **12:**151-176.

Silber, M. (1992) "The Emergence of Ultra-Orthodoxy," Harvard University Press.

Silber S. J. (2010) Judaism and Reproductive Technology. In: Woodruff T., Zoloth L., Campo-Engelstein L., Rodriguez S. (eds) Oncofertility. Cancer Treatment and Research, vol 156. Springer, Boston, MA.

Sorenson, D. (1990) Uncertainty in pregnancy. *NAACOGS Clin Issu Perinat Womens Health Nurs,* 1:289–296.

Stanworth, M. (Ed.). (1987). *Reproductive technologies: Gender, motherhood and medicine*. Cambridge, UK: Polity Press.

Staetsky, L. D. & Boyd, J. (2015) Strictly Orthodox rising: What the demography of British Jews tells us about the future of the community. Institute for Jewish Policy Research, 1-23.

Steptoe, P.C. & Edwards, R.G. (1978). Birth after reimplantation of a human embryo. Lancet, ii, 366.

Suri, H. (2011) Purposeful sampling in qualitative research synthesis. *Qual Res J,* **11**(2):63–75.

Sundby, J., Schmidt, L., Heldaas, K., Bugge, S. & Tambo, T. (2007) Consequences of IVF among women: 10 years post-treatment. Journal of Psychosomatic Obstetrics & Gynaecology, 28(2):115-120.

Sundby, J. & Jacobus, A. (2001) 'Health and Traditional Care for Infertility in The Gambia and Zimbabwe' Pp. 258–68. in Women and infertility in Sub-Saharan Africa: A Multi-disciplinary Perspective, edited by J. T. Boerma and Z. Mgalla. Amsterdam: Royal Tropical Institute.

Talbot, L.A. (1995). Principles and practice of nursing research. St. Louis, MO: Mosby-Year Book.

Taragin-Zeller, L. (2019) "Conceiving God's Children": Toward a Flexible Model of Reproductive Decision-Making. *Medical Anthropology Cross-Cultural Studies in Health and Illness*, **38**(4):370–383.

Taylor-Guthartz L. (2019) Overlapping Worlds: The religious lives of Orthodox Jewish women in Contemporary London. (PhD thesis, UCL) (2016), Chapter 2: 'Context and Methodology of Research'.

Teman, E. (2010) Birthing a Mother: The Surrogate Body and the Pregnant Self. Berkeley, CA: University of California Press.

Teman, E., Ivry, T. & Bernhardt, B. A. (2010) Pregnancy as a proclamation of faith: Orthodox Jewish women navigating the uncertainty of pregnancy and prenatal diagnosis. *American Journal of Medical Genetics,* **155**:69-80.

Teman, E., Ivry, T. & Goren, H. (2016) Obligatory effort [Histadlut] as an explanatory model: A critique of reproductive choice and control. *Culture, Medicine and Psychiatry,* **40**(2):268–288.

Thompson, C. (2005). *Making Parents: The Ontological Choreography of Reproductive Technologies.* Cambridge, MA: MIT Press.

Throsby, K. & Gill, R. (2004) 'It's different for men': masculinity and IVF. *Men and Masculinities,* **6**(4):330-348.

Treharne, G. J. & Riggs, D. W. (2015) Ensuring quality in qualitative research. *Issues in qualitative research,* 57-72.

Tremayne, S. (2012). The "down side" of gamete donation: challenging "happy family" rhetoric in Iran. In M. Inhorn and S. Tremayne (Eds.), *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives* (pp. 130-157). New York, NY: Berghahn.

Tuckett, A. G. (2005): Applying thematic analysis theory to practice: a researcher's experience. *Contemporary Nurse*, **19**:75-87.

Unnithan-Kumar, M. (2010) Female selective abortion beyond 'culture': family making and gender inequality ina globalising India. *Cult Health Sex,* **12**(2):153-66.

Waldenberg, Eliezer Yehudah 1985 Tzitz Eliezer (in Hebrew). 2d ed. 15 vols. Jerusalem, Israel: n.p. Waldenberg, Eliezer Yehudah, and David Meir 1982 "In Vitro Fertilization" (in Hebrew). *Assia*, **9**(33):5-13.

Webber, J. (1994) 'Introduction', in id. (ed.), Jewish Identities in the New Europe (Oxford: Littman Library of Jewish Civilization), 1-32.

Williams, M. E. (1997) Toward greater understand of the psychological effects of infertility on women. *Psychotherapy in Private Practice*, **16**(3):7-26.

Willlig, C. (2013) Introducing qualitative research in psychology (3rd ed). Maindenhead: Mcgraw-Hill International.

Wirtberg, I., Moller, A., Hogstrom, L., Tronsand, S. E.& Lalos, A. (2007) Life 20 years after unsuccessful infertility treatment. *Human reproduction,* **22**(2):598-604.

White, M. T. 2009. Making sense of genetic uncertainty: The role of religion and spirituality. *Am J Med Genet Part C* **151:**68–76.

Whiteford, L. M., & Gonzalez, L. (1995). Stigma: The hidden burden of infertility. *Social Science & Medicine, **40***(1), 27–36.

Whittemore, R., Chase, S. K. & Mandle, C. L (2001) Validity in Qualitative Research. *Qualitative Health Research*, **11(**4):522-537.

Wolowesky, J. B & Grazi, R. V. 2014 Current Jewish perspectives on maternal identity. *Gynecol Endocrinol* **30**(12):929-30.

Wyvrekens, E., Provoost, V., Ravelingien, A., De Sutter, P., Pennings, G. & Buysse, A. (2014) Beyond sperm cells: A qualitative study on constructed meanings of the sperm donor in lesbian families. *Human Reproduction*, **29**:1248-1254.

Varpio, L. & McCarthy, A. (2018) How a needs assessment study taught us a lesson about the ethics of educational research. *Perspect Med Educ,* **7**:34.

Yardley, L. (2000) Dilemmas in qualitative health research. *Physicol Health*, **15:**215-228.

Yairi-Oron, Y., Rabinson, J. & Orvieto, R. (2006) A simplified approach to religious infertility. *Fertil Steril,* **86**:1771-2.

Yairi-Oron, Y., Rabinson, J. & Orvieto, R. (2006) A simplified approach to religious infertility. *Fertility and Sterility,* **86**:1771–1772.

Ylannee, V. (2016) Too old to parent?, Discursive representations of late parenting in the British press. *Discourse & Communication,* **10**(2):176-97.

Yogev, Y., Simon, Y., Ben-Haroush, A., Simon, D., Orvieto, R. & Kaplan, B. (2003) Attitudes of Israeli gynecologists regarding candidate screening and personal responsibility in assisted reproductive technologies versus adoption in Israel. *European Journal of Obstetrics & Gynecology and Reproductive Biology,* **110**(1):55-57.

Zegers-Hochschild, F., Nygren, K. G., Adamson, G. D., de Mouzon, J., Lancaster, P., Mansour, R. & Sullivan, E. (2009). International committee for monitoring assisted reproductive technologies. The ICMART glossary on ART terminology. *Human Reproduction*, 21, 1968–1970.

Zhao, Y., Brezina, P., Hsu, C. C., Garcia, J., Brinsden, P. R. & Wallach, E. (2011) In vitro fertilization: Four decades of reflections and promises. *Biochimica et Biphysica Acta* 843-852.

APPENDICES

(1)Glossary: Hebrew words and Jewish concepts

Averah

Is the term in Hebrew used to refer to a sin or a transgression against God or man. In Hebrew this word means to transgress a moral boundary. An *averah* is the opposite of a *mitzvah*.

Cohen or Cohanim (Kohen)

Cohen is the Hebrew word for priest. In Jewish law, Cohanim are required to be of direct patrilineal descent from the Biblical Aaron who was Moses brother. As priests Cohanim had special jobs to perform in the time of the Jerusalem Temple; they were in charge of the daily and holiday duties of sacrificial offerings.

Halacha, Halachot

Halacha is a Hebrew word that is usually translated as Jewish law. A more appropriate translation is the 'path that one walks'. The word in Hebrew derives from the words to walk or travel implying that Judaism is not just a religion but a way of life. *Halachot* is the plural of *Halacha.*

Judaism

Judaism was founded over 3500 years ago and is one of the oldest Abrahamic religions. A relationship between faith and practice is commonly seen in Jews. Jews believe that God appointed them as his people so that they could set an example of ethical and holy behaviour in the world.

Kosher, Kashrut

The Hebrew word *Kosher* can be translated as fit. This word refers to the food that one is permitted to eat according to Jewish law.

Levy/ Levi

The descendants of the Tribe of Levi. Levites are integrated in Jewish communities but hold a distinct status. These have higher religious duties in their congregations.

Mamzer

A person born as a result of forbidden relationships or a descendant of a mamzer. In modern Jewish culture this refers to a person born as a result of adultery, a Jewish man with a married Jewish woman, born out of incest or someone whose parent is a *mamzer*. This nonetheless, is not synonymous with illegitimacy as it does not include children born to unmarried women.

Mashgiach

This refers to any Jew who supervises the *Kashrut* of any food establishment or in this case an IVF lab. Generally referred to as religious supervisors. The religious supervisor represents a *Kosher* certification of a Rabbi and establishes if treatments are done in an acceptable *Kosher* way. A similar word is *Shomer* which translates as 'Jewish legal guardian'.

Mikveh

This refers to a ritual bath designed for purification. This pool of water must be composed of stationary water and must contain a percentage of water from a natural source such as an ocean or rain. Both men and women use the mikveh for ritual purification but it is particularly special for women as they must immerse themselves in these waters once every month after their menstrual periods or after childbirth in order to become pure again and resume sexual activity.

Mitzvah

The literal translation of *Mitzvah* is command. Jews have been commanded to fulfil 613 commandments from the *Torah* and 7 Rabbinic commandments. This makes a total of 620 positive commandments.

Niddah

The literal translation of the Hebrew word niddah is exclusion. This refers to the menstruating woman who is excluded from sexual activity. Generally, this term can be used to refer to “menstruation”, “menstruating woman”, “bleeding period”, “menstrual blood” and “menstrual impurity”. A woman is *Niddah* from the moment she finds blood in her undergarments. From the first day of bleeding she is not allowed to have sexual intercourse and must wait 14 days from the first bleeding day in order to submerse herself in the *Mikveh* to re-establish pureness and resume sexual activity.

Shabbat

Also known as the Sabbath and in in Jewish practice it is the day of rest. This starts on the nightfall of the sixth day of the week and continues through to nightfall on the seventh day of the week. On this day Jews abstain from any sort of creation. This could imply using technology, money, cooking, cleaning or doing anything that could be considered as work. Jews use the *Shabbat* to celebrate the creation of the world and with it remember that God is the creator and the central part of their lives.

Yichud

Yichud is the prohibition of an unmarried man and woman to be together in the same room without a *shomer*. This is in order to prevent the man and woman from having the opportunity or being tempted to commit promiscuous or adulterous acts.

(2)Glossary: Currently Available ART

ART- Assisted Reproductive Technologies

Treatment used to overcome infertility which mainly refers to in vitro fertilisation (see below).

CRISPR (Clustered regularly interspaced short palindromic repeats)

CRISPR is a type of DNA that is found in certain bacteria and archaea. This DNA can be used in the process of cutting certain parts of the genome in the process of gene editing.

Gametes

The male gamete is the sperm and the female gamete is the egg.

Genome editing or Gene editing

A form of genetic engineering in which the DNA of a living organising is replaced, modified or deleted from the genome. This technique focuses on the targeting specific locations within the genome.

Embryo

The egg and sperm join together to make an embryo.

IVF- In Vitro Fertilization

If a couple cannot get pregnant naturally, they may go through IVF. The woman is given fertility drugs so she produces more than one egg. The eggs are collected from the woman in a minor surgical procedure. They are mixed with the partners sperm in the laboratory where they are kept for up to five days. Hopefully most of the eggs will form good quality embryos. Usually one embryo is transferred to the women's womb in the hope that she will get pregnant.

ICSI- Intracytoplasmic Sperm Injection

If a man has very poor quality sperm, the sperm will not be capable of fertilising the egg. In these case the couple go through the same procedure used in IVF but in ICSI, one sperm is injected directly into the egg to allow fertilisation.

PGT- Preimplantation Genetic Testing

PGT was developed to help couples who are at risk of transmitting a genetic or chromosomal abnormality to their children. The couple go through normal IVF procedures and a few cells are removed from the embryos. These cells are used for genetic testing and those free from the disease can be transferred to the woman.

Sex Selection

Using PGD techniques, the sex of the embryo can be determined. Some couples use PGD for sex selection because they wish to have a child of a particular sex.

Gamete donation

This includes the donation of eggs and sperm. Couples might need donated gametes if the female or male are infertile within the union. It could be that the couple only needs male or just female donation or both.

Egg freezing

The process by which the women's eggs are collected and frozen for future use. Egg freezing is also a method for fertility preservation in women who suffer from cancer or any other condition that may affect the viability of the woman's eggs.

Social egg freezing

A woman's fertility declines with age and is mainly dependent on the quality of her eggs. If a woman wants to delay her fertility, they may wish to undertake social egg freezing to ensure that her eggs remain 'young'. She will be given fertility drugs to produce several eggs which are collected in the same way as for IVF but they are frozen as soon as they are collected. When she is ready

to try to get pregnant, the eggs are thawed and inseminated with her partner's sperm. The resulting embryos can be transferred to her womb or refrozen.

Embryo Freezing

Usually after IVF or ICSI, people will have a number of unused embryos after the first cycle of treatment. It is common practice for people to have these embryos frozen so that they can be used later on in future treatment cycles. Other options include the donation of these embryos to other couples or for research purposes and training.

Surrogacy

Surrogacy involves a woman carrying a baby for another woman or couple. There are two types of surrogacy; traditional and gestational. Traditional surrogacy occurs when surrogate also provides the egg that is used to create the embryo. With gestational surrogacy, the surrogate solely carries the baby, and the egg and sperm come from the commissioning couple or an egg donor.

(3)Prayers for fertility and infertility

There are some pages online that are available to all, which focus on specific prayers and texts that couples can recite before or after treatment . This goes along the idea that women and men who struggle with infertility need to pray harder in order to conceive. One specific page offers prayers for: pregnancy, after miscarriages, for couples suffering with loss and a prayer for before ART (https://www.myjewishlearning.com/article/how-to-pray-to-have-a-child/ 27/03/2019).

The prayer for pregnancy asks God to help the person praying in the same way He helped the matriarchs. The prayer again emphasised that it is God who holds the key to fertility and again it reminds people that only He can make the infertile woman a happy mother:

> *"Dear God, and God of our ancestors, You have blessed untold loving couples across time, providing each with children in a tumble of generations. May it be your will that we join their lot tonight. Make tonight a night of joy and tenderness, a night in which my beloved and I conceive a child. Hold us close in your embrace, God, just as we hold each other tightly. Remember us as you remembered Sarah. Care for us as you cared for Rebecca. Tend to us as you tended to our mothers, Leah and Rachel.*
>
> *You alone hold the key to the womb. Open our chambers of life. Choose from your sacred treasury of souls and send us a child who is wise and caring, healthy and whole. With your help, may our family grow through the years, and through your kindness may we be a blessing to all who know us.*
>
> *May the words of our mouths and the desires of our hearts please You, our Strength and our Deliverer."*

This prayer is said before having sex. It focuses on God healing, helping, guiding and again knowing what is best for everyone. From the blessing above one can see that the prayer even focuses on the energy of the night. Additionally, people are not just praying to conceive, they want to conceive in a

tender and loving way. This prayer highlights a big difference between having infertility treatments and conceiving naturally. There is something unique natural conception, having infertility treatments removes the spontaneity of sexual relations and reminds us of the technicality of ART. The idea of test-tube baby rings true to Orthodox Jews who might want to conceive in this tender and natural manner.

On the other hand, the prayer couples are supposed to say before ART focuses on the openings of the body and how their ability to work in tune will allow the woman or couple to conceive and have the child that they desire.

> *"God, creator of all, you wisely formed the human body. You created it with openings upon openings and vessels upon vessels. You know well that should even one of these open when it should remain closed, or close when it should remain open, we could not long survive. God of life with the key to the womb, guide the ways of my openings and closings so that they receive and hold and then safely release a child. Blessed are you God, healer of all flesh, who guides the wonders of creation."*

With this prayer a couple really accepts and acknowledges that God is the sole controller of fertility, infertility and procreation. With this acceptance comes the supplication to have children as a healing to the suffering mothers and fathers.

Please find here some short prayers that women are at times recommended to say when trying to get pregnant or just before starting infertility treatments.

Prayers obtained from:https://www.myjewishlearning.com/article/how-to-pray-to-have-a-child/ 27/03/2019.

A Prayer for a couple who suffered a miscarriage on the first trimester:

> *"Here we are, the two of us together. The two of us alone. We counted the days and measured the weeks that our child grew within. But we count no more. Our eyes longed*

to see the birth of our child, our arms yearned to cradle our new little one. Our mouths longed to sing soft lullabies of love. But now our child, our dreams, are no more. Sing us a lullaby, God, to fill our silence. Sing us a lullaby to soothe our fears, comfort our sadness and make the darkness go away. Source of healing and light, sing us a lullaby and help us to find healing in your embrace and among those who love and care for us. And when the time is right, help us dare to choose life again. Blessed are you God, whose compassion continually renews us."

A prayer for hope after suffering loss:

"Dear God, you made the world overflow with water, with streams and rivers that nourish the earth, pools and ponds that teem with life. But not me. I am like a wadi; I fill up and empty to no purpose. Nothing is held by me, nothing nourished. That is not the way it should be. It is you God who causes the day to break, assigning dawn its place in the east. It is you, God, who sets the world on its course, guiding its paths as it glides through the heavens. It is you, God, who closed the sea behind doors when it burst forth from its womb, swaddling the new waters in dense clouds. You know the joy of birth. Share a bit of that joy with me, God. Hear my prayers and heal my broken heart. Send me a child so I may rejoice in them as mothers have rejoiced throughout the generations."

There are many other prayers, psalms and actions women are recommended to do before starting any treatment or even submersing themselves in the Mikveh. Whilst doing my research in the community I came across a booklet that was prepared by the Eden Center in Israel. This booklet consists of a series of prayers and psalms that women are encouraged to say to help them face infertility and pregnancy loss (http://theedencenter.com/wp-content/uploads/2018/03/Eden_Fertility_dedications-to-read.pdf).

Here are some prayers found in the booklet:

Hannah's Prayer - 1 Samuel, Chapter 2

"1.And Hannah prayed. She said: My heart glories in the Lord, my horns raised in pride by the Lord, my mouth wide in scorn for my foes: for my joy is in Your salvation.

2. There is none so holy as the Lord, for there is none but You, there is no Rock like our God.

3. Stop speaking high and mighty, on and on, these swollen words that leave your mouths – for the Lord is the God of knowledge, His acts precisely measured;

4. the bows of strong heroes are broken, while those who once stumbled gird greatness.

5. Those who were once full of bread go to hire, while the hungry rest; while the childless woman births seven children, the mother of so many sons falls desolate.

6. The Lord kills, and He brings life, He throws us down to hell and He lifts us.

7. The Lord makes destitute, enriches, debases; He raises –

8. He lifts the poor out of the dust, and raises abject men from the dunghills to seat them up there with princes, to bequeath them chairs of honour, for the earth's precipices are the Lord's and upon them He balances all the world.

9. He will guard the steps of His followers, while the evil are silenced in darkness, for it is not by strength that men master.

10. The Lord – His opponents are broken, He thunders the skies above them, the Lord will judge to the ends of the earth, will grant His own king strength, He will raise proud the horns of His anointed."

Prayer for the childless - Likutei Tefillot 1:53

"Merciful Father, hear our prayer and listen to our cry. Let all childless women be remembered for good, and may they become pregnant quickly and easily, and may they give birth – through Your compassion – to viable, enduring children. May Your people, the children of Israel, number as many as the sand by the sea, which cannot be measured and cannot be counted. Just as you had compassion for our first forefather, Abraham and his wife Sarah, our mother. You remembered them for good and blessed them in their old age by giving them Isaac

and you promised to make his descendants as numerous as the stars in the heavens. So too have compassion on all the childless women of Your people, the House of Israel, who look expectantly to You alone to grant them enduring offspring to serve and fear You. Have mercy on them for Your sake, and remember them for good. Fulfil their requests with compassion; consider them and hear their prayer. Help them become pregnant quickly and with ease, and may they be privileged to give birth to enduring offspring, who will be a source of joy to their father and mother, who should have the merit to raise them to Torah, marriage and good deeds, to a full and happy life. Amen."

Prayer for the infertile woman - book Tefillah Hannah

"Please, O Eternal, please let Your ears be attentive to the prayer of Your maidservant [(name), daughter of (mother's name)], and may I find favour, kindness and compassion in Your eyes. Turn to Your maidservant prayer in Your abundant mercy and kindness, Amen. So may it be Your will. Master of the Universe! Just as You took account of, and remembered for good, Sarah, Rachel and Channah- -You heard their prayer and fulfilled their request; opened their womb, caused them to become pregnant, and they gave birth — so may it be Your will, O Eternal, our God and God of our forefathers, Father of compassion, for the sake of Your mercy and kindness, and for the sake of Your great and holy Names, perform righteousness and kindness for me. Remember me and take account of me for good, and help me become pregnant, your maid servant [(name), daughter of (mother's name)]. May I become pregnant from my husband [(name), son of (mother's name)] with offspring who will endure, holy offspring that will be healthy, and may we merit to raise them to serve and fear You. Amen, may it be Your will."

Fertility prayer - Yesh Tikva

"May it be your will God, our Lord and the Lord of our forefathers, that you shall hear my prayers and bless me with full breasts and womb. Remember me for good, and help me become pregnant quickly and grant me an easy pregnancy. That with your mercy, I may give birth to sons and daughters, and shall have enduring offspring. Give

me and all those without children the strength and courage to persevere on our journeys. Grant us healing and comfort. Strengthen us and surround us with love and support. As you remembered Sarah, Rebecca, Rachel, and Hannah, and just as you have heard the voices of the righteous men and women when they beseeched you, please listen to my beseeching. Listen with mercy and wilfully hear my prayer. Fulfil my wishes for good, and so may it be Your will, and let us say Amen."

Between pro-natalism and *Halacha*: Jewish Orthodox Rabbis in London discuss some controversies of ART

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Abstract

Judaism is characterized by its pro-natalist nature due to its strong focus on procreation. This importance derives from the first commandment of the *Torah* to "be fruitful and multiply". As a result Jewish law is generally permissive towards allowing couples to use assisted reproductive technologies (ART) to fulfil their parenting wishes. However, not all Rabbis are aware of the law. Rabbis hold a very important place in the life of an Orthodox Jew, acting as general life advisor, moral support, *Halachic* advisor, spiritual guide and in some cases giving medical advice. This study aims to evaluate the views about and knowledge of ART of ten Jewish Orthodox Rabbis from different communities in London. All interviews were carried out by primary author in Synagogues or the Rabbis' homes. Three of the Rabbis were very familiar with Jewish laws on ART, while the others had only vague knowledge. Their knowledge often paralleled that which has been reported from set *Halachic* laws. Rabbis were particularly positive about the use of IVF to help couples have children, and in some cases this extended to the use of preimplantation genetic testing (PGT), social egg freezing and solo motherhood. Generally

Rabbis forbade fertility treatments for same-sex couples, but on examination found there was no concrete law that forbids two men to have and raise a child. This study highlights the way ten Orthodox Jewish Rabbis think. With this research we aim to provide some insight into this much under-researched community.

Keywords: religion, Judaism, Assisted Reproductive Technologies, ART, infertility, Jewish law, procreation, IVF, rabbis, surrogacy, sex selection

Introduction

The Jewish religion is strongly characterised by the practice of *Halacha* and a deep faith in God (Schenker, 2002 & Schenker, 2008). The four major groupings in Judaism are Orthodox, the strictest form of Judaism by rigid adherence to Jewish laws and scriptures, Conservative Judaism refers to the progressive way that Jewish laws is being looked at and practiced, Reform Judaism known for the updating of Jewish laws to modern ways and lastly, Secular which includes the Jews that do not practice any laws. Around the world only 10% of Jews consider themselves Orthodox. For the 90% remaining Jews, approximately 70% think of themselves as Reformed or Secular and around 20% consider themselves conservative (National Jewish Population Survey 2000–2001). This study focuses on the lives of Orthodox Jews and Orthodox Rabbis.

Be fruitful and multiply

Fecundity holds a very important place in the life of Jews and in particularly in the life of Orthodox Jews. This can be noted from the important position that Jewish law, commandments and obligations hold in the life of an Orthodox Jew. For instance, the commandment to procreate which appears in the first book of the *Torah, Genesis,* is a central pillar for Orthodox Jewish families. For many Orthodox Jewish women pregnancy and childbirth are a way of life (Birenbaum-Carmeli, 2008).This is further the fulfilment of their mission in life and what will

bring them closer to God (Teman *et al*., 2011). Procreation is a positive *Mitzvah* that is greatly encouraged. As such within some Orthodox families we can find ten or more children per family unit (Ivry *et at*., 2011).

Nevertheless, fertility is not as straight forward for every couple. Chana a Jewish charity that helps infertile couples in the UK reports that one in six couples in London struggle with infertility (www.Chana.org.uk). When facing infertility there are many options for Orthodox Jewish couples. Some include the use of ART: Jewish law is generally lenient towards the use of infertility treatments to overcome childlessness.

As Kahn points out this leniency can be derived from the three main principles in Jewish law that, with certain restrictions allow Jews to recur to fertility treatments when trying to conceive (Kahn, 2006). Three main pillars include: Fulfilment of the first commandment "*be fruitful and multiply*" (Genesis 1:28), *Mitzvah* of Loving and Kindness – *(Gemilut Hassidim)* in which Rabbis argue that almost anything can be done to alleviate the couple who is suffering due to their inability to convince and lastly, family integrity to prevent any difficulties such as divorce.

Jewish law on ART

Ultimately the permission of IVF is based on the very first commandment given to man to be fruitful and multiply (Schenker., 2008 & Genesis 1:18). Rabbi Meir Amsel presented that all prohibitions towards **IVF** were valid but if the woman was certain that it was her husband's sperm that was used then it may be possible to permit the procedure (Amsel., 1978). Other Rabbis that permit IVF base their leniency on the couple who is struggling emotionally, psychologically because of their lack of parenthood. Additionally, these Rabbis focus, on the basis that the gametes used must originate from both partners of the couple (marriage) who cannot conceive. For example, Rabbi Ovadia Yosef (1920-2013) was of the view the prohibition to waste semen did not apply because

ultimately the seed would not be wasted as it is used to produce offspring. He was also of the opinion that the child would not be illegitimate as a forbidden sexual relationship did not take place. Rabbi Shlomo Goren (1977-1994) had a similar view and therefore permitted **IVF** when the couples' own egg and sperm are to be used.

Thus, regardless of the multiple positive commandments in Jewish law to have children some Rabbinic opinions oppose the use of ART. Rabbi Waldenberg, Rabbi Moshe Sternbuch and Rabbi Hayyim Kanievsky are some examples of Rabbis who in the past have openly stated that IVF should not permitted on the basis that allowing this could lead to a slippery slope where God's hand is forgotten from the process of creation (Irshai., 2012). Rabbis also felt that the externality of the **IVF** process could potentially destroy the image we have of the human being and therefore create a segregation between naturally conceived humans and those created in the laboratory. Further reasons for forbidding **IVF** include the high level of supervision that is necessary and impossible to attain to make sure that the process is done in a 'Kosher' manner (Rabbi Eliezer Yehuda Waldenber 1915-2006). Rabbi Waldenber further thought that children born as a result of ART did not have a mother or father in terms of *Halacha* due to the separation of the ovum and sperm from its parents' bodies. Rabbi Moshe Sternbuch and Rabbi Hayyim Kanievsky were of similar opinions. For them the prohibition to waste semen and parental lineage are very important and vital to maintain Jewish sanctity (Rabbi Moshe Sternbuch head of Jewish court in Har Nof, Israel) (Rabbi Hayyim Kanievsky resides in Benei Brak, Israel).

When moving to **gamete donation** some Rabbinic authorities forbid either egg or sperm donation on the basis that the couple should "build a wall around" the sacred marital bond (Rabbi Elyashiv & Rabbi Morgenstern, 2009). Rabbi Samuel Halevi Wosner (1913 – 2015) was of the opinion that gamete donation should be forbidden on the basis that ''a man shall cleave unto his wife, and they shall be one flesh'' (Gen. 2:24) therefore understanding that if the couple is to procreate they should have offspring formed from their own flesh (Wolowelsky *et al*., 2007). Furthermore, according to Jewish law the use of

donor sperm violates the exclusivity of marriage going as far as adultery (Wolowelsky *et al*., 2007; Genesis 38:9-10; www.haaretz.com). This law is derived from a biblical verse "Thou shalt not implant thy seed into thy neighbour's wife" (Leviticus 18:20).

Sperm donation is usually frowned upon due to the prohibition to masturbate and therefore waste seed (Talmud Niddah 13a). Other concerns with sperm donation focus on the possible inadvertent incest of future generations due to the use of Jewish sperm donors. When it comes to egg donation, *Halacha* is more lenient. The first Jewish live birth from egg donation was reported in 1986 (Navot *et al*., 1986). The patient was Orthodox and had the permission of the Chief Rabbi of Israel. Rabbis that are in favour of allowing gamete donation felt that the questions are similar to that surrogacy. These revolve around the Jewish status of the egg donor.

Debates on the permissibility of **egg donation** focus on the religion of egg donor. Jewish identity is established via matrilineal descent (Schenker, 2008 & Schenker, 2002). According to *Halacha* **maternity** is very complicated to define when using an **egg donor**. This questions what exactly establishes motherhood; the genetic material or is it carrying the baby to term (Schenker, 2008). In any case Jewish identity holds a very important place in the life of Orthodox Jews.

Therefore understanding this dilemma can change the way in which Orthodox couples will proceed with ART. Some Rabbis have tried to give rulings on the matter. Rabbi Goren is amongst the few that believe that the genetic mother is the *Halachic* mother. Rabbi Jacob Ariel agreed with this notion and further stated that it is preferable to use a non-Jewish donor over a Jewish donor to eliminate possibility of incest. On the other hand other Rabbi Nehemiah Goldeberg and Rabbi Abraham Izhak Ha-Levi Kilav believed that the birth mother is the ***Halachic* mother**. Rabbi Joseph Engel further stated on his book that "paternity is determined at the beginning of the pregnancy but maternity is determined only after birth". Rabbi Benjamin Aryeh Weiss further agrees to this statement basing his favor towards the birth mother on the explain that was given by Rabbi Abhu who stated that a woman's egg implanted into the body

of a different woman becomes assimilated into the second woman's body and losses its connection the woman who provided it. This is further extended by Rabbi Waldenberg who opposed IVF but believed that if it had taken place anyway the birth mother becomes the *Halachic* mother.

The debate on **PGT** is two sided. Discussions tend to focus on the perceived notions of the sanctity of the embryo the mental health of parents when deciding if PGT should be allowed . The most solid argument favours the parents' mental health and capabilities, not that of the child. Even though PGT does not heal the embryo it does lighten the parents' mental anguish and fear over giving birth to a sick child (Zilberstein & Rothschild, 1987; Grazi & Wolowelsky, 1992).

Regarding the **status of a fetus and embryo** Jewish law states that a full human status is only acquired at birth (Schenker, 2007 & Schenker, 2008). Until then the destruction or testing of the embryo is not considered murder or misuse, nevertheless, potential life must not be compromised and must be treated respectably (Schenker, 2008). The *Talmud* states that during the first 41 days from fertilization until the finalization of organogenesis, the embryo is considered 'plain water'; the embryo is not considered a person in any legal way (Eisenberg & Schenker, 1997).

Despite the very contradicting opinions Jewish law has on ART it is generally accepting of ART. Prior to starting treatments each couple will visit their Rabbi and with him discuss these laws and explore which treatment will be best for them. Only then can couples proceed with a specific fertility treatment. Thus how well informed Rabbis are about ART and their respective *Halachot* has a major influence on which treatment will each couple proceed with.

Rabbis and Jewish law

Jewish law can be broken down into the written and oral laws. Written law which consists of the five books of Scripture express God's revelation, teaching and guiding of humanity. The *Torah* is as a single unit; a holy text that includes

moral values and practical laws. On the other hand, oral laws expand, interpret and elucidate the written Torah and regulate new customs and laws. The oral Torah can be divided into various parts: *Mishnah*, *Talmud* and *Responsa Literature* and *Post-Talmudic Codes* (Schenker & Halperin, 1995; Schenker, 2002 & Schenker, 2008).

Rabbis hold a very important role in the life of Orthodox Jews. The word Rabbi comes from the word in Hebrew of *Rav* "master". The literal translation of the word Rabbi means my master. This denotes the seriousness in the title of a Rabbi. The word master refers to the responsibility and the level of knowledge and the important place that each Rabbi needs to have in terms of Jewish understanding of the *Torah* and the 613 *mitzvot*. In Judaism Rabbis are teachers of *Torah.*

The Rabbi holds a very important role in the life of an Orthodox Jew more importantly in the life of infertile people. Such individuals require emotional, spiritual and *Halachic* support. It is very important that when couples who reluctantly open up about their infertility to their Rabbi they will be able to find a Rabbi that is fully aware of all treatments and if not at least a Rabbi that will be able to point them in the right direction. For this reason it is important that all Rabbis are well informed and are aware of all ART and their practice according to Jewish law. The Rabbis is and should be a source of information and for many infertile Orthodox Jewish couples they could be the only source or the first point of contact for information.

Rabbis are faced with great responsibilities within the community. They need to provide support in all areas of life for all their congregants. People contact and rely on their Rabbis for a wide array of matters. Some people like to contact their Rabbis for questions on religious observances, on social matters, on life occurrences, spousal relationships, familial relationships, counselling and at times even for fertility advice. In some cases Rabbis are seen as clinical and medical advisors (Ivry, 2010). Rabbis play an important role in these cases, in helping couples understand medical treatments and helping them explore options for them to proceed with ART.

Ivry mentions in Kosher Medicine, the need to consult a Rabbi changes depending on the person's denomination (Ivry, 2010). This is also a form of religious expression. Most Orthodox Jews will have a strong relationship with their Rabbis and they will ensure that they visit their Rabbis at least once a week. This is not the case with less religious Jews.

A lot of the modern restrictions to new topics that have emerged since the giving of the *Torah* have been created by Rabbis of great importance from the Jewish faith on behalf of all Jews in order to protect laws and the establishment of the Jewish faith. Some of these new rulings include all those that pertain to ART.

Aims of this paper

This paper aimed to understand and explore the knowledge some Orthodox Jewish Rabbis form North West London communities had of *Halacha* on ART.

Methodology

The study involved semi-structured interviews with ten Orthodox Jewish Rabbis in London. Rabbis were randomly recruited using a Google search for Rabbis of Orthodox Jewish communities in different areas of London. All Rabbis were contacted via email and asked if they wanted to be a part of the study. If they agreed they were sent the consent form and information sheet about the project.

Interviews consisted of 31 questions that explored Rabbis' opinions on and knowledge about various ART, including IVF, embryo freezing, social egg freezing, PGT, sex selection, sperm and egg donation; and went on to discuss related topics such as motherhood and Jewish identity, surrogacy, and the use of ART by single women and same-sex couples. These topics aimed to cover

most ART and related topics and therefore give Rabbis a chance to express their knowledge of and opinions about Jewish law on such treatments.

Interviews of forty-five minutes to one hour took place mostly in synagogues except for two interviews conducted at the respondent's homes. All interviews were carried out by the primary author who is an active member of an Orthodox Jewish community in North West London. The insider position of the primary author helped respondents feel at ease and be more comfortable when answering. This insider position was also beneficial as primary author was already familiar with some Jewish laws on the practice of ART and also on prevailing attitudes within the community. Interviews were transcribed verbatim by the primary author. Names and other identifying information were changed in order to protect Rabbis' identities. Details of the Rabbis are given in **Appendix1.**

Qualitative description alongside thematic analysis was used to analyse the data from the interviews. Qualitative description specifically focuses on discovering and understanding a process, phenomenon, or the views and perspectives of people involved in the study without delving too much into interpretation of answers. (Caelli *et al*., 2003; Sandelwoski 2000 & Merriam, 1998). This was helpful for the research aim of exploring Rabbis' attitudes to ART and their use. Thematic analysis provided a way to analyse the data more deeply and identify themes relevant to the research question (Tuckett, 2005; Attride-Stirling, 2001 & Boyatzis, 1998). When analysing the data Braun and Clarke's six steps were used to identify themes (Braun and Clarke, 2006). Themes were mostly identified by the first author and were later discussed with the second and third authors. Meetings were held regularly so that analysis was consistent and all authors were in agreement. These discussions also helped to mitigate any possible biases in the primary author's analysis due to her Jewish background and close proximity to the study group.

Ethics approval was obtained from University College London ethics committee, reference no. 9831/001, June 2016.

Results

The discussions with the Rabbis led to the development of six major themes. These include, feelings of uncertainty towards ART, IVF: not so simple, PGT opening the doors to the unknown, God has the keys to various things, a last option and lastly nuclear family vs allowing treatment for same-sex couples. These themes will be discussed and explored here.

Feelings of uncertainty towards ART

All Rabbis interviewed had many years of experience when dealing with many life problems such as bereavement, weddings and *Halachic* questions relating to most subjects such as Kashrut and Shabbat observance. But this was not the case with infertility treatments.

The majority of Rabbis said they had been asked about fertility issues in some form by members of their community. Three of the Rabbis interviewed (Rabbi Cohen, Rabbi Lewin and Rabbi Abrahams) **were familiar and experts in the field of ART and *Halacha*.** This in fact meant that they were up to date with all laws and ART. When answering questions they felt confident and fully aware of all details and possible complications, including 'loopholes' that can enable treatments for Orthodox couples. **The other Rabbis had a general and basic knowledge of ART such as IVF and ICSI.** This had been something that they had come across or had been asked about by their congregants. Some were unsure of laws and rulings on ART, but had been able to advise couples who to go to in order to receive the correct *Halacha.*

Rabbi Lewin and Cohen were doctors and *Halachic* specialists. Rabbi Epstein had 20 years of experience in the field of ART and *Halacha.* When these Rabbis were asked about their interactions in the community about ART and *Halacha* they openly talked about some of the questions they had previously been asked.

> *"They ask me on two levels, I have a medical background as well the Rabbinic side of things, so I get asked medical questions,* ***the risks of assisted fertility techniques*** *and the usual* ***medical issues****, sometimes they contact me as a second opinion when people have already been to fertility clinics and they want a second opinion about the risks and dangers and so on and the other category I get asked is* ***Halachic permissibility*** *and advise for married people with fertile problems or dealing with them within marriage a whole array of all those questions. I can go into specifics, like i****s donor insemination allowed, is insemination by husband allowed is three parent babies allowed, is surrogacy of all kinds, should the donor be Jewish or not Jewis****h, should the surrogate be Jewish or not so it is a whole array of those questions." (Rabbi Lewin)*

> *"I get questions within the community and also beyond my immediate community. People* ***ask me general questions*** *about when it might be* ***appropriate to start fertility treatments****, sometimes they ask for advice for example* ***on which medical practitioners will be sensitive to their religious needs*** *as well as their medical needs and then once they have already embarked in the process and they want to know all the technical questions, sometimes also counselling to talk about the psychological toll that facing fertility and infertility treatments might have on them. But on a technical level once they have embarked on the process they have a lot of technical questions about what is and is not permitted.* ***What processes are recommended*** *and if they are certain that they are having this particular treatment that is time sensitive they want to know what is permitted on Shabbat and what cannot happen then, like if one goes to the hospital on Shabbat can the other one come too. All types of* ***technical questions*** *about the processes itself and the attendance issues for the family in particular* ***Shabbat observance****." (Rabbi Abrahams)*

Other Rabbis who were not specialists in the field of ART still received questions on the subject.

> *"When I function as the Rabbi of my community they ask me **for spiritual guidance** and information as to how to go about things and how to access certain services. When I am answering questions from service providers I answer questions about **allocations of funds** or you know **moral questions** about whether they should provide treatment for certain people." (Rabbi Meisel)*

Rabbi Feinsberg makes clear that his specific area as a Rabbi is not *Halacha*. He defines his job "*my job is to ensure that people have the opportunity to find out the Halacha".* He stated that in the past he had helped people with moral and spiritual support when undergoing cancer and needing fertility preservation. Rabbi Feinsberg shared some of the cases he had been asked about:

> *"There were a number of issues that have risen in the past, some of them are **historical medical conditions** where the couples are concerned about their fertility before they get married and second of all are historical medical conditions where for example **one the partner has a sexuality transmitted disease which they have even though they have become religious and they are concerned about the ramifications** of that in terms of their ability to have children, that is pre- marriage as if to say. (Rabbi Feinsberg)*

> *"Then there is **post marriage** which is where they find it difficult to have children on two levels, number one is the difficulty in having children at all and then you also have the issue of people who have had one child and then find it difficult to have a second or a third child, so secondary fertility. These are the four areas that I have encountered. So, either people who know that they have a problem before they get married or people who have a medical condition which they are concerned may affect their offspring if they are blessed to have them, that's one group and then there is post- marriage people who come to see me." (Rabbi Feinsberg)*

Rabbi Woolf recognises that his community "*is a very interesting one, it either has very young kids or very elderly people, so it is not an issue that like some*

of the other younger communities where it would be discussed." Infertility and ART have not played an important role in his community due to the age range of his congregants. Nevertheless, Rabbi Woolf discussed a case he was presented with 25 years ago:

> *"I think if I remember correctly the **wife was struggling to fall pregnant** and they tried for quite a few years, that was probably the only time that I was asked to help and I think I put them in touch with whoever I understood to be knowledgeable and right. I think at the time there were organisations that come and go in the Jewish community that deal with issues of infertility and I **think I put them in touch with them because it is not my sphere of knowledge**." (Rabbi Woolf)*

Rabbi Woolf due to his limited knowledge in the matter directed the couple to a service that could help them.

This action was also reported by Rabbi Epstein:

> *"More often than not, the advice I have given them is more of a **first aid basis** like why do you not speak to this organisation or that one they are very experienced in these matters and so on." (Rabbi Epstein)*

IVF: it is not so simple

In general Rabbis had positive views towards the use of ART. They thought that this was an area that had been deeply discussed in Halacha in the past and as such Rabbis has somehow found the best ways to proceed and allow couples to have treatments.

Rabbis generally thought that most **IVF practices** were acceptable according to Jewish law. Nevertheless, two Rabbis thought that IVF was problematic due

to uncertainty over how Jewish identity can be established when there is a possibility of two mothers: birth mother and egg donor. This point reflected what is already written in the literature and it went along the idea of what other Rabbis have identified as a major problem when undergoing ART. Jewish law is strict about determining Jewish identity and for these two Rabbis undergoing IVF could in some ways compromise the establishment of one's Jewish status. Two other Rabbis thought that IVF was problematic in relation to Judaism due to the possibility of donor insemination and its complications, one of them being the possibility of incest.

Most Rabbis in this study thought that **supervision in labs** was essential to ensure that process is done in a complete 'kosher manner'. Those that thought that it was not necessary based their opinions on the technology which they thought was already strictly regulated. These Rabbis also thought that Rabbinical advice and consultation was more important than Rabbinical supervision on labs for people undergoing ART.

Rabbi Cohen points out:

> *"If it is **IVF between husband and wife** there are practically no prohibitions although there are some who disagree with it but I think the current understanding of most if not all Rabbis is that between husband and wife IVF is permissible." (Rabbi Cohen)*

Rabbi Lewin agreed and stated that there are only really problems when third party materials are used:

> *"The technique and the technology is **not problematic** at all including the discarding of very early stage embryos, eggs that are not used, that is not an issue. The problematic issues are really the question of first of all the **permissibility of using material from other than spouse** in other words insemination by donor, that is an issue, I am not saying that it is forbidden but it is a question and the second and probably the most common question is the identity of the child most*

> *importantly if the child will be Jewish or not depending on whether the surrogate was Jewish or not and all those permutations." (Rabbi Lewin)*

Other Rabbis did not think it was so simple. Rabbi Epstein for instance thought that there were questions that needed to be considered before totally allowing couples to go through IVF:

> *"You know finding an **appropriate way of removing sperm** this raises Halachic questions and there are solutions" (Rabbi Epstein)*

Rabbi Woolf focused on potential incest from gamete donation:

> *"What I am aware of is that there is a problem of **where you obtain for instance the egg** and if it is taken from someone and she gives one egg to one couple and another egg to another couple there are issues of incest in terms of Jewish understanding that could be a brother and sister who meet later in life and you know they meet at university and then they have to be told sorry you cannot do that. So, those are the things that I am aware of." (Rabbi Woolf)*

Rabbi Abrahams speculates as to why some Rabbis might not be so positive and lenient towards IVF:

> *"Rabbis who question whether this is a good thing to do, whether you are **interfering with the natural processes**, whether the process of IVF which will require the man to ejaculate, whether that is something which is appropriate. But vast majority and all main stream Halachists are very positive about all these things and it is viewed as a miraculous thing which will enable people who wouldn't otherwise have children to have children." (Rabbi Abrahams)*

PGT opening the doors to the unknown

Only four Rabbis felt comfortable to speak about PGT in detail and discuss the various cases and possibilities of their use. In the cases of Rabbi Abrahams, Rabbi Lewin and Rabbi Cohen this could be explained due to their background.

Rabbi Lewin explained the general views in detail. His opinion represented the views Rabbi Abrahams and Rabbi Lewin shared.

> *"It is acceptable as a technique, Israel has a very **advanced program for PGT**, Shaarei Tzedek has a good program both on early stage four or eight cells embryos. PGT is widely used and has full Rabbinical approval, the problems with PGT are it is a scarce resource so we do not allow it for everybody. Shaarei Tzedek has a committee that decides whether the potential problem is serious enough to allow it." (Rabbi Lewin)*

Other Rabbis felt like they did not know enough about the area therefore they could not formulate their specific rulings on PGT.

> *"I am not sure that I formulated a view on this issue. I mean, because I think **there is an ethical unknown** as to where the boundary is of what is a genetic condition and what is the genetic propensity." (Rabbi Abrahams)*

Rabbi Abrahams was worried that permitting PGT could lead to what is known as the **"slippery slope"** of genome editing. This was the association that a few Rabbis made as they thought of PGT as a potentially very dangerous technique that in the "wrong hands" could lead to eugenics.

God has the keys to various things

PGT was also discussed for **sex selection** and for the elimination of **inherited disorders.** Some Rabbis were of the opinion that PGT for medical reasons was essential as it helped the parents in cases where they were not psychologically and financially ready to have these children. Other Rabbis thought this was only important in cases of **Tay Sachs disease**. In terms of sex selection for non-medical reasons, which is prohibited in the UK, some Rabbis stated that Jewish law does not forbid it but frowns upon it. Two Rabbis were completely opposed to it, as it could have a negative impact on society in general as the beginning of a slippery slope. Six Rabbis felt that it would depend on the reason behind it; it could not be entirely social, i.e. not just choosing the sex of a child for 'family balance' or personal desires to parent boys or girls specifically.

Rabbi Lewin discusses the situation in Israel:

> *"Current Israeli law **allows PGT to be used for sex selection only when there are already four children of one sex in the family then you can use it**. This is not an Halachic decision it is a secular legal position in Israel" (Rabbi Lewin)*

When focusing on Jewish law he states that sex-selection should not be allowed:

> *"The Halacha says that you **fulfil the commandment to reproduce technically when you have two children mainly a boy and a gir**l, but the obligation is not to produce a boy and girl, the obligation is to live a normal married life and what results is given by God so there is no obligation to use any technology to show that you have a boy and a girl." (Rabbi Lewin)*

Rabbi Abrahams agreed:

> *"I can see **no place for that in the Jewish system**. I think that it leads down the roots that were popular in China and ancient Greece and so on. In a world where we already feel pressure to have only a certain number of children, this will inevitably lead to abortion and rejection of children and it will produce in some societies an imbalance of genders and it seems to be entirely immoral." (Rabbi Abrahams)*

He bases his idea on God being the sole controller of some specific cases:

> *"There is a Guemarah that talks about **God having the keys to various things and one key is the gender of the child.** So, today we have the means to know the gender of the child and in societies where we feel comfortable that people will not reject or abort based on gender, but I think that once we start talking about gender selection, I am not comfortable with that at all. What is the basis of this? I would like to even out my family, I would like to have more boys or girls. I am uncomfortable with this stuff, one could imagine in very rare cases that perhaps it was understood where a couple had one child and could only be able to have one more child and it was absolutely clear that this was the last chance, but I think that, that would have to be very rare and subject to evaluation in principle, I do not like this." (Rabbi Abrahams)*

Rabbi Abrahams shows his strong negative views on the matter and lastly focuses on how if it came to extremes the decision would need to be looked at for couples individually.

Rabbi Feinsberg argues that the *Halacha* is not too far off from what is allowed in Israel:

> *"I understand that in Israel they have a law that allows this. There is an Halachic side which is according to what I have heard, I am not and I would never advocate this but according to what **I understood the law in Israel is***

> ***actually not that far away from the Halacha.*** *If you are asking me as an uneducated Rabbi then the answer would follow those directives." (Rabbi Feinsberg)*

He adds:

> *"The whole thing scares me but the question is the* ***ultimate benefits for the Jewish people*** *seem to be outweighing the fear of manipulation and that is the bottom line. I was brought up as a child with what was going on in China and it just scares me it is just such a strange phenomenon like the fact that you have to have four children of the same sex before you can ask for the other sex is such a brilliant limitation and compromise." (Rabbi Feinsberg)*

Rabbi Feinsberg can see the benefits for using sex-selection for family balancing. He also felt that the restriction of the law was fair. He also mentioned a specific case where he advised the couple to follow some Halachic source about having sexual intercourse in a specific way to have a girl:

> *"I have had someone approach me about sex selection and I advised them on a paragraph of Rashi where it* ***explains how a couple might affect the sex of their future child when having sexual relations.*** *So, I taught it to husband in detail and I put him in touch with a particular doctor who has had a lot of positive outcome in this area. He had three sons and was desperate for a daughter so it worked. (Rabbi Feinsberg)*

Rabbi Epstein focuses on how potentially having too many children of the same sex could be psychologically straining for Halachically allowing couples to use sex selection:

> *"There have been Halachic discussions as to whether if it will be a situation where it has put great strain on a marital relation, say for example* ***the guy has nine daughters*** *etc. and it puts strain on the marriage, the Rabbi would probably say let me give you some advice*

on how to be a proud father and so theoretically I could possibly consider where there was another factor involved if there was serious emotional distress in a marriage relationship because of that then maybe but not normally I would consider it for other medical reasons." (Rabbi Epstein)

A last option

Rabbis thought, social egg freezing, gamete donation and surrogacy should only be considered if they are a last option for a couple who cannot have children.

With regards to **social egg freezing** (i.e. where eggs are frozen for no specific medical condition but rather for social needs, e.g. age of the mother limiting potential fertility in the future); four Rabbis felt unsure whether it should be allowed. These Rabbis understood how some women could have difficulties in **finding the right partner** and therefore leave it too late to have children naturally. It was difficult for them to consent to this idea because the idea of a single mother conflicts with the Jewish belief that focuses on nuclear families with two heterosexual parents at the core of tradition in Judaism. Three Rabbis stated that there was no problem with social egg freezing as long as the woman would **use the frozen embryos with her future husband**. What was important for these Rabbis was the preservation of her fertility and her future chances of becoming a mother and helping her husband in the process of fulfilling his commandment to procreate.

Rabbis could generally understand why women would want to freeze their eggs for social reasons. They understood the difficulty some women face because **of being single and not being able to find the right partner**. Rabbis understood that Jewish values focus on a **nuclear family and this at times contrasted solo-motherhood**. Nevertheless as Rabbi Cohen, Rabbi Lewin, Rabbi Epstein and Rabbi Levy pointed out if there was no other option and women really wanted to become mothers then it could be permissible.

Rabbi Woolf felt that allowing egg freezing and allowing solo-motherhood could create a generation of people **that undervalued the miracle of life**.

Rabbi Levy focused on how social egg freezing could help women psychologically:

> *"For medical and psychological wellbeing, I know that there are women that for whatever reason they have **remained single and sometimes have slipped into depression because of it**. So, if you can solve this psychological trauma then yes I don't think there is an issue for it." (Rabbi Levy)*

Other Rabbis focused on how this could be a woman's last choice to motherhood:

> *"If a woman has **no choice and she tried her best** and she could not get married and time is running out and there is no other choice, then it would be allowed but to freeze eggs and follow you career and forget about it." (Rabbi Cohen)*

> *"We do not have a problem with that, in fact I have dealt with a number of a few young women who are wanting to freeze their eggs. There is **no Halachic problem with that.**" (Rabbi Lewin)*

> *"I can see the principle of doing so for someone who is **single and wants to get married but has not yet found a partner** and would like to be able to preserve the opportunity of a healthy pregnancy at a later stage." (Rabbi Epstein)*

He further discusses a specific case with a woman from his community:

> *"I have come across instances in the community where a woman has not been able to have children and was*

> *not able to **find a marriage partner** and has had children through IVF alone. It is not my role to be judgmental I will support her with the consequences of her actions and I empathise with her as a woman who was in her 40s and could not find someone and she very much wanted to be a mother so this is what she did. I acknowledge that this is the role she took." (Rabbi Epstein)*

Rabbi Meisel was of the opinion that freezing eggs for social reasons should only be allowed if the woman who initial froze her eggs then got married and used these with her rightful husband.

Rabbi Woolf felt differently about it and in his opinion this is not something that should be taken lightly because it challenges the most important part of Judaism, the family:

> *"I can understand in today's climate the message comes across, **do not bother me now with children**, I want to have fun, and you know when the time comes I will have children. That is something that I would personally dislike because of the way we view the blessing of the ability to give life. Who will guarantee that when she feels ok now is the right time that she will fall pregnant even if she freezes her eggs. So again, there it may be medically feasible or possible but my gut feeling is that **it would be in keeping with our world view of the blessing of life**, the unbelievable privilege of life and by trying to almost dictate and determine when and how this is going to happen also smacks it with a little bit of arrogance and it takes away the understanding that our lives and life itself is given by the almighty and it is something that should be cherished and when it happens it happens and you cannot say things like this year you have to be in Bermuda and you do not want to burden yourself with falling pregnant but maybe next year. All of that is coming from a stand point position that is not consistent with the way we look at family and family life." (Rabbi Woolf)*

In relation to **gamete donation**, Rabbis were uncertain; two Rabbis thought that egg donation could be allowed but **sperm donation should be strictly**

forbidden to remove possible wastage of sperm. Rabbis also mentioned the possible problems of gamete donation and the establishment of Jewish status. Other issues such as the **religion of sperm and egg donors** were also raised. Seven Rabbis thought the sperm donor should **not be Jewish** to remove the possibility of incest. This would be to prevent the future marriage of unknown siblings. Three Rabbis were unsure. In terms of **egg donors**, four Rabbis said that it would be best to have a non-Jewish donor, again to prevent incest. Rabbis also speculated on the problem of **Jewish status**; for three Rabbis it was better to **convert the child once born**. Furthermore, the Rabbis interviewed referred back to the varying opinions given by influential Rabbis which were mentioned in the introduction. Schools of thought are divided between whether it is the **egg donor or birth mother who establishes Jewish identity**, therefore the question of permissibility depends on which Rabbi you ask.

When asked if full **surrogacy** (treatment where the egg is also donated by surrogate mother) should be allowed, half of the Rabbis were unsure due to the religion of the surrogate and the establishment of Jewish status. Four Rabbis felt that **gestational surrogacy** was better than full surrogacy as the child would then be the genetic child of the couple who was going to raise it.

Four Rabbis thought that **sperm donation** was permissible for **single women** due to the negative impact infertility has on some women. However, three Rabbis thought that single women should not be able to receive fertility treatments due to the great importance that Judaism places on having a family consisting of a father and mother.

Nuclear family vs allowing treatment for same-sex couples

This theme discussed treatment for same-sex couples. Here there debates on two sides. Rabbis mostly based their negative views to these treatments based on first the *Halachic* prohibition of homosexuality and secondly the huge importance that a nuclear family has in Judaism. Judaism views a nuclear

family as a father, mother and child. This value is contested by allowing same-sex couples to become parents.

The majority of Rabbis did not want to go deeper into the conversation on treatment for same-sex couples and gave a straight out no saying that treatments for same-sex couples are not allowed based on the prohibition of homosexuality.

Only Rabbi Lewin and Rabbi Woolf were open to discussing why in some cases it could be problematic to allow same-sex couples to have treatments. Rabbi Lewin focused on the technical issues. Halachically homosexuality is forbidden but having a same-sex couple have a child is technically not the same:

> *"You have two men living together that is not recognised as a marriage in Judaism now, they want to adopt a child, how the child is produced goes back to the questions asked originally, this is strongly discouraged because we feel it is important for children to be brought up in a normal nuclear father and mother, adopted or otherwise but there is no technical, you know if the legal authorities were to give an adopted child, however the child is conceived it doesn't matter. today you have transgender people having babies, an external transgender male who used to be a female so in Judaism that is regarded as a woman giving birth." (Rabbi Lewin)*

Rabbi Woolf thought that this way of procreating did not match the Jewish values of family. However, he thought there was no concrete answer to cover every case:

> *"I would be disinclined to give a blanket answer to that because each individual case needs to be looked at but looking again at the aim of Jewish life and family this would not be commensurate in the way we look at things because you are almost banishing Jewish life as we know it onto the dustbin but that does not mean that you could not look at a particular situation so we would not, I certainly would not say no or a blanket yes. But simply*

yes to serve anyone with such a delicate and important part of life and given the way we look at the process of birth as being part of family, community and continuity it certainly would not be commensurate with that if there was a law that said you have to we would probably fight that because you are deleting the whole concept of family from Jewish experience." (Rabbi Woolf)

Discussion

Rabbis have been discussing the uses of ART within Jewish law for many years. Jewish laws on treatments are devised from these discussions and conversations. Yet these laws are not entirely the same for every couple. Individuals must discuss with their Rabbi which treatment would be allowed in their case, and then decide. Thus, decisions are made for all people and couples on a case by case basis.

Understanding these laws and being able to have these discussions with every couple is a very important part of the Rabbi's role. This study aimed to gain an understanding of the knowledge of ART and relevant Jewish law of ten Orthodox Rabbis in London. This study does not aim to be representative of the Rabbinic population of London, but to indicate the opinions and knowledge of ten Rabbis within this under-researched population.

The majority of the Rabbis interviewed held important positions in the community and regularly met with women and men from all ages. Their position in the community made them known, available and approachable to all congregants and most importantly they were sources of Jewish law. In such a position Rabbis are expected to have information about everything including information about ART and their corresponding Jewish laws. However, from the discussions with the Rabbis it was noted that some were not entirely familiar with ART and thus did not know the *Halachot* of their use. Some felt that they would have to refer people to other Rabbis or other sources as they themselves were not completely sure about specific laws. By contrast, Rabbi

Lewin, Rabbi Abrahams and Rabbi Cohen were specialists in the field and were familiar with all Halachic views to ART.

Some Rabbis felt that this topic is something that is not spoken about openly in their communities. For example they had never had open lectures about any type of infertility or ART. If this subject was spoken about it was done privately between the couple and the Rabbi, nobody else was involved. Some Rabbis thought that infertility is not spoken about openly and this secrecy at times limited what people knew about their reproductive health.

As the emerging themes show, Rabbis face challenges and dilemmas inJewish law on ART. For some methods Jewish laws are established, such as treatments for same-sex couples and IVF and PGT. It is difficult to give an opinion or a ruling on interventions that have not yet been clarified or that are still being debated by influential Rabbis in the field of fertility treatments. Some of these topics include: egg donation and Jewish status of the child,; whether egg and sperm donors should or should not be Jewish. These issues were encountered when Rabbis were interviewed and parallel the information that is available from the Rabbis that decide *Halachot*. These Rabbis have not yet agreed who exactly establishes Jewish status if both a birth mother and a genetic mother are involved. Nevertheless, there is a common practice that some Rabbis were aware of which involves converting the infant to Judaism when it is born, and then at a later stage the child can decide if to remain Jewish or not.

Reflections

The primary author is a member of the modern Orthodox Jewish community in North West London. Being Jewish and a part of the community was an advantageous starting point for connecting with and understanding the Rabbis. This gave the primary author an insider's view into Jewish law, and the restrictions and complications derived from *Halachot.* In addition, because of the small size of the community most participants were already known to the primary author, which helped respondents feel at ease and be more

comfortable when answering, as Mauther and Doucet have stated (Mauther & Doucet, 2003). Equally, however, it could have been a limiting factor preventing the Rabbis truly opening up about their attitudes and opinions for fear of being judged within the community by the primary author. This notion is very important when trying to understand the position of the primary researcher (Attia & Edge., 2017).

As Drake states, this insider position of being Jewish carries the risks of blurring boundaries, imposing personal views and beliefs, and the researcher's perceptions (Drake, 2010). As the primary author shared Orthodox views with Rabbis, the assumption of the researcher being familiar with participants' thoughts and opinions carries the risk that participants withheld information that they assumed was obvious to the researcher. Conversely, it could have been that the primary author took for granted or overlooked certain aspects of participants' experience (Daly, 1992). In order to mitigate some of these risks, it was important to ensure that all authors took part in reading interviews and ensuring that analysis was not biased or too general.

All Rabbis recognised themselves as Orthodox, but could have been either Orthodox or Ultra-Orthodox. Ultra-Orthodox refers to the strictest practicing Jews. Due to the small number of the cohort, it is impossible to truly conclude if this difference in denominations affected the way Rabbis thought about specific rules and practices of ART. Further work could be done to investigate if belonging to different Orthodox denominations impacts the way Rabbis think and apply *Halachot* on the practice of ART.

All Rabbis of the cohort had children. It would be interesting to see if Rabbis who had not yet had children or personal experience of infertility felt the same way about *Halachot* to ART or if their rulings differed. These investigations would give greater insight into what prevents Orthodox Jews from using ART to help conceive.

Conclusion

This study by no means pretends to represent the entire Orthodox Rabbinic population of London. It simply offers some insight into ten Rabbis' knowledge of ART and Jewish law. It concludes from the interviews that although most Rabbis have come across ART not all had been directly asked by their congregation members about treatments and their practice. Some Rabbis were completely familiar with Jewish laws on the use of fertility treatments and this was shown in the way their thoughts and opinions paralleled that of great *Halachic* devisors in the field of reproductive technology and Jewish law. This was true particularly for three Rabbis, two of whom were doctors and one a Jewish law specialist. Nevertheless, some Rabbis who were highly important and influential in their communities still felt that they did not know enough on the subjects asked, and this limited their ability to help those that might come forward when needing support. Rabbis in this study also felt that the conversation about infertility is not often done in public and this has an impact on what people know about their fertility in general. Judaism is a religion of procreation and this is reflected in the permissive way Jewish law permits almost any practice of ART. There is no general consensus on any specific treatment but after Rabbinical discussion on each individual case most couples are then allowed to proceed with ART in order to become parents and alleviate the struggle of being childless.

Appendix 1 Rabbis demographic information

1. Rabbi Lewin, 63 years old, Orthodox, Doctor, Rabbi and Senior lecturer in a community of 1000s of members
2. Rabbi Levy, 29 years old, Orthodox, School teacher, 600 students
3. Rabbi Feinsberg, 57 years old, Ultra-Orthodox, Director of Jewish organisation, 15,000 members
4. Rabbi Abrahams, 48 years old, doctor and community Rabbi, 900 members
5. Rabbi Woolf, 67 years old, Orthodox, community Rabbi, 3000 members

6. Rabbi Cohen, 69 years old, Orthodox, expert in Jewish law
7. Rabbi Meisel, 53 years old, Ultra-Orthodox, community Rabbi, 520 families
8. Rabbi Epstein, 46 years old, Orthodox, community Rabbi, 10-20 families
9. Rabbi Landau, 53 years old, Orthodox, community Rabbi, 20000 students
10. Rabbi Jaffe, 66 years old, Orthodox, community Rabbi, 1300 members

References

Amsel (1978), p. 44.

Attia, M. & Edge, J. (2017) Be(com)ing a reflexive researcher: a developmental approach to research methodology. *Open review of educational research* **4**(1):33-45.

Benjamin, O. & Ha'elyon, H. (2002) Rewriting fertilization: Trust, Pain and exit points. *Women's Studies International Forum*, **25**(6):667–678.

Birenbaum-Carmeli, D. **(**2008) Your faith or mine - Family planning intervention in an ultra-orthodox Jewish community in Israel . *Reproductive Health Matters*, **16**(32):185–191.

Birenbaum-Carmeli, D. (2008) Your faith or mine: A pregnancy spacing intervention in an ultra-Orthodox Jewish community in Israel.

Birenbaum-Carmeli, D. (2016) Thirty-five years of assisted reproductive technologies in Israel. *Reproductive Biomedicine & Society Online.*

Birenbaum-Carmeli, D. & Carmeli, Y. S. (2009) Kin, Gene, community reproductive technologies among Jewish Israelis. Berghahn Books, New York, USA.

Birenbaum-Carmeli, D.& Carmeli, Y. S. (2019) Introduction: Reproductive technologies among Jewish Israelis: Setting the ground. (Chapter from: Kin, Gene, community reproductive technologies among Jewish Israelis. Berghahn Books, New York, USA.

Bord of deputies of British Jews, Jews in numbers Available on: https://www.bod.org.uk/jewish-facts-info/jews-in-numbers/ 14.05.2019

Chana, 2019 Available on: www.Chana.org.uk

Daly, K. (1992) Parenthood as problematic: insider interviews with couples seeking to adopt. In: Gilgun JF, Daly K and Handel G (eds) Qualitative Methods in Family Research. Newbury Park, CA: Sage, 103–125

DellaPergola S. (2018) World Jewish Population, 2017. In: Dashefsky A., Sheskin I. (eds) American Jewish Year Book 2017. American Jewish Year Book, vol 117. Springer, Cham.

Drake, P. (2010) Grasping at methodological understanding: a cautionary tale from insider research. *International Journal of Research and Method in Education* 33(1): 85–99.

Eisenberg, V. H & Schenker, J. G. (1997) Pre-embryo donation: ethical and legal aspects. *International journal of gynecology and obstetrics*, **60**(1) 51-57.

Feldman, E. & Wolowelsky, J. B. (1997) Jewish law and The new reproductive technologies. Katav Publishing house, USA.

Genesis 1:18
Genesis 1:28
Genesis. 2:24

Genesis 38:9-10

Grazi, R. V. & Wolowelsky, J. B. (2014) Current Jewish perspectives on maternal identity. *Gynecological Endocrinology,* **30**(12): 929–930.

Grazi, R. V. & Wolowelsky, J. B. Addressing the particular recordkeeping needs of infertile orthodox Jewish couples considering the use of donated eggs.

Grazi, R. V. Wolowelsky, J. B. & Jewelewicz, R. J. (1994) Assisted Reproduction in Contemporary Jewish Law and Ethics. *Gynecol Obstet Invest*, **37**:217–225.

(a)Grazi, R. V. & Wolowelsky, J. B. (1992) Donor gametes for assisted reproduction in contemporary Jewish law and ethics. *Assist Reprod Reviews*, **2**:154-160.

Guide to the Perplexed – Maimonides (circa 13th Century C.E.) – Translated from Original Arabic Text by M. Friedlander. New York: Dover Publications; 1956.

Haaretz, 2019 Available on: www.haaretz.com

National Jewish Population Survey 2000–2001

Pew Review Centre – Relgion & public life, Accessed: 14/05/2019. Available on: https://www.pewforum.org/2012/12/18/global-religious-landscape-jew/

Inhorn, M. C., Birenbaum-Carmeli, D., Tremayne, S. & Gurtin, Z. (2017) Assisted reproduction and Middle East kinship: a regional and religious Comparison. *Reproductive biomedicine online*.

Irshai, R. (2012) Fertility and Jewish Law: Feminist Perspectives on Orthodox Responsa Literature. Brandeis University Press, Waltham Massachusetts, USA.

Ivry, T. & Teman, E. (2017) Pregnant Metaphors and Surrogate Meanings: Bringing the Ethnography of Pregnancy and Surrogacy into Conversation in Israel and Beyond. *Medical Anthropology Quarterly* **32**(2).

Ivry, T., Teman, E. & Frumkin, A. (2011) God-sent ordeals and their discontents: Ultra-orthodox Jewish women negotiate prenatal testing. *Social Science & Medicine,* **72**:1527- 1533.

Johnson, P.; Perennial, H. (1998) A history of the Jews. New York: Harper Collins Publishers.

Kahn, S. (2006) Making Technology Familiar: Orthodox Jews and Infertility Support, Advice, and Inspiration. *Culture, Medicine, and Psychiatry,* **30**:467–480.

Leviticus 18:20

Mauther, N. S. & Doucet, A. (2003) Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology* **37**:413–431.

Schenker, J. G. (1997) Infertility evaluation and treatment according to Jewish law. *European Journal of Obstetrics, Gynecology and Reproductive Biology* **71**:113–123.

Schenker, J. G. (2002) Gender selection. *Journal of Assisted Reproduction and Genetics* **19**:400–410.

Schenker, J. G. (2005) Assisted reproductive practice: religious perspectives. *Reproductive BioMedicine Online,* **10**(3): 310-319.

Schenker, J. G. (2007) Assisted Reproductive Technology in Israel. *J Obstet Gynaecol Res,* **33**(1):51-5.

Schenker, J. G. 2008 Assisted reproductive technology: perspectives in Halakha (Jewish religious law). *Reproductive Biomedicine Online,* **17**(3):17-24.

Schiffman (1989), p. 132.)

Silber, S. J. (2010) Judaism and Reproductive Technology. *Cancer Treat Res*, 156:471–480.

Sinclair, D. B. (2002) Assisted Reproduction in Jewish Law. *Fordham Urban Law Journal* **30**(1):5.

Teman, E., Ivry, T. & Bernhardt, B. A. (2011) Pregnancy as a proclamation of faith: Ultra-Orthodox Jewish women navigating the uncertainty of pregnancy and prenatal diagnosis. *Am J Med Genet,* **155**:69–80.

Teman. E., Ivry, T. & Goren, H. (2016) Obligatory Effort [Hishtadlut] as an Explanatory Model: A Critique of Reproductive Choice and Control. *Culture Medicine and Psychiatry* **40**(2).

Wolowelsky, J. B., Grazy, R. V., Brander, K., Freundel, B., Friedman, M., Goldberg, J., Greenberger, B., Kaplan, F., Reichman, E. & Zimmerman, D. R. (2007) sex selection and Halakhic Ethics: A contemporary discussion. *Tradition: A journal of Orthodox Jewish thought*, **40**(1):45-78.

Zilberstein and Rothschild (1987) Zilberstein, Yizhak, and Moshe Rothschild. Torah Ha-yoledet [Hebrew]. Bnei Brak: Makhon Halakah Ve-Rfu'ah, 1987.

(5)Orthodox Jewish women in London and ART

Orthodox Jewish women's views on some of the controversies in ART

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Abstract

Attitudes towards Assisted Reproductive Technologies (ART) mirror a person's values; they often challenge a person to question their ethical limits when deciding which treatment is appropriate. Orthodox Jews are characterised by stringent adherence to the corpus of Jewish *halachic* practice, including reproductive practices. This project investigated the views and opinions of British Orthodox Jewish women on some of the controversial ARTs, including Invitro fertilisation (IVF), embryo freezing, social egg freezing, preimplantation genetic testing (PGT), sex selection, gamete donation, surrogacy, and treatments for single women and same sex couples.

Seventeen face-to-face semi-structured qualitative interviews were carried out with British Orthodox Jewish women in London. Interviews highlighted women's opinions on ART. In general the majority of women were familiar with some fertility treatments and they understood that ART may be the only answer for couples who cannot conceive naturally. It was in this light that most women understood ART and their use within strict Jewish laws. Women felt

that single women should be allowed to freeze their eggs and also become solo mothers if that was their only option. These women also thought that couples requiring gamete donation, surrogacy and PGT should be allowed to have these treatments to fulfil their dreams of parenthood. Women had reservations about sex selection when carried out for non-medical reasons. For many of the women there existed a gap between Jewish laws to ART and what they personally thought should be allowed. Themes emerged from the discussions with the women, these include: good uses for ART, role of Jewish law, gamete donation, and Jewish status. Often women debated if their opinion would be right according to Jewish law. Jewish law is very lenient when it comes to procreation due to the pro-natalist nature of Judaism as a religion. This was something that women were not entirely familiar with. A dichotomy between Jewish law and women's opinions appeared upon discussion with the women. The separation between these two sides is questionable as women's thoughts, opinions and values could be based on Jewish principles.

Keywords: Judaism; Jewish law; procreation; Assisted Reproductive Technologies; in vitro fertilisation, preimplantation genetic testing

Introduction

Orthodox Jews are expected to adhere strictly to Jewish law. Many feel bound by the commandment to procreate therefore having children and creating a family could be seen as someone's destiny and life duty. For many Orthodox Jews life is based around fulfilling this mission. Young adults are encouraged to marry young and start a family as soon as they are married. There are various steps that lead to marriage, including: preparation for the right match (*Shiduch),* learning how to sustain and maintain a relationship with one's husband or wife, and learning all the rules involved in sexual relations, family purity (*Niddah),* and how to keep peace in the home *(Shalom Bait)*. Sexual intercourse prior to marriage is forbidden therefore young adults are usually not given any form of information on sex, contraception, reproduction, or fertility before marriage. This information only begins to be disseminated when

they attend *Midrasha* and when later on the right *Shiduch* (match*)* is found. It is then when engaged couples begin bride and groom lessons (these are delivered separately).
(*Midrasha* also known as religious seminary is a centre where Orthodox Jewish women study the *Torah* and other *Talmudic* sources in order to develop their Jewish knowledge- usually girls attend seminary).

The observance of Jewish law extends to every aspect of a person's life including the use of fertility treatments. Over the last four decades Assisted Reproductive Technologies (ART) have expanded to become a part of our society, and have increasingly helped couples, as well as single women, to overcome their medical or social inability to conceive (Zhao *et al*., 2011). Over six million children have been delivered worldwide as a result of ART (Dyer *et al*., 2016). However, despite its benefits the use of ART requires permission.

The Rabbi, as a representative of God, discusses each ART with other great Rabbinic scholars in the context of Jewish law and a person's need in order to explore which ART should or should not be permitted to each person and couple. This is how Jewish law on ART is developed. In some Orthodox Jewish communities, Rabbinical opinion differs on different ART, with some Rabbis permitting treatments under certain circumstances while others completely forbid the same treatment. But broadly speaking, IVF is permitted under Jewish law as long as the entire IVF process is strictly supervised by a trained third party, who must be Jewish (Rabbinical supervision) (Brand, 2010).

Most Rabbis permit IVF if the couple's own sperm and egg are used and if it is the only option for the couple to have children (Rabbi Yosef Shalom Elyashiv, Rabbi Ovadia Yosef, Rabbi Shlomo Goren, Rabbi Waldenberg, Rabbi Judah Gershuni and Rabbi Jacob Ariel). Rabbi Ovadia Yosef emphasizes that the prohibition of wasting seed does not apply in IVF because the seed is used, not wasted and since the offspring would be biologically the child of both of its parents the commandment to procreate would be fulfilled. His only worry lies along the idea that as the procedure is done solely in the lab there could be potential mix ups with other men's sperm. Rabbi Gershuni

and Rabbi Ariel argued that even if the couple uses their own gametes the husband does not fulfil the commandment to procreate because it is an external process.

Rabbis who prohibit IVF base their rulings on: the externality of the IVF procedure, this action making it unnatural and difficult to safeguard paternal lineage as the father's sperm might be mixed up and the possibility of future incest as offspring might marry each other (Rabbi Benzion Mei Hai Uziel & Rabbi Malkiel Tzvi Tenenboim). Rabbi Benzion Mei Hai Uziel further mentions that IVF should be prohibited as it leads to inevitable wastage of seed (Rabbi Benzion Mei Hai Uziel). Rabbi Ovadia Heday states that a man does not fulfil his obligation to procreate via IVF as this method of conception is not a pleasurable way to procreate therefore this takes away from the *mitzvah* (positive commandment) (Rabbi Ovadia Heday).

Solutions to some of these preoccupations have mostly allowed Rabbis to be more lenient and permit the use of ART. Some solutions include: ensuring the entire IVF process is strictly supervised by a trained third party, who must be Jewish and trained in Jewish law (Rabbinical supervision), using non-spermicidal condoms that do not damage sperm vitality and have pinpoint perforation to prevent unnecessary masturbation and collecting the sperm from the woman's vagina after intercourse (Hirsh, 1996 & Abraham, 1984). Though contested and often not seen as the most reliable means to collect sperm they still offer an option to Orthodox couples who worry about masturbation. Lastly, finding ways of having treatments and not breaking *Shabbat* observance has allowed couples to use ART and not feel guilty about their religious observance.

With regards to more controversial techniques such as gamete donation, Rabbis are more reluctant to permit treatments. In Jewish law family lineage is very important. This is passed on from father to child. This is particularly important for Cohen and Levy families as it is believed that according to *Halacha* such families have special tasks in the Jewish temple. With regards to Jewish identity this is established via matrilineal descent therefore this

becomes problematic when donor eggs are used or equally when a surrogate is needed as this increases questions of motherhood. Some Rabbinic authorities prohibit both sperm and egg donation on the basis that the couple should “build a wall” around the sacred marital bond (Rabbi Elyashiv & Rabbi Morgenstern, 2009).

Gamete donation laws have derived from the previous discussions and debates that Rabbis have held on the use of donor sperm for artificial insemination. Sperm donation is often frowned upon and commonly forbidden by Ultra-Orthodox Rabbis. Prohibiting views focus on the possibility of adultery, incest, wastage of seed and not having a clear lineage to the next generations this being either from a non-Jewish or Jewish sperm donor. Using sperm from a non-Jewish donor was even compared to marrying a non-Jew, which again is forbidden according to Jewish law (Rabbi Benzion Meir Hai Uziel, Rabbi Malkiel Tzvi Tenenboim, Rabbi Ovadia Hedaya, Rabbi Moshe Haim Ephraim Bloch & Rabbi Jacob Breish).

Rabbis who permit sperm donation base their judgment on Rabbi Moshe Feinstein’s ruling on a case he discussed for a couple who could not conceive and needed to have artificial insemination with donated sperm. Feinstein’s ruling stated that the couple should be permitted to have artificial insemination from a non-Jewish donor. His ruling stated that this was allowed under extenuating circumstances because both partners were suffering due to their inability to conceive and there was no other way that they could conceive. Allowing this procedure with a non-Jewish donor also ensured that there would be no incest between future offspring. Rabbi Feinstein also stated that this scenario would only be permitted if the husband’s consent was obtained (Rabbi Moshe Feinstein).

Rabbis are more lenient with regards to egg donation. Again, there is much debate on whether donors should or should not be Jewish. According to Jewish law it is the mother who establishes Jewish identity. Therefore in cases where egg donation or surrogates are needed it is uncertain whether it is the birth mother or the egg donor who establishes Jewish identity. Decisions are

made for each couple individually by a Rabbi (Silber, 2010) It is common for some Rabbis to ask for the resulting child to be converted to ensure that there is no doubt of the child's Jewish identity.

For Pre-implantation Genetic Testing (PGT), the debate revolves around the destruction of the embryo and the rationale for its use. Jewish law does not consider an unborn foetus as a person until it is born and completely separated from its mother's body. In fact, until 40 days after conception the embryo is considered "mere fluid". Rabbi Yom Tov Lippman Heller, also known as Tosafot, states that a foetus is not considered to have a soul until it has completely left its mother's body and therefore one is permitted to destroy it. Based on these laws PGT is permitted and it is even noted as a noble act as it could be preventing a disease. In practice arguments in favour hinge on the mental health and capabilities of the parents, not of the child to be born. Using PGT to select a child's gender in complicated medical cases is usually permitted as it would fit the above criteria (Grazi *et al*., 2008), but the *Halachic* advisors' opinions on sex selection for social reasons are more divided.

The majority of research on Jewish women's attitudes, thoughts and feelings about ART treatments has been conducted in Israel. Israel has a unique relationship with procreation and ART. The first IVF clinic in the Middle East opened in Israel only three years after the birth of Louise Brown in 1978 (Birenbaum-Carmeli, 1997). Israel has developed into the world's leading IVF 'Capital' (ESHRE, 2014 & Israel Ministry of Health, 2013). Some studies include: solo motherhood and Jewish women's use of artificial insemination (Kahn's., 2000), the role of Rabbis as a buffer between ART users and doctors (Ivry., 2010), God controlling women's reproductive lives (Teman *et al*., 2011), the deep importance women place on motherhood (Remennick., 2009), childbearing as the most important life goal (Birenbaum-Carmeli., 2008), and the way women understand pregnancy as work of God (Raucher., 2016). These studies have researched the opinions of women that are directly related and impacted by their inability to procreate in a predominately pro-natalist country.

Thus there have so far been no studies exploring the attitudes and opinions on ART of unaffected women. This area is particularly under researched in the UK. This study therefore aimed to fill this gap in our knowledge. It focuses on women who so far have not personally experienced infertility and it tries to explore their views and attitudes towards the practice of some ART.

Methodology

The study involved semi-structured interviews with 17 Orthodox Jewish women in London. Jewish women from three Orthodox backgrounds were interviewed: modern-Orthodox, Orthodox-Charedi, and Orthodox-traditional. These denominations emphasise the way women practice Judaism. Orthodox-Charedi being the most religious and practicing group, modern-Orthodox being the group that is observant of Jewish law but also encompasses modern world thinking and Orthodox-traditional refers to those Jews who have an Orthodox background but that are more lenient with their practices and focus more on the traditional aspect of religion instead of the rigorous observance of Jewish law. These women were chosen because they had no apparent reproductive problems and no special knowledge of ART. Nine women were mothers at the time of the interviews. The youngest woman was 20 and the oldest was 55. The majority of women had attended religious seminary and had access to the internet, Rabbis and other sources of information on ART. Details about each participant can be found in **Appendix 1**.

Qualitative methods are appropriate for exploring previously unresearched areas, as they enable new and unexpected issues to be identified. Qualitative interviews also allow the reasons and rationales behind people's opinions to be explored. These methods provide an insight into what the women think, as the women can express themselves and their opinions in their own words. It allows an open discussion of their thoughts and feelings, and the exploration of unknown areas, with new and unexpected themes often emerging.

Furthermore, it also allows exploration of details and group sensitivities that would otherwise be difficult to observe and identify.

The semi-structured interview schedule consisted of 31 questions addressing women's attitudes and knowledge of various ART (IVF, embryo freezing, social egg freezing, PGT, sex selection, sperm and egg donation, and surrogacy), as well as issues such as motherhood and Jewish identify, or treatment for single women and same-sex couples. Women were asked what they thought about treatments and their opinions to their use. For example women were asked about their opinion on using PGT for sex selection in medical conditions, about egg freezing for single women and the use of ART to help same-sex couples. Most questions were open ended and they allowed women to comment on whether treatments should or should not be used.

All interviews were carried out by the first author, who is an active member of an Orthodox Jewish community in North West London.. This author therefore had insider's view on the women's lives and attitudes. In addition, most participants were known to her, which provided the familiarity that participants needed to be able to open up about their personal views.

Names of Orthodox Jewish women who might be interested in taking part were suggested by Rabbis known to the primary author, who then contacted the women to ascertain their interest. This route was chosen because in the Orthodox Jewish community, direct contact with women is easier and the response more likely to be positive than indirect contact via a Rabbi, especially regarding such private topics. If interested, participants were sent the consent form and information about the research project, prior to the interviews. These documents aimed to prepare the women for the interviews by giving them some general information on the purpose of the research. Further contacts were made via snowballing. Adverts were also placed in the Jewish learning exchange (a centre Jewish students).

The interviews were audio recorded with the consent of participants. They were transcribed verbatim by the author. Most interviews took place in Jewish organisations or in the participant's home.

Qualitative description alongside thematic analysis were used to analyse the data from the interviews. Qualitative description specifically focuses on discovering and understanding a process, phenomenon, or the views and perspectives of people involved in the study without delving too much in interpreting answers. (Caelli *et al*., 2003; Sandelwoski 2000 & Merriam, 1998). This was beneficial for this research as its aims was to observe and explore women's attitudes to ART and their use. Thematic analysis provided a way to analyse the data and discover themes with no particular concrete structure (Tuckett, 2005; Attride-Stirling, 2001 & Boyatzis, 1998). When analysing the data Braun and Clarke's six steps were used to identify themes (Braun and Clarke, 2006). Themes were mostly identified by the first author and were later discussed with the second and third authors. Meetings were held regularly so that analysis was consistent and all authors were in agreement. These meeting were also held in order to mitigate any possible biases in the primary author's analysis due to Jewish background and close proximity to the study group.

Ethics approval was obtained from University College London ethics committee, reference no. 9831/001, June 2016.

Results

This study focuses on the interviews held with 17 Orthodox Jewish women in London. We recognise that this study is not representative of the Jewish population of London and much less of the UK but it helps to try to understand some views and opinions and the way some British Orthodox Jewish women think about ART.

In general, the majority of women had some form of knowledge of ART and therefore were familiar with some fertility treatments. In some cases, like for

PGT, sex selection and gamete donation, women needed more information and case scenarios to understand treatments.

Most women had positive opinions about different infertility treatments. They could see the benefits of using treatments to conceive if unfortunately couples had no other way. Most women felt positive about IVF and thought that couples should use this technology if they needed assistance when trying to conceive. One woman thought that IVF was very problematic because of family lineage. She thought that using IVF could put in danger the clear structure of mother, father, child especially when introducing egg or sperm donors. The same was true for PGT, most women felt positive about using PGT to help prevent medical conditions in couples' future offspring; conditions which couples would not be able to cope with as parents. In general majority of women felt negatively about using sex selection for non-medical conditions. Social egg freezing was something that most women had not heard about, but it was something that they accepted if a woman was single and she was thinking about her future prospects. With regards to gamete donation some women thought strongly that if this was only option for couples, they should to go ahead with treatments. The same was true for surrogacy. Lastly some women felt positively about single women and same-sex couples having treatments basing their opinion on the couples' desire to be parents.

With regards to the Jewish laws to ART two points were drawn from the interviews with the women. Firstly, most women were not entirely aware of the specific laws to treatments and in particular to the positive and pro-natalist nature of Jewish law. For instance some women were not aware that Jewish law permits the use of egg donation and it even suggests that the egg donor should be non-Jewish. Some women felt that they did not known enough about treatments and the laws, thus they felt that they were giving their personal opinion and not something that Jewish law would necessarily agree with. Secondly, the majority of women balanced their knowledge of what they knew law says against the couple's needs in order to decide which treatments should and should not be allowed.

Analysis of the interviews revealed several relevant themes. Due to the limitation of space, this discussion focuses on the following two major themes: being lenient towards the use of ART because it helps couples; does Jewish law allow it? These themes focus on the two main principles that the women used when thinking and discussing their opinions of ART.

Being lenient towards the use of ART because it helps couples

ART was seen as a solution to a deeply important problem: infertility. They felt strongly about the way some infertile couples experience grief due to their infertility, and therefore felt that if ART could end this suffering then the technologies should be permitted.

As Viviene said:

> *"Whatever help you can be to a couple that have this experience of infertility… we should try to make use of everything that is available to us." (Viviene)*

Women felt that help should be available to all couples struggling with reproduction. This extended further than just having children. One example was the use of PGT to identify genetic conditions present in the embryos. Several women talked about the religious stipulation that instructs every Jew to try to alleviate another's pain or struggle; this is the fulfilment of a *mitzvah* (a good deed). Some women thought that if a couple was suffering due to the condition their potential child might have, it would be permissible -- even an act of kindness -- to allow these couples to use PGT. Some women thought that preventing the birth of a person who could have a life-threatening condition is equivalent to saving someone's life; therefore according to Jewish principles this is the couple's duty:

> *"If it is a life-threatening condition that the baby would have then I think that would be a good reason to test for it… you would not want to create someone that would then be in danger of dying… from a Jewish perspective you know you need to save everyone's life… I do not think you should create a person with one of those conditions." (Annat)*

Does Jewish law allow it?

Jewish law provides an entire way of life for Orthodox Jews, setting boundaries and giving guidance on a "moral" and "good" way of life through the lens of Judaism. For Orthodox Jews, these are guidelines to live by. The women's answers reflect and remind us of the importance Orthodox Jewish women place on Jewish law when making life decisions. Some women refused to give their personal opinion as they felt that these were such serious topics the answers should be provided by rabbis or by the *Halacha* itself. Most women referred to Jewish law as a ground of laws that dictates what they should and should not do. When the Jewish law was not known, women suggested that rabbis needed to be part of the decision making.

> *"I think you need to ask a rabbi, if you are a type of person who lives a religious life, who lives within an actively Jewish framework." (Batsheba)*

Batsheba was able to see the individuality of people and the different ways Orthodox Jewish women might experience and live their religious practice. The decision depended on the importance each person places on Jewish law.

Some women's responses suggested that if Jewish law went against their opinion or personal view of the need and use of ART, they would prioritize Jewish laws. Rose was of this view:

> *"I think it should be checked… But according to Judaism I understand if the answer is no." (Rose)*

Like many women in the study, when thinking about ART Rose could understand why some treatments might not be permitted according to *Halachot.* Rose thought that above all else before any treatment is done, Jewish law should be consulted.

Some topics were more controversial than others, for example, when exploring treatment for same-sex couples, women also used Jewish law as a basis. According to Jewish law homosexuality is forbidden, and some women felt that in itself was enough to justify preventing couples from having children together. The need for a nuclear family was often mentioned along with its vital importance in the Jewish Orthodox lifestyle.

> *"Being an Orthodox Jewish person I am quite anti-same sex relationship thing… but being an ethical person I think why shouldn't two girls who live together not look after a child, or two blokes… But we don't yet know the ramifications of growing up in an I am a two daddies family." (Candice)*

Some women experienced an acute dichotomy of thought. The women knew Jewish law on same-sex couples, yet they could not see anything wrong with two people who love each other wanting to have a family. Women thought that couples should be free to make these decisions on their own, independently. As Orthodox Jews they could understand the essential wrong in the formation of a family by a same-sex couple, but at the same time they could not help feeling that couples should be allowed to be happy.

They felt similarly about treatment for single women and social egg freezing for non-medical conditions. They could identify with what it would be like to want as a single woman who had not found a partner and was therefore not married. When thinking of other women struggling to become mothers, the participants tended to be more tolerant and refer to Jewish law less often.

Amanda defends egg freezing for single women:

> *"It depends on the circumstances… If it is a woman who is really not finding a husband and really wants to have a child and she is going to end up lonely and sad… I*

really do think it should be a choice for the woman." (Amanda)

Amanda as a mother understands the desire and need to be a mother therefore she empathises with women who might be struggling to have what she has.

Malka also focuses on how having children for some women is their greatest happiness:

"I think it should be… who is to deny them this happiness if they cannot find the right partner or don't want to have one." (Malka)

When discussing treatments, in general women thought ART could be problematic because of gamete donation and in specific because of Jewish identity. According to Jewish law, Jewish status is passed on via matrilineal descent. Women in this study felt that due to the importance of Jewish identity egg donation and surrogacy could therefore be problematic as often donors are anonymous.

"In terms of egg or sperm donation that would be a problem… In Judaism, we define Jewish status through the mother and if there was an egg donation and it would come from a non-Jewish woman it would be hard to assess the Jewish status of the baby." (Malka)

Women were not entirely sure if Jewish law would allow couples to have treatments with donated gametes, because of the difficulty of knowing and ensuring Jewish status. Nevertheless, they thought these questions were both important and difficult to answer. If necessary, couples struggling with infertility might be able to use such treatments but only in accordance with the Rabbi's final ruling.

"That is a halachic question that only a Rabbinic person could answer. I do not know the answer to that myself. I

know there are varying opinions, I think it depends on which religious authority you approach as to whether or not they will tell you it should or it shouldn't so I wouldn't want to answer that." (Candice)

Discussion

A key finding of these interviews is the potential conflict between two aspects of Orthodox life: the culturally instilled pro-natalism on one hand, and the Orthodox attitude to Jewish law on the other. The participants' sense of their role as mothers impacted the way they felt about some couples wanting to have children and therefore using ART to achieve this. For some Orthodox denominations, there are expectations that women's sole role is to bring children into the world. This puts immense pressure on women and increases their general desire to have children even if they are not married. Their sense of their role as mothers and the pressures from the community encouraged the participants to see issues from a pro-natalist perspective. Despite the positive light *Halacha* shines on the use of ART in general, the women discussed points of tension in some cases between pro-natalism and Jewish law or Rabbinical opinion.

In many cases, women were struggling to find a balance between personal moral opinions and Jewish law. As mentioned, they found it particularly hard to talk about treatment for same-sex couples. They felt conflicted between wanting same-sex couples to have a family and (in accordance with Orthodox views) be happy, and the strict Jewish law against homosexuality. Most of these women felt that anyone who wanted a child should have one, and for some this included same-sex couples. Similarly, the women were more flexible with regard to treatments for single women, and referred less to Jewish law in their answers.

In other cases Jewish law was prioritized over their own personal opinion. One example is the establishment of Jewish identity after ART: some women felt they did not know enough about Jewish laws on these topics, and were

therefore unable to give any answer to the questions. Women were not asked what the Jewish law was for any of the scenarios presented, yet at times they thought it was inappropriate for them to answer questions because they did not know the Jewish law on that particular subject. In some cases, Jewish law was stronger than their own opinion. Once more the value that religion plays in the individuals' lives and where their own judgement fits in comes into question.

The way women separated Jewish law and their personal opinion in these cases is intriguing, because it suggests that they felt the two were distinct, despite the often-stated claim that the whole of Orthodox life is based on religious principles and teachings. Where do Orthodox Jewish women's own personal opinions really come from, if not from Jewish law? This study was not able to address this question but it indicates a potentially fruitful line of further research. Before further research can be done in this area it is vital to understand what would happen if women thought a particular ART should be carried out, in disagreement with Jewish law. This would separate Jewish law and personal opinions, give an insight into how closely Orthodox Jews follow Jewish laws in this area, and provide practical information for rabbis and others attempting to give guidance to Orthodox couples faced with infertility.

Women referred to the possibility of different religious authorities having different opinions on various topics. This variability suggests that you might get different answers, depending on which Rabbi you ask. Apart from following Jewish law, Orthodox Jewish women are also required to have someone to talk to about important matters that require Jewish advice. For some women "having your own Rabbi to talk to" is a necessary part of their everyday life. A second question that then arises is whether Orthodox Jewish women leave their fertility decisions to Rabbinical authorities to answer. This is another area that would be of value for future research.

Limitations of the study

This study focused on the opinions of 17 British Orthodox Jewish women in London. It no way does this study aim to be representative of all British Jewish women. It simply highlights the way some Orthodox Jewish women understand and view ART.

The primary author and interviewer is an Orthodox Jewish woman. This has both potential pros and cons for the research. On the one hand it gave an insider's unique insight into the women's attitudes. In addition, because of the small size of the community most participants were already known previously to the primary author, which helped respondents feel at ease and be more comfortable when answering, as Mauther and Doucet have stated (Mauther & Doucet 2003).

Nevertheless, as Drake states, this insider position of being Jewish carries the risks of blurring boundaries, imposing personal views and beliefs, and the researcher's perceptions (Drake, 2010). As the primary author shared similar views, the assumption of the researcher being familiar with participants' realities carries the risk that participants withheld information that they assumed was obvious to the researcher. Conversely, it could have been that the primary author took for granted or overlooked certain aspects of participants' experience (Daly, 1992). In order to mitigate some of these risks, it was important to ensure that all authors took part in reading interviews and ensuring that analysis was not biased or too general.

All women in this cohort recognised themselves as Orthodox, belonging to three denominations within Orthodoxy. The way women practice and observe Jewish law could have impacted the way they understood the practice of ART. There were no obvious differences between the way women answered and their religious practices and observances. Yet, due to the small number of the cohort clear conclusions can be drawn about this comparison. Further work could be done to investigate if belonging to different Orthodox denominations could impact the way women think and feel about ART and its practice.

Some women of the cohort had children while others did not. This did not seem to impact the way they answered, but the small sample number makes it impossible to draw firm conclusions. Investigating this in more detail would bring to light more factors that could potentially alter the women's decision making processes. It might also be valuable to investigate the attitudes to ART of Orthodox Jewish women who *have* had fertility treatments, compare them with those women who had children naturally, and examine the part that religion played in their decision making. These investigations would give greater insight into women's beliefs about and attitudes to ART within the British Orthodox Jewish community.

Conclusion

The findings suggest that Orthodox Jewish women in London are only vaguely familiar with ART and their use amongst Jewish law. Women thought positively of most treatments and in their opinion ART should be used readily as they offer childless parents a way to end their infertility struggles. In the discussions there seemed to appear a dichotomy between Jewish law and women's opinions. This segregation of the two entities is questionable as Orthodox Jewish women could, in principle, base all their opinions, values and attitudes on Jewish teachings. A deeper understanding of women's use of Jewish laws would improve the understanding of women's attitudes towards and opinions of ART. This information could greatly improve the knowledge that clinicians, practitioners and counsellors have of such communities. In turn this could help improve the way that Orthodox Jewish couples experience infertility and infertility treatment.

References

Attia, M. & Edge, J. (2017) Be(com)ing a reflexive researcher: a developmental approach to research methodology. *Open Review of Educational Research,* **4**(1):33-45.

Attride-Stirling, J. (2001) Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, **1**:385-405.

Birenbaum-Carmeli, D. **(**2008) Your faith or mine - Family planning intervention in an ultra-orthodox Jewish community in Israel . *Reproductive Health Matters*, **16**(32):185–191.

Birenbaum-Carmeli**,** D. (1997) "Pioneering Procreation: Israel's First Test-Tube Baby." *Science as Culture*, 6:525-540.

Boyatzis, R. E. (1998) Transforming qualitative information: thematic analysis and code development. Sage publications Inc.

Brand, Y. (2010) Essays: Religious medical ethics: A study of the rulings of Rabbi Waldenberg. *Journal of Religious Ethics* **38**(3):495-520.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology,* **3**:77-101.

Caelli, K., Ray, L., & Mill, J. (2003). "Clear as mud": Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, **2**(2):1–23.

Daly, K. (1992) Parenthood as problematic: insider interviews with couples seeking to adopt. In: Gilgun JF, Daly K and Handel G (eds) Qualitative Methods in Family Research. Newbury Park, CA: Sage, 103–125.

Drake, P. (2010) Grasping at methodological understanding: a cautionary tale from insider research. *International Journal of Research and Method in Education* 33(1): 85–99.

Dyer, S., Chambers, G. M., Mouzon, J. Nygren K. G., Zegers-Hochschild, F., Mansour, R., Ishihara, O., Banker, M. & Adamson, G. D. (2016) International committee for monitoring assisted reproductive technologies world report: Assisted reproductive technology 2008, 2009 and 2010. *Human Repro* **31**:1588-1609.

European Society of Human Reproduction and Embriology, 2014. ART fact sheet. http://www.eshre.eu/Guidelinesand-Legal/ART-fact-sheet.aspx.

Genesis 1:28

Grazi, R. V. & Wolowelsky, J. B. (2006) Addressing the idiosyncratic needs of Orthodox Jewish couples requesting sex selection by preimplantation genetic diagnosis (PGD). *J Assist Reprod Genet* **23**:421–425.

Grazi, R. V. & Wolowelsky, J. B. (1992) Preimplantation sex selection and genetic screening in contemporary Jewish law and ethics. *J Assist Reprod Genet* **9**(4)318-322.

Grazi, R. V., Wolowelsky, J. B. & Krieger, D. J. (2008) Sex Selection by Preimplantation Genetic Diagnosis (PGD) for Nonmedical Reasons in Contemporary Israeli Regulations. *Cambridge Quarterly of Healthcare Ethics,* **17**:293–299.

Israel's Ministry of Health (2013). In Vitro Fertilization (IVF) Treatments: Absolute Numbers, Percentages, Rates. (http://www.health.gov.il/PublicationsFiles/IVF1986_2012.pdf)

Ivry, T. (2010) Kosher Medicine and Medicalized Halacha; An exploration of triadic relations among Israeli Rabbis, Doctors and infertility Patients. *American Ethnologist*, **37**(4):662-680.

Kahn, S. (2006) Making Technology Familiar: Orthodox Jews and Infertility Support, Advice, and Inspiration. *Culture, Medicine, and Psychiatry,* **30**:467–480.

Mauther, N. S. & Doucet, A. (2003) Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology* **37**:413–431.

Merriam, S. B. (1998). Qualitative research and case study applications in education. San Francisco: Jossey-Bass.

Nishmat's Women's Health and Halacha, 2016 Halachic Supervision for Assisted Reproductive Technology[Available Online] **http://www.yoatzot.org/articles/?id=659** (Accessed: 10/10/16).

Pollack, D., Bleich, M., Reid, C. J. & Fadel, M. H. (2004) Classical religious perspectives of adoption law. *Notre Dame Law Rev* **79**(2):693–4.

Rabbi Y. A. Elyashiv & Rabbi D. Morgenstern, 2009, oral decision, Personal communication.

Rabbi Yosef Shalom Elyashiv,
Rabbi Ovadia Yosef,
Rabbi Shlomo Goren,
Rabbi Waldenberg,
Rabbi Judah Gershuni
Rabbi Jacob Ariel
Rabbi Ovadia Heday
Rabbi Benzion Mei Hai Uziel
Rabbi Malkiel Tzvi Tenenboim
Rabbi Yom Tov Lippman Heller (Tosafot)

Raucher, M. (2016) Ethnography and Jewish Ethics; Lessons from a Case Study. *Reproductive Ethics Journal of Religious Ethics***, 44**(4)636-658.

Reichman, D. E., Brauer, A. A., Goldschlag, D., Schattman, G., & Rosenwaks, Z. (2013) In vitro fertilization for Orthodox Jewish couples: antagonist cycle modifications allowing for mikveh attendance before oocyte retrieval.

Remennick, L. (2009) Between reproductive citizenship and consumerism: Attitudes towards Assisted Reproductive technologies among Jewish and Arab Israeli women. Chapter 13 in Kin, Gene, Community: Reproductive Technologies Among Jewish Israelis**. E**dited by Daphna Birenbaum-Carmeli, Yoram S. Carmeli**. Berghahn Books New York, USA.**

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description? *Research in Nursing and Health*, **23**(4):334–340.

Schenker, J. G. (2008) Assisted reproductive technology: Perspective in Halakha (Jewish religious law). *Reprod Biomed online* **3**:17-24.

Sherman, J. S. (2010) Judaism and Reproductive Technology. *Cancer Treat Res* **156**:471-480.

Silber S. J. (2010) Judaism and Reproductive Technology. In: Woodruff T., Zoloth L., Campo-Engelstein L., Rodriguez S. (eds) Oncofertility. Cancer Treatment and Research, vol 156. Springer, Boston, MA.

Teman, E., Ivry, T. & Bernhardt, B. A. (2010) Pregnancy as a proclamation of faith: Orthodox Jewish women navigating the uncertainty of pregnancy and prenatal diagnosis. *American Journal of Medical Genetics,* **155**:69-80.

The board of deputies of Brittish Jews (2017) Jewish in number https://www.bod.org.uk/jewish-facts-info/jews-in-numbers/ [Online] (Accessed: 24/07/17).

Tuckett, A. G. (2005): Applying thematic analysis theory to practice: a researcher's experience. *Contemporary Nurse*, **19**:75-87.

Wolowelsky, J. B. & Grazi, R. V. (2014) Current Jewish perspectives on maternal identity. *Gynaecological Endocrinology* **30**(12):929-930.

Wolowelsky, J. B., Grazi, R. V., Brander, K., Freundel, B., Friedman, M., Goldberg, J., Greenberger, B., Kaplan, F., Reichman, E. & Zimmerman, D. R. (2007) Sex selection and Halakhic ethics: a contemporary discussion. *Tradition*, **40**(1): 45-78.

Yevamot 61b and 62a

Zhao, Y., Brezina, P., Hsu, C. C., Garcia, J., Brinsden, P. R. & Wallach, E. (2011) In vitro fertilization: Four decades of reflections and promises. *Biochimica et Biphysica Acta* 843-852.

Zilberstein, Y. (1991) Responsum to Richard Grazi. Shevat 5751 (Feb 1991). Holon, Israel, Beit David Institute.

Appendix 1.

Brief description of 17 participants

1. ***Hildy***

Aged 28; mother of 5; teacher

Hildy considers herself strictly Orthodox. This is important to her as she views herself as a person that has an important job in the community. Hildy teaches young women from the community a variety of Jewish topics from Jewish texts to Jewish laws on family purity. She believes that it is important for her to know about laws and to be able to be empathetic with people around her. Hildy has a very general knowledge with regards to fertility and fertility treatments and her attitude is generally open to treatments. Hildy found it hard to give clear answers to most questions relating to what Jewish law allowed and in the end, it became clear that Hildy herself felt that she did not know enough within the domain of fertility treatments and therefore she could not think of Jewish laws that would apply.

2. Rose
Aged 21; single; student

Rose is the eldest sibling from a family of 3. At the time of the interview she was doing her year abroad of studies in London. She considers herself a modern Orthodox Jew because she likes to see Judaism adapt to the newer generations. She is well aware of fertility treatments but she did not have much knowledge on the Jewish law side of interview. Rose has positive perspective on fertility treatments. Equally she believes that Judaism is a positive religion and lenient religion towards treatments. Rose also thinks that at the end of the day any decision with regards to fertility treatments should be decided by the couple requiring treatments.

3. Amanda
Aged 29; mother of 3; student

Amanda considers herself an Orthodox Jew who does not like labels. For her what is important is to have a good relationship with religion. She believes that she does not know enough about fertility treatments and often throughout the interview this was something that she recognised and admitted. Amanda has strong opinions on abortion, sex selection and social eggs freezing. For her these are all topics that need to be discussed so that people can have the children they desire. Amanda also feels that she cannot judge women who want to have children and therefore have fertility treatments. She feels that she had her children easily and therefore for her it is slightly hard to understand and fully comprehend how some couples might need treatment and how at times Jewish law could be problematic when it came to allowing couples to have children.

4. Malka
Aged 21; student; single

Malka, who is an Orthodox Jew, at the time of the interview had just started her second year of university after leaving a religious seminary school in Israel. Malka is aware and familiar with the scientific terms and some fertility treatments as she did science A levels. She had heard of some treatments and had thought about these with relation to Judaism and as a woman. Malka has strong opinions about treatments and she feels that it is important that Jewish laws are discussed with young girls so that they can be made aware of treatments available and how they can learn to know when their fertility might be a problem. Malka seems to know and understand treatments and be ready to give her opinions. She is also well versed in the area of Jewish law.

5. Aviva

Aged 37; mother of 3; freelance baker

Aviva found it hard to answer most question as she feels that she does not know enough when it comes to Jewish laws and the treatments themselves. She believes that she had her daughters easily and a long time ago as her youngest daughter at the time of the interview was already 12 years old. Aviva thinks of herself an Orthodox woman who is caring with others and when she thinks of fertility treatments what comes to her mind is those couple who struggle to have children. She often thinks how negatively this must affect these infertile couples. For her it is hard to think of a life without her children and this is what makes her more lenient towards what she thinks is allowed and should be allowed according to Jewish law.

6. Ruth

Aged 22; single; student

Ruth is a modern Orthodox Jew who grew up in an Orthodox household. She considers herself a girl who is aware of new technologies and theories. Ruth has heard of some treatments before and this made it easier for her at the time of the interview. She believes that Judaism has some laws that are restricting and limiting of some fertility treatments. She has strict views for some treatments even if she believes that couples who were struggling should have the right to have children. Her strict views are directly related to what she thinks Jewish law permits on the subject of fertility treatments. Ruth thinks that Jewish law does not allow most things and that treatments are complicated in terms of them being ethical and moral at times.

7. Julia

Aged 23; single; student

Julia considers herself Orthodox but leaning more towards the traditional side of things. She does not know much about Jewish law in general as even her family even though being Orthodox tend to be more traditional. This is parallel to what she knows about fertility treatments in general. She admits that she grew up in a family that is aware of new technologies. Her family did not restrict he intellectual or spiritual growth yet she does not know much about what it means to have or to need fertility treatments. In general Julia thinks that decisions should be made by couples. She feels that the need to have

treatments is a very individualistic need therefore it should be decided by those who need the treatments.

8. Vivienne

Aged 55; mother of 8; teacher

Vivienne considers herself an Orthodox Jew who observes all Jewish laws strictly. She is a female educator who teaches Jewish studies and she focuses on teaching women the spiritual side of Judaism. Vivienne also teaches young women before they get married, *Khala* teaching. Her teaching focuses on teaching women all the rules of family purity and more specifically the laws of *Niddah* and spiritual submersion in the *Mikveh*. She mentions that she did not know much about fertility treatments as with her teachings this was something that had never really appeared with the people she has previously taught. This was also paralleled with her knowledge of Jewish laws to fertility treatments. Nevertheless, Vivienne thinks that treatments offer great help for those who cannot have children naturally and this should not be taken for granted.

9. Perl

Aged 34; mother of 4; teacher

Perl is a Charedi Jew. For her religion is very important and in some ways the best guide book to live life by. She works as a female educator within the community. Perl also has the responsibility of teaching young women before they get married. This amongst other general teachings that she does within the community. Perl thinks that some fertility treatments are problematic in terms of Jewish law. Perl thinks that she does not know enough in the matter and more importantly she thinks that if you have a good and knowledgeable Rabbi anything is possible as he would know laws and work around the Halachic prohibitions. Perl feels that before couples chose a treatment or go forth with their journey with fertility treatments they needed to consult with a Rabbi with regards to every step.

10. Annat

Aged 21; single; student

Annat was starting her 3 year of university at the time of the interview. For her it is important to have Jewish knowledge as well as have a good university degree. She has some knowledge of fertility treatments and she is not a complete stranger to Jewish laws and the general view of Jewish religion to fertility treatments. Annat believes that there are ways to have treatments according to Jewish law. She thinks couples should be allowed to have treatments as treatments are great ways of helping those that are not fortunate to have their own children naturally.

11. Clara

Aged 21; single; student

Clara was in her second year of university at the time of the interview. She considers herself an Orthodox Jew who practices all Jewish laws to the best of her ability and with the greatest joy. For her it is a pleasure to observe Jewish laws. This goes along with the notion that she is not entirely familiar with laws towards fertility treatments. Clara thinks that it was important to have a Rabbi on board when it came to deciding treatments and procedures of things. She had very strong views on certain treatments and she thought that her views were based on what she knew of Jewish laws. At times, she felt that she did not know enough on the matter to discuss some topics.

12. Lori
Aged 23; single; student

Lori is a medical student and therefore she is very well versed in the field of fertility treatments. She understands treatments and more importantly she understands why some couples could struggle to have treatments and go through life without children. She thinks that Jewish law can be quite strict at times and this would mean that for couples this would be hard when deciding which treatments to have. Her general opinion is based on the need to help those who want to have children but that cannot. For her it is important to help those couples who are suffering because of their inability to become parents.

13. Laura
Aged 20; single; student

Laura is an IVF baby. This is something she admitted and excitedly discussed at the interview. She considers herself a modern Orthodox Jew. For her religion is important but it is also important to have general knowledge on all matters so that one can apply Jewish laws to daily life. Laura has a very open view about IVF and fertility treatments in general. She thinks that these treatments should be allowed within moral and ethical limits. Laura strongly believes that couples should be helped when trying to become parents as this can really impact their emotional and physical health.

14. Candice
Aged 45; mother of 5; retired

Candice who was retired at the time of the interview used to work as a teacher. She mentions that along her teaching years she noticed that fertility knowledge amongst young Jewish girls was very limited. She thinks that fertility treatments are not openly discussed in the community and this is the reason why young women are not familiar with such topics. Candice thinks that this is the case too with sex education. For her these topics are directly related and their lack of openness in the community means that girls grow up with limited knowledge therefore limited power when it comes to deciding future situations. Candice thinks that most treatments are allowed minus some minor complications with *Halacha.* Nevertheless, she thinks that this could be solved with a good and well knowledgeable Rabbi.

15. Batsheba
Aged 46; mother of 2; scientist

Batsheba works in an organisation that helps women undergo fertility treatments. She has a vast knowledge on fertility treatments and is also very well versed in the field of Jewish law with regards to ARTs. She believes that she is at an advantage because of her scientific degree and the knowledge on *Halacha* that she developed thanks to her position as a scientist at this charity that deals with Jewish women in need of fertility treatments. Batsheba has a very open mind when it comes to discussing treatments. She thinks that there are no absolute answers when it comes to having fertility treatments and this is with regards to Jewish law prohibiting any specific treatment. Batsheba knows that according to Jewish law most treatments are allowed so long they do not break any obvious *Halachic* law.

16. Esther
Aged 22; mother of 1; student

Esther is in her second year of medical school. Esther has been married for a year and at the time of the interview she had a 6 months old baby girl. Esther also helps to teach young women before they get married and this means that she also has some knowledge on the Jewish perspective to treatments and how some treatments might be more problematic than others. She is also familiar with all medical terminology and knows about fertility treatments. She is certain about specific treatments and this is based on the fact that she understands the science behind the treatments. For Esther, this is also based on the fact that now she is a mother and she can understand what it would be like to live without having any children.

17. Lydia
Aged 46; mother of 2; teacher

Lydia considers herself Orthodox and she believes that Jewish law gives her an important grounding on how to live her life. She feels that even though she is a lecturer in university and well versed in some topics of the world and culture she still does not really comprehend all about fertility treatments. Lydia has a basic knowledge on the matter and as such she feels she could not give her opinion on some treatments. Lydia also believes that there must be a good relationship between doctors and Rabbis as they are the ones that ensure that treatments are carried out. In her opinion these are the two parties that people in the Jewish community mostly rely on.

(6)Focus Group

Orthodox Jewish women discuss sex, fertility and reproductive awareness

This focus group was born out of my desire to learn more about what Orthodox Jewish women know about their reproductive health and fertility. This was made possible by the Chief Rabbi's idea to create the Ma'ayan program. This programme was to instruct Orthodox Jewish women on Jewish law, reproductive health, infertility and ART. The women that were recruited for the programme had to undertake some classes given by the professors and clinicians of the Institute for Women's Health. This close proximity allowed us to contact the administrator of the programme directly and ask her if we would be allowed to approach the women and ask for their participation in the study. Once permission was obtained we were able to chat to the women and ask if they would be happy to participate in the focus group. In total five women agreed to join the focus group. This included: Laura, Jenni, Sarah, Hannah and Michal. Women's names were changed to protect their identities. The focus group was carried out on the sixth of December of 2016 during a lunch break between classes in a Synagogue in central London. It was conducted by Joyce Harper as the main moderator and myself as the assistant moderator. In total there were five main questions and six sub-questions. The aim of the focus group was to understand who teaches sex and fertility education in the Orthodox Jewish environment, what is the general idea about sex and reproductive health in Jewish schools, how does this differ between boys, girls, married and single women.

Before starting this focus group, due to my background, I was aware that in some Orthodox Jewish schools all sex, reproductive and fertility education is very limited. Not only limited but also very restricted due to the delicate and sensitive view of all 'sex before marriage is forbidden'. When understanding how sex and fertility education is spoken about in Orthodox Jewish schools it was important for myself to remain flexible to what the women might share.

Some women thought that it was difficult to have this discussion because as Michal mentioned "*it is one thing to talk about girl's periods and things like that and sex is a totally different thing".* Being too open about sex could be dangerous in a community where sexual relations should be kept for after marriage.

Sarah shares her story:

> *"I went to a Jewish primary school not one of the most religious but Orthodox and we had sex education in year 6 and it was about how to make a baby. It was very positive and it was taught in a very positive way. It separated the girls and the boys for the hour. Actually, the boys learnt Guemara at that time or maybe that is just what they told the girls I mean thinking back I think they did and at the time I think the girls just thought this is our special time that we have and the boys went somewhere else." (Sarah)*

Sarah remembered this time with a good light. In secondary school Sarah mentions that she did not receive any sex or reproductive education. Her introduction to this information was kept short and simple.

Hannah, who is a biology teacher admits that in the school where she teaches they solely teach what appears in the science syllabus. She mentions that usually *"sex does not come out specifically but you do talk about male and female gametes".* Hanna goes on to add that it is assumed for students to be taught this type of information at home. In the case where this has not happened Hannah says *"it is suggested that they discuss it with their mother or father because it is felt that that is the most appropriate form to be sharing this information".*

On another note, Hannah also states that in boys schools they do not teach them anything to do with the menstrual cycle before their GCSEs. She also mentions that in some stricter schools they do not even allow the teaching of

the science syllabus that discusses reproductive health. Hannah recognised that contraception is a particular difficult topic to teach and that in most schools its is not taught because "*these girls are not sexually active and it will be something that they will learn when they get married".* An idea that was corroborated by Michal "*being sexually active before marriage is also not allowed. It is taboo".* Jenni takes this further and says teaching young girls about contraception could be problematic because *"some of the contraception methods available are not acceptable in Jewish law*". Michal suggests that in some schools which she is familiar with children are even not taught basic information about consent, their bodies and being touched. This was something that she thought had to change so she started encouraging the headmaster to bring in a course to teach these children about themselves.

Orthodox Jewish girls are expected to abstain from sexual intercourse. In some cases this might be exactly what happens but at times it could also be a complete assumption. Therefore limiting girls' knowledge based on that assumption could be dangerous to their reproductive health and decision-making. Sarah was able to recognise these risks and admits that this is a huge debate in Jewish circles and simply puts it as *"if do you could be condoning sex before marriage. But if you do not do it, you know there are risks".* She takes this further by saying that she would prefer to teach these topics to her children herself: *"I would be really upset if the school came in and did it for me. I am really excited for those conversations".* She thought that it was good for children to learn about these topics at home but it was important for parents to introduce children to them first. Michal was of the opinion that the school should be responsible for teaching these children.

Hannah usually teaches women before they get married in what is known as "*callah* lessons". She remembers being really surprised when a lady from her community who has a very confident personality, who she saw as a go getter, a feminist and a real powerhouse said to her "*when my daughter gets engaged will you talk her through the birds and the bees".* She was really surprised because she expected this woman's daughter to already know much more than other girls because she is not so religious and because of the way her

mother is. Women discussed whether the sensitivity around discussing sex emerged due to Jewish laws or because of what they called “English prudishness”. Michal and Laura admitted to being very shocked when on the Ma’ayan course they were shown a picture of a vagina. Sarah thought it was a British thing, “*Jews have been in Britain for 100s of years and I think we have incorporated every single stereotype”.*

Jenni and Sarah discussed how it was also important to hear this education from the Rabbis. Hannah and her husband usually teach the *callah* teachers too. For them it is important to talk about things in an open and comfortable way so that teachers can then pass on the information to the men and women of the community. This information usually included Jewish laws to various aspects of reproduction and sexual practice such as *Niddah* and contraception. Hannah mentioned that her husband also run a class called “sex drugs and rock and roll” for adults and this was something shocking in many levels for people because they did not expect the Rabbi to openly talk about these subjects.

Other difficulties when following a non-Jewish or non-*Halachic* curriculum would include teaching about same-sex couples. Michal mentions that usually children are just told “In Jewish law and in Jewish ethos we believe that a family is constituted by a man a woman and their children”. Children are told about it but are not explained that perhaps this new family dynamic could be the reality for many children in the 21st century. Sarah stated that in the more Orthodox schools, children are not told about same-sex couples at all.

All women agreed that there might be a number of children coming out of high school who have not been formally taught anything about sex education from their parents or their schools. Their first formal introduction to this education will be a few months before they get married. Laura stated that these classes are usuallt very explicit. Women are “taught how to make pleasure with their husband”, how to expect for him to make pleasure them, “what and which buttons to press, which way you touch, which way you kiss, it is very explicit and it is much more so than you would do in like a classroom or in a

playground". Michal adds that some teachers even have pictures to further explain scenarios to the men and women. She adds "*Every bride knows that during these classes she will get all the information she needs and she can ask any questions."* Women further added that the bride and groom will receive between six to ten lessons all individually.

In the discussion with the women other topics came to the fore-front of the conversation. Women felt that the age of first conception in their communities was relatively the same as to what it had been over the last five to ten years. But as Sarah pointed out that in some cases this changed and some couples might be having children earlier. She states that this is because "in the more religious circles there is more pressure to get married younger and have children straight away." Jenni also thought there were some exceptions to this. She focused on the Modern-Orthodox couples. Jenni thought these women "are much more career orientated" therefore they would focus less on trying to have children straight away. Globally this is something which has been creeping up all around the world. As women become more educated their age of first conception inevitably increases. Nevertheless, in Orthodox Jewish communities couples are expected to have children as soon as they are married. A lot of Jewish life is centred on having children, for example, attending circumcisions, going to *Bar/ Bat Mitzvah* (celebration of a boy/girl becoming 13/12), *Simcha Torah* (Jewish holiday that commemorates the completion of weekly *Torah* portion, children are specially brought to synagogue in this occasion to celebrate and given sweets), *Purim* (holiday where it is custom for children to dress up), to name a few. These occasions could become challenging for couples who want to be part of their communities but do not yet have children. Jenni refers to this and mentions that deciding to have children later could increase pressures some women receive from their communities. For those women that would deliberately chose to have children at a later stage in their lives Sarah states that they could be told to "get on with it and start a family". When women were asked if they knew at what age fertility started to decline they all thought at 40 years of age. This was also what they thought other women knew. There was really no place for women to learn that their fertility starts to decline for a much earlier age. Michal and Jenni reflected

on this information and felt that women should have the right to be able to do what they wanted with their careers and still known how this might affect their lives therefore be taught about potential fertility preservation methods.

After much deliberation about how to deliver this education women suggested two main ways to go about it. Jenni thought following a specific curriculum could be helpful for schools:

> *"I think there are two different ways of doing it. There is one way which is GCSE biology syllabus and the other one is an additional enriching type of syllabus. I think the focus is a bit different one focuses more on the matter and around it and have people growing up to understand social interaction and have a healthy awareness. So, I suppose there is where the Jewish community might be more sensitive because they want to do it in a Jewish way." (Jenni)*

Sarah suggested this would need certain approval:

> *"You have to do that in communication with some of the Jewish organisations because you need that ok, that certificate. So that people see it and they know alright this is "Kosher" otherwise it will be so complicated." (Sarah)*

This focus group concluded that sex education in the Jewish community is rarely given and when given it is based on the scientific curriculum. In the more Orthodox Jewish schools some of the information which is viewed as non-necessary is not taught in order to help maintain the "sex after marriage" discourse. Some of these schools totally abstain from all sex, reproduction and fertility talk. Women discussed the way sometimes schools expect parents to be teaching their children about such matters. The women were divided about this. Some thought that it was the school's responsibility and others thought it was the parent's. Women also agreed that some people might feel uncomfortable discussing topics of sex and reproduction because of the "British prudishness", something which they contested against the "taboo" of sex in *Halacha*. One clear pillar of this education in the Jewish communities

includes the "*callah*" teachers who teach brides explicitly information on sex, contraception, reproduction and fertility in a *Halachic* and Jewish sensitive way. Grooms also have these lessons with "*hatan*" teachers (*callah* Hebrew for bride and *hatan* for groom). Sarah and Jenni concluded that any information if to be taught in Jewish schools would have to be approved and "certified *Kosher*" by acknowledged Rabbis in the community. A simple way of introducing this information would be to make a curriculum that would help teach people about their fertility, reproductive health and sex in a way that will not necessarily encourage young students to have sex before marriage whilst still giving them all the information they would need to understand their body and be aware of their fertility decline.

(7)Recruitment Adverts

Figure1. Advert placed on Jewish Orthodox Facebook group

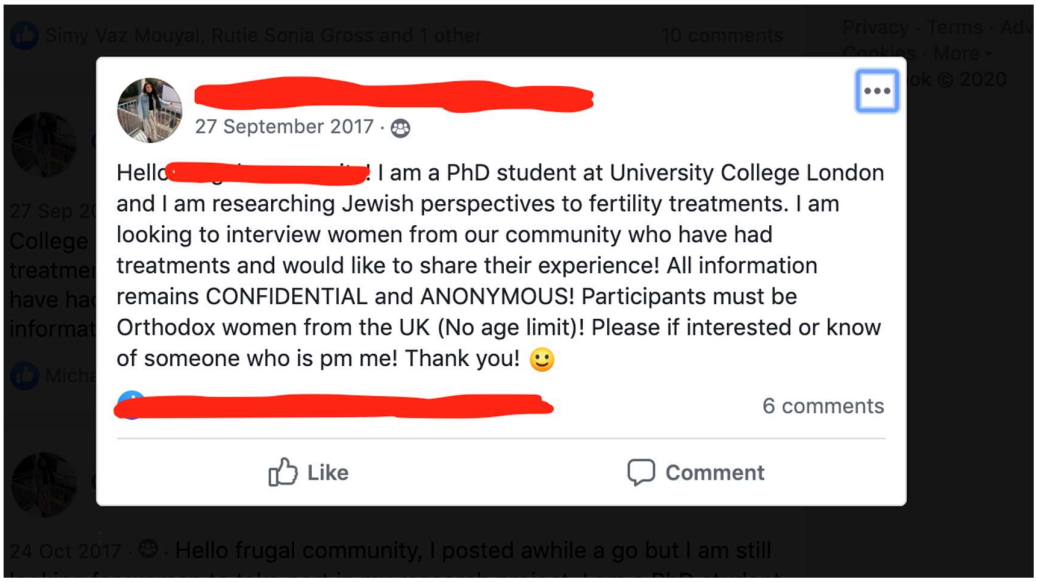
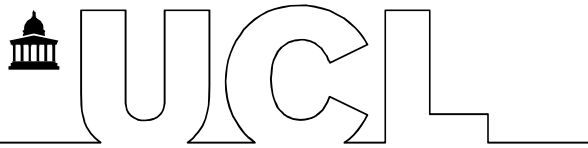


Figure2. Advert placed on Jewish weekly advertiser

(8)Consent forms for interviews with infertile women

UCL EGA INSTITUTE FOR WOMEN'S HEALTH



Religious ethics on Assisted Reproductive Technologies (ART)

Consent Form

I agree to take part in this interview. I give consent for any information that I give to be used in research and published anonymously.

Date: _____

Print Name

_____

Signature

_____

Signature of Interviewer

_____

UCL EGA INSTITUTE FOR
WOMEN'S HEALTH

Information sheet for the Research Study on:
Religious ethics: Experience of fertility treatments
Semi- structured interview

This study has been approved by the
UCL Research Ethics Committee
(Project ID Number 9831/001)

You have been invited to take part in a UCL-led research study being conducted to examine religious ethics, specifically Judaism, on assisted reproductive technologies (ART).

Before you decide whether you would like to take part, we wanted to explain what this research is about and what it will involve.

What is the aim of the study?
The main purpose of this interview is to explore women's experiences to fertility treatments in the Orthodox Jewish community.

What is the study trying to find out?
The overall aim of the project is to help individuals within the Jewish Orthodox community to have both better access to fertility treatments and increase everyone's' fertility knowledge. Results will be published as scientific literature.

What will happen if I take part?

The study is made up of a semi-structured interview which will be carried out by Alegria Vaz Mouyal a PhD student at University College London, Institute for Women's Health, under the supervision of Professor Joyce Harper and Dr Zeynep Gurtin. Interviews may last between an hour and an hour and half. It can be carried out where it is most convenient for you. Sessions will be recorded and transcribed by PhD student Alegria.

What will I be asked to do?

You will be sent the list of questions in advance of the interview and then on the allocated day, Alegria will record your answers to the questions.

Are there any risks in taking part?

The UCL Research Ethics Committee have approved this study, and we do not anticipate any risks to any individuals taking part in this study.

What are the potential benefits?

We hope that this study will help us produce guidance on fertility treatments for the Jewish community.

Will I have access to the results of this study?

Following completion of the study, we aim to publish the results in a peer-reviewed journal.

Will information about me be available to anyone?

Only anonymous data will be collected as part of our study. Any data that will be published, will be general population averages, and will not identify any particular individual.

Who will have access to the research records?

Only members of our research team will be able to look at the information we collect. Our study complies with the Data Protection Act (DPA) of 1998.

How can I contact the researchers?

If you have any questions or would like further information about this study, please get in touch via the contact details below.

Alegria Vaz
Institute for Women's Health
University College London
Email: [redacted]

We would be grateful if you could participate in this semi- structured interview.

Your consent is important to us

Please read carefully and indicate your choice below.

I (the participant):

- have read the above information page, and understand what the study involves.
- understand that if I decide at any time that I no longer wish to take part in this project, I can withdraw immediately.
- consent to the processing of my anonymised personal information for the purposes of this research study.
- understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.
- agree that my data, which is fully anonymised, can be shared with other researchers

This study has been approved by the
UCL Research Ethics Committee
(Project ID Number 9831/001)

I confirm that I am over the age of 18, I have read and agree with the statements above

Agree/disagree

(Please circle the appropriate answer)

Signature

Date

Thank you for your kind co-operation.

Alegria Vaz Mouyal, PhD student, UCL

(10)Semi-Structured Interview Guide

1. **Personal Information**

1.1 Age

1.2 Marital Status

1.3 Do you have a paid job?

1.4 Highest Education Level (e.g. GCSEs, A-Level, International Baccalaureate, undergraduate degree, etc)

2. Affiliation with religion

2.1 Do you affiliate to a particular stream/ denomination of Judaism?

2.2 Is religion important for you? If yes, in what way is that?

2.4 Do you have someone to talk to about religious matters?

2.5 Have you previously asked advice from a religious scholar in your community regarding matters outside religion?

3. Fertility experience

3.1 What is your story?

3.2 When it came to choosing treatments did you reach out to any religious leaders in the community for advice?

3.3 Did your fertility experience result in your increased or decreased practice of your religion? If yes, Why?

4. Fertility care givers and religion

4.1 How did your clinic respond to your religious needs- did they take any notice to religion/ culture?

4.2 Did you feel that medical professionals had a good training in relation to diversity and culture?

(11) Support resources for women

Charities for support in the Jewish community

Chana

Support for Jewish couples struggling with all aspects of infertility.

https://www.chana.org.uk
London based

Jewish women's aid

Support for Jewish women facing sexual and domestic abuse. This charity also helps to put in place support for emotional and psychological support.

https://www.jwa.org.uk/
London based

Domestic Abuse Helpline: 08088010500
Sexual Violence Support line: 08088010656

Puah

Can offer support on Rabbinical advice, medical treatments and emotional and psychological help – **online and via phone**.

https://www.puahfertility.org/

Based in Israel and USA

USA:

1709 Kings Highway

Brooklyn, New York 11229

Phone: 718.336.0603

Fax: 718.336.0683

Mailing Address: P.O. Box 297185: Brooklyn, New York 11229

Israel:

Phone: 02.651.5050

Fax: 02.651.7515

Tahareinu

Offer support to women and men when dealing with difficulties of *Niddah* observance and complications.

https://www.tahareinu.com/

London Branch

Address:

Gate House, Grosvenor Way

London E5 9ND

United Kingdom

Tel number: 02031501536

Dor Yeshorim

Help all Jewish women, men and children for genetic testing and screening.

https://doryeshorim.org/

London Branch

Hotline: 02088800208

Mrs Roth: 02088063038

Mrs Roth Mobile: 07968384542

Golders Green and Hendon please call:

Mrs Nahva Rose: 07984932634

Jnetics

Help to prevent and manage Jewish genetic disorders in the UK.
https://www.jnetics.org/
London Based

Tel number: 02081585123

ATime

Originally an American charity that now has an UK branch to help Jewish couples struggling with all aspects of infertility.

https://www.atime.org.uk/
London Based

Tel number: 02088002153

(12)Shternie's Interview: Example of transcript and interview notes

28/09/2017

I: Interviewer
Shternie: Participant

I: Hi Shternie, thank you so much for welcoming me to your home. If it is ok I will now ask you some questions. I will start with the more boring questions. What is your age?

Shternie: I am 27.

I: Are you married?

Shternie: Yes.

I: Are you in paid employment?

Shternie: No.

I: What is your highest education level?

Shternie: NVQ level4.

I: To which denomination of Judaism do you belong to?

Shternie: Orthodox.

I: Is religion important to you?

Shternie: Yes.

I: Why is that?

Shternie: I think if you don't have religion and you don't have belief then you don't have something to hold on to then you are just going to go down.

I: Do you have someone that you can talk to about religious matters?

Shternie: Yes, I have 2 very good Rabbis.

I: Did you ever ask them before about fertility questions?

Shternie: Yes.

I: I would now be happy to hear your story, whenever you are ready.

Shternie: My story is, I was a young girl when I got married I was 20 years old and I always thought that sex equates babies and very naively, it is not that I was brought up naïve I knew about sex from a young age and I had access to porn as well when I was younger so I had a bit of an unrealistic expectation and then I remember the first night of marriage and it didn't really work and then only finally after a week we managed to have sex together. But my husband instead of ejaculating he produced a lot of urine and for me as a woman I felt disgusted for him as a man he was ashamed and embarrassed. Anyway, next thing we tried again and it happened again, it is not like he was not getting an erection because he could get an erection but he was urinating. So, he went to his doctor and he said it is because you are religious and you do not know what you are doing. Afterwards I went to my doctor and he managed to refer my husband to a urologist where they did lots of tests and they found that he had a blockage, because when they did the sperm samples all there was in the sample was red blood cells and urine. So, they found a blockage and he had a surgery to remove the blockage and it was a metro-ejaculation it is where they basically electrocute the man through their bum to shoot the blockage out and through that the sperm they found inside they froze. It was a very low sperm count with only 2 % mortality and 1% morphology very low and they found it and froze that and said that it could be used for ICSI. At that time, we were refereed for IVF anyway, we were waiting for things to happen and a few months later just before my appointment I found out that I was pregnant which was quite a shock because we were told it would be impossible with his sperm, so yeah great I was excited but then I lost it at 8 weeks and had a very traumatic experience I was not treated very well in the hospital, 2 of the nurses quite anti-Semitic they were openly talking about Christianity in front of me but very much in a negative way like, did you ask them if they want the Halal lunch and another nurse said she was pregnant to get out of doing her Job whilst I was in the middle of a miscarriage and quite ill with it and then when I had my scan I was in Barnet the person doing the internal scan never told me that he had students in and instead of talking to me and asking me how I was feeling he would say to the students – oh look you can see here that she conceived from the right ovary and that this and that happened and he was just talking to the students about what I was going through without saying a word to me and that was really degrading. A few months later, by now he could ejaculate but it was very hard and as I said his sperm count was very low, he could ejaculate more frequent. We were told that we could go for ICSI, so I had a few blood tests before, MMR, HCG and HIV and this and that and my blood test came back and they said you are not immune to MMR, but I had had the vaccine when I was a child but still it said I was not immune. So, I had to do it again, I had all the IVF drugs in my fridge and I had all ready for this and now I needed to put it all on hold for another 3 months because of the vaccine. 3 months after I had another blood test and again it said I was not immune to MMR even though I had just had the vaccine, anyway, they finally concluded that I cannot become immune to it because my body cannot become immune to it. So, they agreed to go through with the IVF anyway, it was so hard, they put me through menopause with the spray and the injections were very hard like everything would be like "I cant do it" yes it wasn't fun and when I was going through the cycle they were going to use the frozen sperm from my husband but again it was very low and we wanted to

use fresh sperm because they said that they could use a needle and take it straight from the testes to them use that sperm and that is what we wanted because they said that that would have a better quality for ICSI. That is what we wanted and what we had agreed on, the problem is that on the day of egg collection it was Passover so me my mum and my husband we had spoken to a Rabbi and were allowed to get on a car on the Jewish holiday but the problem is we were told that we could not sign anything on the day. The problem was that to be able to do this little procedure they needed a signature otherwise they could not do it. So, this mean that the sperm they used was not very good sperm and they had to use that. We were very upset, they told me afterwards that I had produced 18 eggs and on the day of the embryo transfer they said that was very good because the 2 highest scoring embryos would be inserted. So, they asked me to sign a form saying that if there were twins I would not be upset, so I was like fine, I would be delighted to have twins. Then a week and a half later I started bleeding and I went into quite deep depression because I thought well felt that they had promised me twins of course they had not but I was expecting twins, I was not expecting nothing and I had built up my hopes very high and I was convinced that it was going to work. A few months later they used the frozen eggs and that time I did not build up my hopes and I just kept telling myself it wouldn't work, but when it actually did not work I again plunged into quite deep depression. I work with children in a nursery that is my background and at that time all the teachers were pregnant all the mums were pregnant, the kids were always talking about babies and this and that and it is not an easy environment to work in and I remember sitting in the stuff room one day and a teacher was saying that she was getting married, she was not religious, and she was saying "I have worked it all out. I am going to get married on the Tuesday I am going to get pregnant then I am going to start my maternity leave from here and there" I was thinking what a stupid woman it doesn't just happen like that and then I found out later in a staff meeting that this teacher was going on maternity leave and I just run out of the meeting in front of 45 members of staff crying hysterically. Anyway, afterwards about a year or a year and half later, my husband he wasn't ejaculating urine anymore but it was not completely sperm the chances of me becoming pregnant were very low. About a year and half later we went to a fertility show where everyone is selling their fertility clinics and medications and there was one stall that was selling an item calling proxeed and it was claimed to be a miracle drug that boots your fertility and this and that so my husband took it for 3 months and then afterwards he went back to andrology and he had more tests and everything had increased by 50% so this was very good and the andrologist spoke to us and told me exactly when to have sex and when to use the ovulation tests and long the sperm lives so when not to have sex etc very quickly I became pregnant.

I: That was a natural pregnancy?

Shternie: Yes, that was and afterwards all my pregnancies were natural. So, I had another 3 natural pregnancies afterwards and lots them all. Then they found out I had a heterogeneous mutation of thrombophilia meaning that my blood is very think so it clots a lot when I am pregnant so it causes clots in the placenta which kills the babies but all these pregnancies they thought they

were ectopic as I was in a lot of pain, for all the miscarriages I got very ill and mentally too, I got very low and then I started to get a phobia of sex because for me sex equated miscarriage and failure it was just horrible. But then I became pregnant again and I was not supposed to become pregnant then I was not allowed any hormones since I was using the diaphragm and I was in Saint Marys hospital and they said I was not allowed to become pregnant because they were doing all these tests, in the meantime I had gone to a private gynaecologist for the testing and he had given me the answers about this, but afterwards when he realised it was for fertility he gave me a bill of over £1000 but then I realised I was pregnant so the lady in Saint Marys shouted at me over the phone, basically I had forgotten to use the diaphragm, so I asked to go see someone and she strictly wanted me to come when I had my appointment but I was worried that I would have lost the pregnancy by then. So, I was not sure if to use the hormones and the aspirin anyway I phoned the private gynaecologist and stopped taking the aspirin and it was so horrible to inject myself every day. At about week 8 I begun to feel sick and my mum said it is amazing it is like a proper pregnancy until it became sever hyperemesis and I ended up in hospital for most of my pregnancy and now my 2 and half year old is chatting away upstairs in his bed. Thank God, he is healthy, he was born not breathing and needed resuscitation and was in special care for a week but he is alive and he is healthy. I am petrified of ever having another child again and that is my story.

I: Thank you so much for sharing that with me, and you are very strong for reliving this story with me.

Shternie: I am not strong look I am not (points at the fresh marks on her arms) I was in hospital again yesterday I am not strong at all.

I: You are strong for being able to open up and speak about it.

Shternie: I had a very bad experience with the counsellor, at first it was ok and then as soon as she found out I was bisexual, bisexuality is not allowed in the Jewish community because I am going to cheat on my husband and it is my fault that he cannot ejaculate because I cannot turn him on. Those were the things she was saying to me. My husband went mad, he said so what if she is bisexual she is with me and she is not cheating on me. I have now made a formal complaint but mentality she made me very ill and when I had my first miscarriage she said it was good because I had mixed sexual feelings.

I: This is nothing to do with you as a woman or your sexuality.

Shternie: I know I cannot imagine never having another child and I have not been in the hospital for 3 and half months but I was there yesterday and I had the police and the ambulance take me to hospital all the nurses in the Royal free know me by name.

I: Look now you need to just focus on yourself and give yourself time to get back into it and appreciate what you have.

I: Do you think infertility has affected your mental health?

Shternie: It has definitely made it worse, every time I had a miscarriage, it was horrible. I never got the support in the hospital, before I had IVF they asked me if I wanted free counselling in 3 months- time. So, yes, they never dealt with it in hospital.

I: When you were going through this experience did you speak to a Rabbi about it, say to ask about different things etc…?

Shternie: Yes, we were in touch with a Rabbi and at one point we were speaking about sperm donation and I went to a support group not for Jewish people but for everyone in the London clinic, I went once a month and there was a really lovely lady there who had 2 adopted children.

I: Did your family know do they know now what you went through and are still going through?

Shternie: Yes, so for my first miscarriage my parents were away so I had my mother in law with me and she was also with me when another pregnancy ended quite early, I had her in with me during an internal scan, anyway she never looked. I am quite close to my mum, I am close to my parents they are a good support.

I: Do you think that his experience has brought you closer or further from religion? Did you find any consolation in religion?

Shternie: I am not sure, in some ways further and in other ways nearer because it meant that we had to speak to our Rabbi more often but then further because of that counsellor, I thought well maybe that is what all Jewish people think and maybe she is right and I am not allowed to be a mum and every time I am finding things hard I think maybe she is right and everything is because I am bisexual. I refuse to see a counsellor, I am still Orthodox but I refuse to see a Rabbi or speak to anyone religious as I am afraid that they will judge me like she did. Nevertheless, last week I have a very good chat with my Rabbi and he was great support.

I: When you were in the Barnet hospital you also felt that the nurses were also not understanding and great with religion?

Shternie: Yes, not at all. They were not understanding and I was so upset I wrote a letter to complain.

I: Do you think healthcare professionals need to be more aware of religious aspects?

Shternie: Yes, definitely and not only for fertility but how to deal with things emotionally, think a lot of doctors and embryologists are only focused on the egg and the sperm and not the person, like we are actually people and not just

an egg or sperm or body to inseminate you are a person as well and to offer someone counselling 3 months after a miscarriage is laughable.

I: What about with religion, should health practitioners should be more informed?

Shternie: Yes, I am still angry at my husband's doctor who said that it was because we were religious that he ejaculated urine and that we did not know what we were doing. Also, the fact, I understand that you need to sign for different procedures but they knew beforehand that my husband would not be able to sign on that day and they had promised that it would be ok and then on the day it was not. That was very upsetting, I always think that it would have been the better sperm if it would have worked. But you know what I cannot keep living in the past now I have my baby.

I: Yes, that is right and everything happens at the right time. Thank you so much those are all the questions for today.

Notes:

- Participant had fresh marks in her arms and a bandage
- Fresh scars from self-harming
- Participant was anxious throughout the interview: she kept changing position in her chair
- It seemed that the participant carried the blame for husband's sperm problem
- Low self- confidence constantly blaming herself
- Participant felt that he community made it seem like everyone needed to produce multiple children "Baby factory": this puts lots of pressure on individuals and makes it harder to go out of the house and feel happy with ones' life
- Participant said husband felt ok about their inability conceive but that she took all the blame and felt the failures personally and constantly blamed herself for it

(13)Reflexivity Journal: Example from Shternie's interview

Shternie's interview

Shternie seemed to be very welcoming and sweet. She welcomed me in to her home, we had the interview in the evening. Her husband was not home and her baby was upstairs sleeping. In the house I saw many cute pictures of her family and they seemed to be a totally "normal Orthodox family".

Before the interview started she told me that she had just come back from the hospital a few days ago. She did not say exactly why that was but she hinted and pointed at the fresh marks on her skin where potentially she self-harmed. Despite this remark, as the interview goes on Shternie is totally open and honest with me, she talked about her infertility struggle and she did not seem to be intimidated by the fact that I was a stranger coming in to her house.

Throughout the interview Sthernie appears anxious, she moves constantly in her chair and though she is open about her experience she seems almost embarrassed or ashamed of what she is sharing. It seems like she feels at blame for their inability to conceive. Infertility to her seems like a personal burden she is carrying. It also appears that she thinks religious "Orthodox" people are not very nice and that they judge her for having mixed sexual feelings.

During the interview we had to pause the recording a couple of times as Shternie began to feel very emotional. These breaks were good for her. This allowed her to take a breath and stop for a few seconds before continuing to share her difficult story. During the breaks I offered to get her a hot drink, this made her laugh because we are in her house after all and she should be the one offering.

This interview was particularly difficult. Though I had been preparing myself to interview women that had struggled with infertility and women who would of course have and were facing emotional and psychological stresses I had never

thought that in this midst I would interview a woman who was struggling with infertility as well as mental health. This caught be a bit “off-guard”. During the interview I tried my best to remain calm, positive and to practice my active listening skills. It was so important for me to appear as an accepting person that would not judge her for her feelings and her actions. I think I did well.

Actions after this interview:

- Add on to the list of support mental health resource – Jewish Women’s Aid
- Read up about how to talk to women who self-harm
- Develop kindness and patience when talking to women struggling with infertility and mental health
- Access at the time of each interview if more/ less questions need to be asked
- Remain flexible with the interview guide

(14)Women's reproductive biographies

Sarah

Aged 55; became a mother of twins using Jewish donor eggs at 46; Modern-Orthodox.

Sarah was determined to have children and did all she could in order to achieve her reproductive dream. Currently Sarah, who is a single mother, is not working and is dependent on the family business to have an income for her family. She seemed strong and quite independent but due to the financial struggle she had to refer to her family for support when having ARTs and her livelihood. Sarah believes religion is vital and the backbone to the structure of her life. Her personal challenge included marrying a friend whom she did not particularly like in order to have a child that would be fully recognised as Jewish. Sarah did not have viable eggs of her own so she needed to have egg donation in order to children. Initially the London Beth Din recommended her to use a non- Jewish egg donor to prevent any future problems of incest or the future offspring marrying each other. She was not too keen about this so she found a way to have a Jewish egg donor as this was what she was more comfortable with. Soon after having her twins she got divorced as the relationship with her husband was solely in order to have children that would be recognised by Jewish law.

Rachel

Aged 56; history of miscarriage, ectopic pregnancy, and several IUIs; at 40 and 42 she naturally conceived a daughter and son; Orthodox.

Rachel firmly believes that being Jewish gives meaning and purpose to her life. This thought was strengthened throughout the interview as Rachel constantly referred to her infertility challenge as a test sent to her by God in order for her to better herself as an individual. She struggled with multiple gynaecological complications including abnormal cervix cells at the age of 35 that lead her to loop incision of the cervix. That year she had another loop excision of the cervix and in 1998 she had a hysteroscopy. She then had a

miscarriage which resulted in her needing a D&C. She went on to have a laparoscopy to check why she was not getting pregnant. She had an ectopic pregnancy that left her with only one healthy fallopian tube. In between miscarriages, she had a few IUIs that all failed and she then started to consider IVF. While preparing to undergo IVF Rachel conceived naturally and had her first child at the age of 40, a girl. She went on to have another baby naturally at the age of 42. Rachel based her desire to have children on the need she felt to give and share love.

Ana

Aged 30; in her first attempt at IVF she conceived a daughter at age 27; Now she is trying for a second child; facing miscarriages and difficulties; Modern-Orthodox.

Ana is an alumni of a religious seminary. She comes from a Charedi background and has been Orthodox all her life, nonetheless she considers herself modern Orthodox and using her own words an “open-minded person”. She got married at the age of 19 and for the first five years her husband and her did not worry about conceiving and having children as they had ‘fun’. She considers herself a workaholic and refers to her work as ‘my baby’. Ana is a bookkeeper and works for an accountancy firm. She mentions that for her having children was not a stress and throughout the interview one can sense that she wants to have children to belong to her community as that is what it is expected of her. Ana states that she is not the norm in her community. In the Jewish community it is a tradition for people to get married and have children straight away. After the first IVF cycle she was blessed with a daughter. At the time of the interview she was getting ready to embark on the third round of IVF cycles in the pursuit of her second child.

Yael

Aged 37; one miscarriage and had a baby boy thanks to egg donation at 38 after her second attempt of IVF; Modern-Orthodox.

Yael is married and has a master's degree. She is not originally English but has lived in London for many years. Yael comes from a family of doctors and is familiar with most medical terminology. She started seeking treatments at the age of 37 and she found that she had a unicornuate uterus and was in premature menopause leaving her no choice but to opt for egg donation and pray that she would be able to carry a baby to term with her smaller than usual uterus. Yael was very emotional when talking about her husband. She felt that she was really blessed to have him as a partner in this challenge. At the time of the interview Yael was five weeks pregnant. Later on, she contacted me and informed me that she had miscarried but after another successful treatment she managed to have a baby boy in 2018 with the help of egg donation.

Miriam

Aged 38; mother of four, two naturally conceived & two with the help of Chlomid; she was 25 when she had her first child; Orthodox.

Miriam is self-employed and firmly believes that religion is everything. It is a guide for her day-to-day life. It is also what gives structure and meaning to her life, her family and her community. She comes from a family of late bloomers. All women in her family started their periods late and all had children at the age of 30. Orthodox Jews would consider this as an older mother. Miriam wanted to follow Jewish law when seeking help with infertility despite her negative feelings about sperm collection. When discussing her infertility experience she seemed to be very emotional and affected by Jewish laws and the restrictions these imply. She also admitted throughout the interview that she felt very closed about her infertility and this was not something she wanted to share openly. Miriam is a mother of four. She considers herself lucky and blessed by God. Just when she gave up trying and seeking help she was 'given' two more children unexpectedly. She considers herself to have had a happy ending. Miriam admits that having children was vital in her life and something that she could not have done without.

Shternie

Aged 27; male infertility; after multiple miscarriages and complications she conceived a child via IVF at 25; faces severe depression; Orthodox.

Throughout her interview Sheternie described herself as someone who is weak mentally and unwell psychologically. Her words were corroborated by her physical appearance. Shternie had displayed fresh scars most likely from self- harming on both arms and a newly set bandage. Shternie also mentioned that as the years went by in her marriage, she started to identify as bisexual and this caused her some problems in the community as often counsellors treated her differently. Throughout the interview she was anxious and nervous. She demonstrated this by not being able to stay still in her seat and constantly moving and changing position in her chair. Nevertheless, Shternie opened up to me and told me her infertility journey. Shternie comes from a very Orthodox family background but she considers herself just Orthodox. She got married at 19 years old and in her simple thinking she always thought “sex equates babies”. Soon after the wedding, Shternie finds out that her naïve thoughts were not real. During intercourse, her husband could not ejaculate normally instead he produced a substance that looked like urine. Her husband has a condition known as retrograde ejaculation. After seeking medical help, the couple start multiple rounds of ICSI. Some cycles resulted in pregnancy, but all ended in miscarriage. These failed attempts started triggering depressive thoughts and negative feelings about herself. From here her mental health deteriorated and got worse progressively. Sheternie feels pressure to have children from her community. She admits to never having truly opened up to anyone about why her and her husband need IVF. She hides it from her community that essentially it is due to her husband and this inevitably increases her feelings of self loathe and inferiority. Shternie became a mother at the age of 25. Currently she lives in fear of the possibility of restarting the ‘baby making machine’.

Shosh

Aged 33; history of ectopic pregnancies, gynaecological complications, IUIs, IVF, miscarriages; childless; Orthodox.

Shosh believes Judaism is important and is essential in life as it is every Jew's mission to ensure that as a religion it survives and it is passed on through the generations. Soon after she was married she started trying to conceive at the age of 27. She managed to get pregnant but had an ectopic pregnancy that resulted in one of her fallopian tubes being removed. She started with IUIs and eventually she needed more help and opted for IVF. At the time of the interview Shosh has just come out of the back end of multiple rounds of IVF cycles some with PGT that resulted in pregnancies but that eventually ended in miscarriages. She has recently developed diabetes and due to this complication, she needs to wait before she can go any further with fertility treatments. Shosh believes that there is a huge pressure in the Jewish community for couples to have children straight away. She insists that this is a negative pressure that only adds to the negative struggle of undergoing fertility treatments. Unfortunately, Shosh has not yet been able to have a child.

Rebecca

Aged 32; history of medical conditions and PCOS, used Chlomid and tried IVF; mother of four naturally conceived children; she became a mother at the age of 27; Orthodox.

Rebecca is a full-time teacher. She considers herself Charedi but more Orthodox. Her father is a Rabbi and she firmly believes that Judaism only helps to give light to the world and help find meaning in everyone's day-to-day life. Rebecca knew that she had PCOS from a young age and has struggled with various medical problems including a mixed connective tissue disorder which mimics lupus and abdominal surgery just before she started trying to conceive. Due to her health conditions, Rebecca and her husband David could not start trying to have children straight away and she needed to go on the contraceptive pill. She then started treatment with Chlomid. This was not very successful as it was believed that she suffered a mid-facial paralysis due to

her ingestion of the Chlomid pills. After multiple brain scans and tests, it was then decided that she could undergo IVF. Just before her IVF, Rebecca found out that she was pregnant. Rebecca has now conceived naturally and given birth to four children. At the time of the interview, David was present. He took part in answering some questions and was quite knowledgeable about all treatments and scenarios. Both Rebecca and David were happy and comfortable discussing their struggle to parenthood and both were comfortable and open in each other's company.

Leah

Aged 35; has Rokintansky syndrome; mother of three children born via surrogacy with a non-Jewish surrogate; she became a mother at the age of 26; Modern-Orthodox.

Leah believes that religion and community are everything. These two components for her go hand-in-hand and represent Judaism for her. Religion is the means by which her family and community stick together and a code by which she lives her day-to-day life. She considers herself Orthodox but mostly modern Orthodox. Leah discovered at the young age of 16 that she did not have a uterus: she had Rokintansky syndrome. This meant that if she ever wanted to have children she would need to have a surrogate to carry her 'babies'. When she met James, her husband, she told him about her situation and he was accepting and decided to work through the problem with Leah in order for both to have children and have the family that they both so much wanted. They got married when Leah was 24 and only started looking into having children one year after their marriage. They knew that they would have to endure IVF treatment and also face obstacles with regards to surrogacy and Jewish law. Leah and James are now parents to three healthy children all born through IVF with their own gametes vias surrogacy.

Lisa

Aged 36; After many complicated cycles of IVF she became a mother of three children via IVF; became a mother at 31; Orthodox.

Lisa believes that the beauty of Judaism as a religion rests on the tradition and the importance placed on family and togetherness. She firmly believes that having children gives meaning to womanhood and a woman is not complete if she fails to have her own child. At the age of 16 she had an ovarian cyst removed and from the age of 19 she started taking the contraceptive pill. Lisa got married when she was 26 and only started trying to conceive when she was 28. Lisa admits that she never thought that it would be difficult to have children. She assumed that it would have happened as soon as she stopped taking the contraceptive pill. Due to an emergency trip to A & E Lisa discovered that the surgical removal of the cyst had left her with scar tissue that was getting inflamed every time she ovulated. On her first cycle of IVF there was a complication which resulted in the medical blocking of one of her fallopian tubes. Her second treatment resulted in a healthy pregnancy. Two years later, after much pressure from her family, Lisa and her husband started pursuing IVF again and they had twins.

Naomi

Aged 45; history of IUI, IVF and ICSI; had a son with the help of egg donation at 42 (non-Jewish egg donor); Orthodox.

Naomi was 36 when she got married. For her it was obvious that it would be harder to conceive as she was already at an advanced age. After having an ovarian reserve count, she found that she had a very low egg count but still she could try and with a little help she might be able to conceive. Naomi was introduced to the world of fertility treatments by having first IUIs. She had a few cycles which were not successful. In the middle of an IUI cycle she developed severe back pain and she had to stop any kind of fertility treatments for three years. After that rest period, Naomi restarted treatment. She had a few cycles of IUI and unfortunately these failed too. Upon recommendation from her doctor she started looking into IVF and ICSI. As it turns out after the three year gap a new test on her follicle count revealed that she had no viable eggs left and her only option would be egg donation. She admits her husband was not crazy about the idea of needing an egg donor, but this was the only way in which ‘things’ – to quote her words – could to be done. Naomi mentions that

for her this situation was complicated not only because she did not fully understand it would work with egg donation but also because internally it was hard for her to accept that she would need an egg donor. Her anxiety and stress were also affected by the vast implications involved with regards to Jewish law and the use of egg donors. Naomi was 42 years old when her little boy was born as a result of egg donation.

Vicky

Aged 36; first IVF cycle resulted in a child at 35; Modern Orthodox.

Both her and husband believe that 'secular education' – in her terms having a university degree – is very important. For her Judaism is what holds her family together and what gives structure to her life. Vicky started trying to conceive when she was 32. For two years she tried without seeking help but this did not work. After that time, Vicky looked for medical help. After some tests, she discovered she had a few gynaecological problems. Vicky needed to wait a few more months before she could restart fertility treatments as she was on strong medication for her gynaecological problems. She openly admits that following some Jewish laws with regards to *Niddah* could have limited her chances of getting pregnant and this makes her upset as she felt that she had to lie to the medical professionals when they asked her about her intimate life with her husband. After waiting for a long period of time. Vicky had IVF and was successful on the first cycle. She had a baby at the age of 35.

Dina

Aged 34; male infertility; mother of two via sperm donation (non-Jewish Sperm donor) and IUI; she became a mother at the age of 29; Traditional.

Dina considers herself Orthodox but mostly traditional and at times not fully observant of Jewish laws. Her husband Joel was present at the time of the interview. This was particularly interesting as Joel's sperm was not viable. They required sperm donation in order to conceive their children. Before this discovery, Dina and Joel had three rounds of IVF with Joel's sperm but unfortunately all cycles failed. They also had a round of ICSI which was also

unsuccessful and then they later decided to opt for treatment with a sperm donor. She used donor sperm for the first IUI. This was successful and they managed to have a little boy. For their second child, the couple tried six rounds of IUI until it finally worked. Joel states throughout the interview that these children are very much his and Dina agrees in stating that these are both their children as they will raise them and guide them throughout their lives. Dina knew she wanted to have a child so needing sperm donation was not a limitation for her. Including the difficulties that this poses in terms of Jewish law. In fact, at the time of the interview, Dina replied to the questions in a style of 'matter-of- fact', her path to motherhood was what it was and she could not change it. This was the way in which Dina seemed to have taken her situation.

Karen

Aged 30; history of IUI, IVF, ICSI; childless; Modern-Orthodox.

Karen is a firm believer that religion is very important. Her family has always been more observant but throughout the years to quote her words "I think through time and learning I learnt to appreciate why we do certain things and that it is for our better self to better ourselves". She considers herself 'middle of the road' and an intellectual. Karen got married when she was 23 and she admits that she was not desperately trying to get pregnant and start a family. She mentions that this was more something that her husband wanted. To add to this Karen's husband has always wanted to have a large family. Karen had tests to try to identify any medical problems but there seemed to be no obvious reproductive problem for Karen so she was recommended to start on IUI. In total, she had four and all failed. In consequence, she was recommended to start IVF. Karen tried ICSI for the first cycle and she describes the experience as it being very hard physically and emotionally. Karen hates how the treatments have distanced her from her husband and the pressure that it puts her relationship through. At the time of the interview after having had three cycles of failed IVF and ICSI resulting in no children, Karen and her husband are looking into having treatments in other countries, perhaps USA, Canada or Israel.

Victoria

Aged 39; history of miscarriages; mother of two via IUI; became a mother at 30; Modern- Orthodox.

Victoria is a lawyer. For Victoria having children was not initially a priority. Victoria and her husband were happy to travel and have fun together before becoming parents. She admits that she used to take fertility for granted thinking that if young girls could get pregnant from one night stands, why would she not be able to have a child with the man she loved and was rightfully her husband? She got married in 2003 and three years into the marriage she started trying to conceive. Initially she got pregnant naturally and that unfortunately ended in a miscarriage. After that she started getting help from her doctor with ovulation kits and that eventually progressed to IUIs. After a few trials of IUI she managed to have her daughter. One and half years after her daughter was born she decided to start trying again and soon after she was pregnant with her second child.

Gail

Aged 28; history of IUI, IVF and naturally monitored cycles; mother of five all naturally conceived; became a mother at 20; Orthodox.

Gail had her first daughter naturally when she was 20. Soon after that she started taking the contraceptive pill. When her daughter was about one and half she decided to stop the pill as it was playing around with her cycle and she kept spotting which meant she had to keep going to the *Mikveh* and had to start the *Niddah* process again. After a year of trying with no results she decided to seek medical help. After a few test it was found that at the age of 22 Gail had a low ovarian count and would require IUI or IVF in order to conceive. Gail then started to prepare for her IUI. What usually happened in these IUIs is that Gail would over stimulate and for that reason they would need to postpone treatments. After speaking to an acquaintance, she decided to change doctor. Gail then decided to have naturally monitored cycles. This meant that her ovulation would be controlled by scans and the best time to have intercourse would be highlighted to her. She then got pregnant on her

second monitored cycle with the additional help of progesterone and she had a boy. Six months later she found out she was pregnant again and she continued taking progesterone. Soon after her third child was born she found out she was pregnant with her fourth and this happened again with her fifth child. After that she had two miscarriages. She firmly believes that this is related to the fact that she did not take progesterone for those two times. At the time of the interview Gail was six months pregnant with her sixth child.

Sandra

Aged 45; history of IUI, IVF and ICSI; mother of three, one naturally conceived & two via ICSI; she became a mother at the age of 32; Orthodox.

Sandra became a mother naturally for the first time at the age of 32. After trying and failing to get pregnant a few times for her second child she started seeking help in order to become pregnant. For many years Sandra struggles with infertility without knowing why. She visits many doctors and specialists and all tell her that there is no clear medical reason as to why she cannot conceive. This then takes her through multiple rounds of IUI which were failed attempts at conceiving. Then she tried IVF and ICSI. Initially these were not successful either and only after multiple attempts did she manage to conceive two children with the help of ICSI. Sandra describes this experience as soul destroying. Knowing that she had had a first child naturally only made her feel less "normal". She felt that this experience isolated her from her community which expected her to have a large and numerous family. Now when she looks back Sandra recognises how she took fertility and reproduction for granted. With her children came the realisation that fertility is a blessing and a gift from God.

Rina

Aged 32; history of miscarriages, medical complications and IVF; mother of two via IVF; she became a mother at 29; Orthodox.

Rina is a woman who likes the idea of being religious. She sees Judaism as an important part of her life as she has been a practicing Jew for all her life. She got married when she was 23 years old. Three years after her marriage

and not being able to conceive, she went to a fertility specialist. Rina and her husband were diagnosed with unexplained infertility and it was decided that their best bet to parenthood would be IVF. Rina got pregnant twice following the IVF cycles but both ended with a miscarriage. After having a few blood tests she found that she had very thick blood and that this could explain why she was miscarrying. Knowing this information on her next cycle with IVF she got pregnant and had a girl. Once her baby was born they decided not to take any contraception and keep trying for a second child. As this did not occur again Rina sought out help and underwent another IVF cycle. During this cycle, there was an emergency as Rina was cut internally during embryo retrieval and she lost a lot of blood and this caused a delay in the process that set her back for six months. Six months later she had another IVF treatment with frozen eggs. This resulted in an ectopic pregnancy and a healthy pregnancy. In other words, she was carrying two embryos; one in her uterus and another in her fallopian tube. Thankfully she managed to have the ectopic pregnancy removed, sadly with the fallopian tube, but she managed to carry the second healthy pregnancy to term to deliver her second child. Her second child was eight months old at the time of the interview but even so Rina spoke of perhaps undergoing further treatments in order to increase her family.

Dalia

Aged 58; history of miscarriages and IVF; had a baby at 41 via IVF; Orthodox.

Dalia is an engineer. She used to own her own business but she sold it when she had her daughter in order to focus on being a mother. Being Jewish for Dalia is a privilege. Dalia felt that for her being religious was an advantage, especially when she owned her business. She got married when she was 37, Dalia admits that it was a late age to get married but also admits that she was not looking to get married young in life and she wanted to be established and have some money of her own and her independence. Soon after she was married she had a miscarriage and then it happened a second time. At this point she was about 39 years old and for her this was the turning point that pushed her towards finding reasons as to why she was not able to carry a pregnancy to term. After having a few unsuccessful IVF treatments, she got

pregnant naturally and the baby was found to have some malformation that was not compatible with life and it again ended up in a miscarriage. She then got pregnant a 4th time but again it ended in a miscarriage. Dalia and her husband really thought there must be something wrong as they kept having multiple miscarriages. At this point she was 41 years old. She was found to have very thick blood. After a few trials of IVF, she had a girl through a pregnancy that she describes as miraculous.

Sam

Aged 40; history of IUI and IVF; mother of four naturally conceived children; became a mother at the age of 30; Modern-Orthodox.

Sam considers herself modern Orthodox and openly accepts that Judaism is the blue print for her life and her day-to-day routine. Sam got married when she was 24 years old. Both her husband and her wanted to start a family straight away but unfortunately it did not go as they intended. They were living in the USA at the start and she went to seek medical help and had a few tests done in order to see what was happening in terms of her reproductive system. After a few months of unexplained infertility, she was told she should try IUI. Unfortunately, this did not work and so Sam started trying to conceive with IVF. Unfortunately, this also did not work. In between trials Sam and her husband decided to move back to the UK. Once established in London they decided to start looking for help. Sam had a few cycles of unsuccessful IVF and then decided she needed to take a break; she could not cope with it emotionally, physically and financially. Suddenly one day she begins to feel unwell, to her surprise they found that she was three months pregnant. Sam proceeded to have three other children naturally after that pregnancy. In the end, she had four children in the space of four years.

Joana

Aged 51; history of IUI and IVF; mother of one via IVF and twins via egg donation and IVF (non-Jewish donor); currently mother of one; death of one foetus and one baby; became a mother at 39; Modern-Orthodox.

Joana converted to Judaism at the age of 37, soon after meeting her husband. From that moment on Judaism became her life. Joana describes religion as giving her direction and helping her find a place in this world. She believes that Judaism is also a religion based on tradition, family life and unity. Only when she finished her conversion was she then able to marry her husband. Straight away they wanted to have children because they were aware that they were going into it late. Joana had a feeling that she might have some issues as she knew that she ovulated early on after her period and this was slightly problematic with the 14 days of sexual abstinence of *Niddah.* She went through a few IUIs to discover that they were not very helpful for her and so she moved on to IVF. With IVF, she did manage to get pregnant but after six weeks they could not detect a heart-beat. On her third attempt, she got pregnant and she had a girl who is now 12 years old. When her baby was a couple years old she decided to start treatments again. Unfortunately, this was not successful and so they decided to try egg donation. On the first trial, it worked and she got pregnant with twins. Due to some medical complications one of the babies died but she still needed to carry both to term in order to save the other baby. 16 months after birth the baby developed epilepsy and unfortunately he passed away a few months before my interview with Joana. In general Joana seemed very emotional when discussing the twins. For her they were her babies even if they were from egg donation and most importantly the loss of both in such dramatic ways was a very traumatic experience for her.

Maya

Aged 23; history of PCOS, IUI, IVF, PGT and miscarriage; childless; Ultra-Orthodox.

Maya says that Judaism is all she knows. She got married at the young age of 18. Maya never had regular periods and so she went to a Rabbi to try to understand what was happening to her. The Rabbi recommended them to go see a doctor. This was only 10 months into her marriage. At the clinic, Maya was put on Chlomid and she managed to get pregnant twice but unfortunately both times ended in a miscarriage. At this point, Maya and her husband decided that it is time for them to change clinic as they felt that at their original

clinic they were not understood and their desires to have children and the struggle that they were facing were not recognised. She was already married for two years and in her community, nobody waits that long to have children. Maya started seeing a different doctor who put her on IUI cycles that were unsuccessful and then she was recommended for IVF. Very recently she was diagnosed with PCOS and doctors are researching why she keeps having miscarriages. Maya already knows her next steps and these will be cycles of IVF which will include PGT. At the time of the interview Maya was getting ready to start another IVF treatment.

Jessica

Aged 53; history of IUI, IVF, ICSI and ectopic pregnancy; mother of two, one conceived via ICSI & second naturally; became a mother at 30; Orthodox.

Jessica is a single mum (divorced a few years after treatments) who believes that being Jewish forms the basis of who she is and gives her a moral code by which to live by. Jessica got married when she was 27 and she positively assumed that she would have had a baby by the age of 28, latest by her early 30s. After a few years of trying she started seeking help holistically. These treatments did not succeed so Jessica and her husband decided to seek medical help. Six years into trying to conceive they were recommended to start having IUI. The treatments were not successful. At the time, her marriage was fine. They were coping with struggle. After multiple IUIs they start trying IVF and ICSI. On her first egg collection they found that she had not produced any eggs. The second cycle which did result in some embryos was still unsuccessful. After that they had a cycle with frozen embryos but this was also unsuccessful. After a short break and a debate of perhaps continuing with adoption they decided to try one more time and she managed to get pregnant. It was a complicated pregnancy which appeared to have been twins; one ectopic and one in utero. Sadly, she had to have the ectopic pregnancy removed and with it went her fallopian tube nonetheless that was a fruitful pregnancy and resulted with a boy. Much to her surprise two years later she got pregnant naturally and delivered another healthy boy.

Sophie

Aged 50; history of IUI, IVF, egg donation, adoption & miscarriages; mother of one via adoption; became a mother at 36; Modern-Orthodox.

When she first got married she used to work in the city as a trader and both her and her husband were happy to travel around and live life. Three years after they were married they started trying to conceive but they were not successful so they decided to seek help from fertility specialists. They were recommended to start with IUI. These did not work. After all the IUIs it was decided that they should try IVF. They had a few treatments and all were unsuccessful. Sophie was still under the diagnosis of unexplained infertility. Sophie and her husband then decided to change clinic and try their luck somewhere else. Nevertheless, changing clinic did not change their luck as treatments at this clinic were also unsuccessful. Throughout the years, Sophie recalls that both her and her husband became closer to religion and they felt that the overall experience brought them closer to God. Sophie recalls having had a total of 14 IVF cycles and seven IUIs; none successful. This notion led her and her husband towards adoption as they both very much wanted to become parents. After a two years wait they almost confirmed one adoption but that plan fell through when the biological parents of the child backed out of their decision. A year later they did manage to adopt a baby girl from the USA. A few years went by and Sophie and her husband started to think of restarting treatment as in their community having just one child was not readily accepted. Sophie was already 40 years old so egg donation would be perfect. This treatment did result in a pregnancy which unfortunately she miscarried. At this point life seemed very bleak for Sophie and she really felt that God was punishing her and laughing at her misery.

Andrea

Aged 46; history of IVF and ICSI; mother of two via IVF & ICSI; became a mother at 32; Modern-Orthodox.

When Andrea got married she was not entirely Orthodox and she became more religious in order to be able to please her husband as he was more

religious and stricter in terms of Jewish law. She did not want to get pregnant straight away after getting married so both her and her husband went to their Rabbi and asked for help with contraception. Fast-forward three to four years later the pressure from the community she lives in increased and everyone around her was having children non-stop. This increased her desire to be a mother and so her infertility journey started. These feelings were not helped by the fact that Andrea is a midwife. Her husband already had a child from his previous marriage so for him this was not a big deal. When they started having tests done to try to understand their infertility, it was found that her husband had no motile sperm, which was pretty strange as he had already been a father. Andrea had a cycle of ICSI that was unsuccessful and this very much impacted her. It was also hard on as her husband's son was living with them and he constantly spoke about his other siblings from his mother's side. This was hard on Andrea emotionally, physically and psychologically. Andrea then had a few other frozen cycles and these were unsuccessful too. She did not give up and kept having cycle after cycle. Finally she managed to get pregnant and gave birth to a girl through ICSI with her husband's sperm. After this girl was born she was eager to get back on to trying as she felt that having one child only opened her appetite for more children. She succeeded again with a frozen cycle. She wanted to keep trying to conceive but physically she just could not. Andrea was very sick and it seemed that her body was sending her a message that she should not try anymore. Nevertheless, she wanted a third child. Her husband now thought this was not a good idea so he suggested they speak to a Rabbi to see what to do. The Rabbi advised them not to have any more treatments. Much to her despair this is what Andrea and her husband then did.

Ruth

Aged 32; history of multiple miscarriages; mother of three, one naturally conceived & twins via PGT; became a mother at 25; Modern-Orthodox.

As soon as she got married both her and her husband decided that they wanted to wait before having children. When they did decide to start trying, they got pregnant straight away but she had a miscarriage on the 14th week.

After that she got pregnant again and this time she managed to have a girl. Ruth waited a year before trying again for a second baby. She then got pregnant for the third time but again the same occurred and she had a miscarried at 12 weeks because the baby did not have a heart-beat. She then had a few pregnancies and they all ended in miscarriages. The doctors decided that it was time to analyse the foetus and see why this was happening so often. The test result showed that the foetus had a chromosomal anomaly. Both her and her husband were then tested and it was found that her husband had a chromosomal translocation. She was recommended to have PGT and with this help she managed to have twins.