

Judaism and women's health

Edith Weisberg, Ian Kern

Jewish law

Jewish law consists of two sections: written law and oral law. The foundation of the written law and the origin of its authority is the Torah, the first five books of the Bible. The Torah is traditionally believed to have been given in a theophany on Mount Sinai and to contain the literal direct word of God. After the destruction of the Second Temple, the Pharisees or rabbis promulgated the concept that at the same time as the Torah was given in writing an oral tradition was also given to Moses and this was handed down and eventually written in the Talmud. The oral law is the repository of commentaries on the Bible and the Talmud that continue to be made even to the present day. The oral laws interpret, expand and elucidate the written Torah and regulate new rules and customs according to changing conditions.

Rabbis are teachers, not priests, and can only give advice or rule on matters of law. They cannot give dispensation. The ultimate responsibility in ethical matters rests with the individual. Individual rabbis often give different interpretations so that people can choose to consult a rabbi whose views may be more in keeping with their own.

Post-Napoleonic Europe and the European Enlightenment brought about an emancipation of Jews from the ghettos and schisms in the practice of Judaism. The 19th century gave birth to Reform Judaism, particularly in Germany, which stressed the ethical principles of Judaism and not its rituals. This was in juxtaposition to Ultra-Orthodox Judaism, which was more stringent in its practices and beliefs. In between, a Modern Orthodox movement took into account secular studies and incorporated modern lifestyles while sticking to the authority of the Jewish law. These different denominations of Judaism exist at the present time. The Ultra-Orthodox adhere strictly to the letter of the law, the Modern Orthodox keep the law but take into account and participate in modern scientific scholarship. The Reform Orthodox retain many of the values and ethics of Judaism and observe some of the practices but not usually the laws relating to menstruation or procreation. There are also Secular Jews, who identify with the Jewish community and Jewish culture and may keep some of the traditions such as Passover and lighting candles on Friday night but do not adhere to any of the laws. Finally, nowadays there is a substantial group of non-observant Modern Orthodox Jews, who are affiliated with an Orthodox community, but are less stringent in their practices.

Family planning

The differences in these groups can be seen in their attitude to the biblical injunction to "be fruitful and multiply"

J Fam Plann Reprod Health Care 2009; **35**(1): 53–55
(Accepted 28 November 2008)

Sydney Centre for Reproductive Health Research, Family Planning NSW, Sydney, Australia

Edith Weisberg, MBBS, FRANZCOG ad eundem, *Director of Research*

Prince of Wales Hospital, Sydney, Australia

Ian Kern, FRCS, FRACS, *Consultant Emeritus*

Correspondence to: Dr Edith Weisberg, Family Planning NSW, Research Department, 328–336 Liverpool Road, Ashfield, Sydney, NSW 2131, Australia. E-mail: edithw@fpnsw.org.au

Summary points

- **Uterine bleeding** During and for 7 days after any instance of uterine bleeding, orthodox women abstain from sexual intercourse.
- **Contraception** Male condoms and vasectomy are not allowed. Hormonal contraceptive methods are the most acceptable followed by diaphragms. Methods that cause irregular bleeding may be unacceptable because of the requirement for 7 days' sexual abstinence following uterine bleeding. Reversible methods are preferred.
- **Abortion** Jewish law distinguishes between (at least) three phases in fetal development: (1) up to 40 days (the embryo is considered to be "water" and so emergency contraception may be permitted by orthodox rabbis); (2) from 40 days until delivery (abortion would not be murder but rather ending a potential life and would be restricted to cases in which the mother's health was threatened) and (3) once the head is delivered (the infant is considered to be a full human being).

(Genesis 1:28), implying a continuation of creation and a purpose in life. Although the accepted minimum is to have at least one boy and one girl, the Ultra-Orthodox continue to procreate to make sure they have fulfilled the commandment, whilst the Modern Orthodox feel they have fulfilled the commandment if they have at least one child of each sex, and the Reform Orthodox note the continuation of the verse "and fill the earth" to argue that now that the earth is full there is no obligation to have children.

In Judaism sex is not considered shameful or sinful but is regarded as a blessing from God to be enjoyed by both males and females and not merely as a means for procreation. Sex is permissible only within the context of marriage as its primary purpose is to reinforce the love and bonding between the couple. Sex is the woman's right not the man's, and is one of the three basic rights women have in marriage. The other two are food and clothing. A man has a duty to make love to his wife but cannot force her to have sex, use manipulation or withhold sex as punishment. The code of ethics states that a man must first satisfy his wife sexually before himself. Equally the woman may not withhold sex as a punishment for her husband. The general view is that any sexual act is permissible as long as it does not involve ejaculation outside of the vagina. Some passages in the Talmud encourage foreplay to enhance arousal for the woman.

Laws regarding menstruation

Menstrual laws are derived from Leviticus in passages that were concerned with ritual purity, in particular in relation to temple practices. The woman is said to be in a state of *niddah* ('set apart') but only in regard to physical contact with her husband, not other members of her family. A state of *niddah* applies to any bleeding of uterine origin including that occurring following childbirth. It does not apply if the bleeding originates from the vagina or cervix as in atrophic vaginitis or a cervical ectropion.

The minimum period of *niddah* resulting from menstruation is 12 days for Ashkenazi Jews (those from Eastern Europe) and 11 days for Sephardi Jews (those from Spain, North Africa or the Middle East) since the rabbis regarded a normal menses as lasting 5 (or at least 4) days, followed by 7 days of abstinence. Very observant women also refrain from intercourse for 12 hours prior to the

expected onset of menses and check for blood by self-examination to ensure intercourse does not occur in the presence of blood that has not yet been expelled from the vagina. During *niddah* husband and wife have no physical contact and cannot sleep in the same bed, see each other naked or touch any object at the same time (e.g. the wife cannot hand her husband a plate of food but must place it in front of him). At the end of menstruation the woman must determine that all bleeding has ceased by internal self-examination. Once there are no traces of blood the woman counts 7 days before going to the *mikvah*, a ritual bath of fresh water. Following immersion at the *mikvah*, the period of *niddah* is over and intercourse is resumed. In women with regular cycles of 28–31 days, this means that intercourse occurs at the most fertile time of the cycle, thus promoting procreation. In women with short cycles and long periods, conception is difficult because they are still *niddah* at the time of ovulation.

The rabbis point out that abstinence for 2 weeks gives couples an opportunity to build up a strong non-sexual bond and increases the couples' sexual desire, making the sexual relationship more special. Both Ultra-Orthodox and Modern Orthodox Jews follow this practice whereas Reform Jews usually do not.

Abnormal bleeding outside the menstrual cycle requires 7 days of no contact and then a visit to the ritual bath before intercourse can resume. Consequently even the most clinically insignificant vaginal bleeding may result in a request for a vaginal examination to determine the origin of the blood as such bleeding can be very disturbing to the couple and their intimate relationship.

Assisted conception

Jewish law prohibits male masturbation based on Onan's sin, in practising coitus interruptus to avoid fathering a child with his brother's widow (Genesis 38:8–10). This applies to all practices that result in ejaculation outside the vagina. However, it is permissible, and indeed could be seen as obligatory, for the purpose of artificial insemination or *in vitro* fertilisation as these create life (though the preferred method in these circumstances is collection of semen from a condom after vaginal intercourse). A very important tenet in Judaism is to have children. Embryo research and therapeutic cloning are regarded by most authorities as permissible since the soul has not yet entered the embryo and such research may produce life-saving treatments.

There are no pronouncements on female masturbation as this does not result in "spilling of the seed". However, some authorities would place female masturbation under the taboo of "impure thoughts".

Contraception

Contraception is permitted by all levels of Judaism if there is a threat to the mother's health. In Ultra-Orthodox families this would be the only acceptable reason to use contraception. Modern Orthodox couples are often prepared to use contraception if they have at least one child of each sex. Contraception for social reasons would be accepted by Reform Jews.

All current methods of male contraception are prohibited not only because of the imperative to have children (which is considered to apply to males not females), but also because coitus interruptus and condoms are forbidden due to wasting seed, and vasectomy is unacceptable (because it is viewed as a mutilation of the body created in the image of God). Some authorities permit the use of a condom to protect an HIV-negative partner in a non-concordant couple as this would protect life.

Female methods of contraception are generally more acceptable. The combined oral contraceptive pill is the method of choice but implants, injections, rings and patches would also be acceptable. Progestogen-only methods such as Implanon[®], which inhibits ovulation, are acceptable but can be problematic if the woman develops frequent or prolonged bleeding or nuisance spotting, as any sexual contact is prohibited during even the slightest spotting episode. In cases of unscheduled bleeding the woman must be free of even the slightest spotting for 7 days and then attend the ritual bath before intercourse can occur. If no other method is suitable the woman can consult her rabbi for advice regarding whether bleeding caused by an intrauterine device (IUD) requires 7 blood-free days.

Older women may prefer diaphragms and spermicides, both of which are permitted by most authorities (because they do not prevent the sperm from entering the vaginal canal). IUDs are problematic as some rabbis consider that they work by inducing an abortion. However, couples with different levels of orthodoxy may well accept some of these methods of contraception, especially if the pill is contraindicated for health reasons. An Orthodox couple contemplating contraception may consult with their rabbi before making a final decision. It is important that couples are given accurate information about the mode of action of different contraceptive methods so that they can decide, if necessary with the help of their rabbi, which method is acceptable.

Other procedures producing even the slightest bleeding, such as taking a cervical smear, may result in an Orthodox woman asking detailed questions of the provider to ensure that the bleeding is not of uterine origin. Indeed they may wish to take the Cytobrush[®] to the rabbi to obtain his view on the origin of the blood. Even the slightest amount of bleeding of uterine origin will necessitate abstinence from contact with her husband for 7 days and a visit to the ritual bath before relations can be resumed. Therefore in planning a gynaecological investigation or procedure that may result in uterine bleeding, however slight (e.g. hysteroscopy), it is advisable, if possible, to schedule the procedure just prior to menstruation to avoid excessive abstinence.

Traditional Jewish law also prohibits the sterilisation of a male, whether by vasectomy or with drugs, based on the biblical verse: "No one whose testes are crushed or whose member is cut off shall be admitted into the congregation of the Lord" (Deuteronomy 23:2). Sterilisation for women is permitted to preserve the health of the mother when further pregnancies would compromise it and no other method is suitable.

Abortion

Similarly abortion is accepted if the mother's health, which includes mental health, is threatened (though in the case of Ultra-Orthodox women it would need to be a threat to the mother's life). What is debated hotly is abortion for social and fetal reasons, and again this would depend on which brand of Judaism is followed. Although the fetus has value as a potential life, it is considered to be "a drop of water" until 40 days of gestation and is not considered a complete human being until the head or greater part of the body is delivered. Until this point the fetus can be sacrificed to save the life of the mother but once it achieves personhood neither the child nor the mother can be killed to save the life of the other. No Orthodox Jewish woman would undergo an abortion without first discussing the issue with her rabbi.

Abortions are not automatically permitted on the grounds of genetic or congenital abnormalities. However,

some rabbis may permit abortion where it is shown that the mother would suffer extreme mental distress from the birth of an abnormal child. Usually abortion is not permitted to prevent suffering of a child with a genetic or congenital abnormality, and prenatal screening is discouraged as it may lead to abortion. However, pre-implantation genetic testing is considered acceptable and would be the method of choice where the couple is known to have a mutation. Some rabbis may permit abortion until the end of the second trimester for a fetus suffering from a fatal condition such as Tay-Sachs disease, a genetic defect with a high prevalence amongst Ashkenazi Jews. Rape and incest can be grounds for an abortion if continuing the pregnancy would cause such distress to the mother that it endangers her health.

Whilst the legal penalties for unwarranted abortion differ depending on the age of the fetus, ethically and legally unnecessary abortion is wrong at any stage of gestation.

Conclusions

In the area of women's health it is important that health professionals treating Jewish women are aware of the important facets of Jewish law regarding sexuality and

reproduction. However, they also need to be aware of the different streams of Judaism to which women belong, and their adherence to these practices, in order to provide appropriate advice and treatment.

Statements on funding and competing interests

Funding None identified.

Competing interests None identified.

Further reading

- 1 Chertok IR, Zimmerman DR. Contraceptive considerations for breastfeeding women within Jewish law. *Int Breastfeed J* 2007; 2: 1. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1779768#B16> [Accessed 2 November 2008].
- 2 Rabbi Solomon Ganzfried (translated by Hyman E. Goldin). *The Kitzur Shulchan Aruch (Code of Jewish Law)*. New York, NY: Hebrew Publishing Company, 1961.
- 3 Rachel Biale. *Women and Jewish Law: The Essential Texts, Their History, and Their Relevance for Today*. New York, NY: Schocken Books (Random House), 1995.
- 4 Rabbi Shmuley Boteach. *Kosher Sex: A Recipe for Passion and Intimacy*. New York, NY: Main Street Books (Random House), 2000.
- 5 Nishmat – The Jerusalem Centre for Advanced Torah Study for Women. *Women's Health and Halacha*. <http://www.yoetzet.org/about.php> [Accessed 2 November 2008].
- 6 Judaism 101. Kosher sex. <http://jewfaq.org/sex.htm> [Accessed 2 November 2008].

NEWS ROUNDUP

Alcohol advice crucial in teenage sex education

Alcohol and attitudes are two of the key factors that health professionals need to be aware of when they are dealing with sexually active teenagers. Researchers from the University of Sheffield, UK found considerable differences between the way that boys and girls aged 14–16 years viewed a series of sexual scenarios – a girl and a boy both reluctant to have sex, a girl who had had a number of partners and a girl who felt pressured to have sex because her friends had paired off with two boys leaving her with a third.¹ “The girls who took part in our focus groups were more likely to see their partner's point of view and were more aware of the complex nature of relationships than the boys”, says nurse researcher, Dr Mark Hayter. Focus groups were held with 35 teenagers who had accessed nurse-led sexual health outreach clinics for contraception. These clinics are often held in conjunction with youth clubs in areas where teenage pregnancy rates are high. “Providing information and contraception is only one element of promoting sexual health. When it comes to female clients, nurses should develop interventions that can strengthen self-esteem and teach young girls how to respond positively to the social pressures they face around sex. It would also be helpful to encourage young male clients to empathise with their female partners. Last, but definitely not least, clinics need to treat alcohol use by their clients as a higher priority, integrating advice and help about harmful drinking into their sexual health promotion work.”

Reference

- 1 Hayter M, Harrison C. Gendered attitudes towards sexual relationships among adolescents attending nurse led sexual health clinics in England: a qualitative study. *J Clin Nurs* 2008; 17: 2963–2971.

Women of distinction

The Royal Mail has issued a set of special stamps featuring women of distinction, who have all taken on the establishment and won. These include Marie Stopes who opened her first clinic in 1921 and pioneered modern methods of birth control. Her work continues in 38 countries around the world through the Marie Stopes International charity. Elizabeth Garrett Anderson became the first woman to qualify as a doctor, founding the Elizabeth Garrett Anderson Hospital for Women. Her sister, Millicent Garrett Fawcett, was a tireless campaigner for women's rights, and

as President of the National Union of Women's Suffrage Societies was instrumental in securing the right for women to vote. Eleanor Rathbone campaigned for Family Allowances and was elected as a Member of Parliament (MP) in 1929. A year before her death in 1946 she saw them introduced. Claudia Jones campaigned for the rights of the black community in the UK and her lasting legacy is undoubtedly the Notting Hill Carnival, which she helped launch in 1959. Labour MP Barbara Castle spent a lifetime fighting for social causes; key among these was the 1970 Equal Pay Act, which she oversaw.

Source: www.royalmail.com

Cheap condoms for a safer sex industry

Prostitutes and other women working in the sex industry still have to pay enormous costs to guarantee a safe working environment. Although HIV infections and sexually transmitted infections remain a great risk in their line of work, surveys show that 20% of prostitutes do not use a condom and for addicted prostitutes this rises to 40%. The Dutch Safe4now Foundation has launched a new European campaign to distribute cheap condoms for the sex industry. Condoms can be bought anonymously on their website (www.safe4now.eu) at 10 Euro for a package of 100 condoms. By launching this campaign the Foundation hopes to increase the use of condoms in the sex industry and reduce the spread of the HIV virus and/or venereal diseases.

Source: www.safe4now.eu

Danish study on HRT and heart attack risk

An observational study published online in the *European Heart Journal*¹ suggests that the type and mode of hormone replacement therapy (HRT) can affect the association between HRT and myocardial infarction. The study is the largest to look at the effects of HRT since the Women's Health Initiative trial was stopped early after finding that HRT increased the risk of women developing a range of conditions including breast cancer and thromboembolism. This study was of 698 098 healthy Danish women, aged 51–69 years, who were followed between 1995 and 2001. It found that overall there was no increased risk of heart attacks in current users of HRT compared to women who had never taken it.

However, in younger women (aged 51–54 years) who were taking HRT during the period of the study, the risk of heart attacks was increased by 24% compared with women who had never taken HRT, and in this group there was increased risk with longer duration of HRT use that was not seen in the older age groups. The study also found that the type of HRT and the way that the women took it made a difference to the risk of heart attacks. Continuous HRT (a continuous combination of estrogen and progesterone) carried a 35% increased risk of heart attacks compared with women who had never used HRT. But if HRT was taken on a cyclical basis (estrogen, followed by a combination of estrogen and progesterone) there was a tendency for these women to have a reduced risk of heart attacks compared to women who had never used HRT. This was also seen if tibolone, a synthetic hormone, was used. If the method of taking the estrogen was via a patch or gel on the skin or in the vagina, the risk of heart attack reduced by more than a third (38% and 44%, respectively).

Reference

- 1 Løkkegaard E, Andreassen AH, Jacobsen RK, Nielsen LH, Agger C, Lidegaard O. Hormone therapy and risk of myocardial infarction: a national register study. *Eur Heart J* 2008; 29: 2660–2668.

Public ignorance over teenage pregnancy rates

Sexual health charity Brook commissioned a poll of 1986 people to find out the public's perception of pregnancy rate amongst under-16s in England. The poll found that 95% of people overestimated the rate of under-16s getting pregnant each year. Just 5% were able to provide a close estimate of the teenage pregnancy rate, which is, in fact, less than 1%. Young people themselves thought that the rate was particularly high, with 23% of 15–24-year-olds thinking that the rate of under-16s getting pregnant each year is over 40% compared with 16% of people aged 25 years or over. 81% of respondents thought the rate had increased in the last 20 years, while it has actually decreased by 12.6% since 1998, the baseline for the Teenage Pregnancy Strategy.

Source: www.brook.org.uk

Reviewed by **Henrietta Hughes**, MRCGP, DFSRH General Practitioner, London, UK