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A comparison of Israeli Jewish and Arab women's birth perceptions

Ofra Halperin, RN, PhD (Senior Lecturer)[a,*], O. Sarid, PhD (Senior Lecturer)[b], J. Cwikel, PhD (Professor)[b]

[a] Emek Izrael College, Nursing Department, Israel
[b] Department of Social Work, Ben Gurion University of the Negev, Beer Sheva 84105, Israel

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ABSTRACT

Background: birth is a normal physiological process, but can also be experienced as a traumatic event. Israeli Jewish and Arab women share Israeli residency, citizenship, and universal access to the Israeli medical system. However, language, religion, values, customs, symbols, and lifestyle differ between the groups.
Objectives: to examine Israeli Arab and Jewish women's perceptions of their birth experience, and to assess the extent to which childbirth details and perceptions predict satisfaction with the birth experience and the extent of assessing the childbirth as traumatic.
Methods: this study was conducted in two post partum units of two major public hospitals in the northern part of Israel. The sample included 171 respondents, including 115 Jewish Israeli and 56 Arab Israeli women who gave birth to their first (33%) or second (67%) child. Respondents described their childbirth experiences using a self-report questionnaire 24–48 hours after childbirth.
Findings: the Arab women were much less likely to attend childbirth preparation classes than the Jewish women (5% versus 24%). Forty-three per cent of the respondents reported feeling helpless, and 68% reported feeling lack of control during childbirth. Twenty per cent of the women rated their childbirth experience as traumatic, a rate much lower than the rate of medical indicators of traumatic birth (39%). The rate of self-reported traumatic birth was significantly higher among the Arab women than among the Jewish women (32% versus 14%). A higher percentage of the Arab women reported being afraid during labour ($\chi^2=4.97$, $p<.05$), expressed fear for their newborn's safety ($\chi^2=12.44$, $p<.001$), and reported that the level of medical intervention was excessive in their opinion, as compared to the Jewish women ($\chi^2=5.09$, $p<.05$; $\chi^2=7.33$, $p<.01$). However, both the Arab and Jewish women reported similar numbers of medical interventions and levels of satisfaction with their medical treatment.
Conclusions: despite universal access to the Israeli health care system, Arab Israeli women use fewer perinatal medical resources and subjectively report more birth trauma than Jewish Israeli women. Yet, they give birth in the same hospitals with the same practitioners and report similarly high levels of satisfaction with the medical services. Taking into account the fact that perceptions of the birth experience differ between ethno-cultural groups will enable professionals to better tailor intervention and support throughout childbirth in order to increase satisfaction and minimise trauma from the experience.

Introduction and literature review

Israeli Jewish and Arab women share Israeli residency, citizenship and access to the Israeli medical system. However, language, religion, values, customs, symbols, and lifestyle differ between the two groups (Klug et al., 2009). Israel is not a melting-pot society, but rather more of a mosaic made up of different population groups coexisting within the framework of a single democratic state. As a multi-ethnic, multicultural, multireligious, and multilingual society, Israel has a high level of informal segregation patterns. Although groups are not separated by official policy, a number of different sectors within the society have chosen to lead a segregated lifestyle, maintaining their strong cultural, religious, ideological, and/or ethnic identity (Jabareen, 2006).

The vast majority of Arab Israelis have chosen to maintain their distinct identity and not assimilate. The community's separate existence is facilitated through the use of Arabic, Israel's second official language; a separate school system; literature, theatre, and mass media; and the maintenance of independent Muslim denominational court, which adjudicates matters of personal status. Although the development of inter-group relations between Israel's

* Correspondence to: Nursing Faculty, The Max Stern Academic College Emek-Yezreel, P.O. Box 105, Givat Ela 36570, Israel.
E-mail address: ofrah@yvc.ac.il (O. Halperin).

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Arabs and Jews has been hindered by deeply rooted differences in religion, values, and political beliefs, the future of the Israeli Arab sector is closely tied to that of the State of Israel. Although they coexist as two self-segregated communities, over the years Jewish and Arab Israelis have come to accept each other, acknowledging the uniqueness and aspirations of each community and participating in a growing number of joint endeavours (Bard and Berman, 2012).

Health indicators in Israel present a picture of poorer health along with lower socio-economic levels in the Arab population as compared with the Jewish population (Israel Center for Disease Control, 2005). For example, life expectancy in 2002 was about three years less for Arab Israelis than for their Jewish counterparts (Central Bureau of Statistics, 2004). In 1995, a National Health Insurance Law (NHIL) was enacted, providing health care services for all Israeli residents (Shvarts, 1998). The aim of the law was to provide equal health care services for all, with the expectation that adequate use would decrease the differences in health status between the two population groups in Israel. Arabs have a pattern of health care utilisation that is characteristic of lower socio-economic status (SES) groups, even after adjusting for levels of SES (Van Doorslaer et al., 2006). This pattern includes less use of specialist care, more use of family doctor care, and higher rates of hospitalisation. Other low-SES groups and minorities have been shown to have this pattern of health care utilisation (Schoen et al., 2000; Baron et al., 2004; Roos et al., 2005; Van Doorslaer et al., 2006), suggesting that factors associated with ethnicity beyond SES may be associated with health care utilisation. In the years since the founding of the State of Israel, the Israeli Arab community sector has made great strides in almost every area of development. For example, the median years of schooling of Arab Israelis rose markedly over a 35-year period (1961–1996) from 1.2 to 10.4 years (Reiter, 2009). For example, infant death rates per thousand live births decreased significantly during that same 35-year period (Reiter, 2008).

Research shows significant cultural differences between women of Arab origin and women of Jewish origin in childbirth rates and practices. The birth rate is 2.98 per 1000 among Jewish women and 3.51 per 1000 among Arab women (Israel Central Bureau of Statistics, 2011). Significant differences between Arab and Jewish women have been reported on participation in an antenatal course and in post-partum follow-up visits, which were higher among Jewish than Arab women (Klug et al., 2009). Arab women are usually accompanied to the delivery room by female relatives, whereas Jewish women are usually accompanied by their partners (Klug et al., 2009). Epidural anaesthesia prevalence is higher among Jewish women (Klug et al., 2009), though Arab women demonstrate more pain behaviours during childbirth (Lewando-Hundt et al., 2001; Klug et al., 2009). Several researchers have explained this behaviour by the lack of language proficiency in Hebrew, leading to the demonstration of pain symptoms as an effective way to attract attention and care without the use of language (Weisenberg and Capsi, 1989; Harrison, 1991; Sheiner et al., 1999). The expressed wish to breast feed is found to be higher among Arab women (Lewando-Hundt et al., 2001; Klug et al., 2009). Studies conducted in Israel show that Arab women reported a higher rate of breast feeding compared with Israeli Jewish women (The Ministry of Health, the State of Israel 2002; Chertok et al., 2004).

Cultural values serve as an important framework for understanding an individual's beliefs about major life events and transitions. Birth is considered a significant life event that is particularly affected by the cultural context (Homer et al., 2002; Cassar, 2006). Health beliefs regarding childbirth experiences preserve cultural values, help the pregnant woman define the significance of childbirth, and promote her ability to cope with the childbirth process, as well as the personal and health consequences (Roberts, 2002; Cassar, 2006). The way a woman in labour responds to the birthing experience is shaped and expressed through spiritual, religious, and cultural traditions (Callister et al., 1999; Cassar, 2006). When significant life events (such as the birth of a child) occur, personal religiosity may increase (Albrecht and Cornwall, 1998), possibly due to a greater sense of wellbeing, personal happiness, and life satisfaction (Callister et al., 1999). How a woman perceives her childbirth experience can influence her overall feeling of satisfaction, competency, and psychosocial well-being (Hardy, 2011).

For most women, the birth of a child is a key life transition, and when well supported by family and medical staff it can be described as a moment of satisfaction and reward (Nelson, 2003). There remain, however, a proportion of women who are deeply distressed following birth. Reports of distress are frequently linked with descriptions of complicated, negative, or traumatic birth experiences (Waldenström et al., 2004; Dahlen et al., 2010; Sarid et al., 2010). Sarid et al. (2010) found that 23% of women defined their first birth experiences as either negative or traumatic, and 32% of a community sample reported at least one such birth experience. This rate decreased in second to fourth childbirths. A first traumatic birth was a strong predictor of reporting subsequent traumatic childbirths. Traumatic births were associated with fears and anxieties during pregnancy, C-section, or vacuum childbirth, as well as a lack of persons who spoke their native language in their social networks.

Soet et al. (2003) suggested that up to 34% of women from the United Kingdom (UK) report their birth experience as traumatic. An Australian study showed similar results, finding that one in three women continued to experience traumatic related symptoms four to six weeks after a traumatic birth (Creedy et al., 2000). In research conducted among Israeli Jewish women, Sarid et al. (2010) showed that stressful life events associated with the reproductive cycle, such as fertility problems, abortions, and traumatic birth experiences, significantly contribute to the development of depressive and pain symptoms several years following the negative birth experiences. Traumatic childbirth was found to be a significant predictor of post-partum depression and a lower rate of breast feeding the infant (Segal-Engelchin et al., 2009).

In the scientific literature, there is no consistent definition of traumatic birth experiences and no systematic way to assess birth trauma. The terms birth trauma and traumatic birth experience are used synonymously. Beck and Watson (2008) define birth trauma as ‘actual or threatened injury or death to the mother or her baby’ (p. 229). Women may also perceive their birthing experience to be traumatic as a result of the intervention that was implemented during the birth process, the mode of birth (caesarean or vaginal), and the way in which women are treated by health care professionals (Beck and Watson, 2008). Women may have a seemingly normal birth, but feel traumatised by believing that their infant will die, feeling violated by intimate examinations, or perceiving hostile or negative attitudes of people around them (Elmir et al., 2010). Experiencing trauma during childbirth, irrespective of the development of posttraumatic stress disorder, can have a negative impact on the mother's psychological functioning and post partum adjustment (Soet et al., 2003).

Women recall their birth experiences over time, and the effect of the traumatic experience does not subside for many of them (Sarid et al., 2010). A traumatic birth experience can have a severe impact on women and their families. Women have reported negative effects on their relationship with their partner, including sexual dysfunction, disagreements, and blame for events of the birth, as well as a negative effect on the mother–infant attachment (Reynolds, 1997; Waldenström et al., 2004; Ayers et al., 2006). Women may have either avoidant or anxious attachments with their child (Ayers, 2004; Olde et al., 2006). In one study, nearly all